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INSURANCE POLICIES: AN ESSENTIAL RESOURCE

Continuing Education
for Illinois Insurance Professionals

INSURANCE POLICIES:
AN ESSENTIAL RESOURCE

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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.

"Insurance Policies: An Essential Resource" is intended to help financial professionals create comprehensive insurance strategies for the common entrepreneur. It explores several major forms of commercial insurance that an owner or risk manager might consider purchasing. Early chapters summarize the most essential and most common kinds of coverage. Later sections address commercial policies that might not always be necessary but should at least be considered by risk-averse businesses. More specifically, the order of major topics in the course material is as follows:

- Chapter 1 provides an overview of fair claims practices in all lines of insurance and explains possible roles for a producer during the settlement process.
- Chapter 2 is about property insurance, including coverage for buildings and coverage for personal property.
- Chapter 3 explains important concepts relating to liability insurance, including bodily injury, personal injury, contractual liability and defense costs.
- Chapter 4 looks at employee injuries and the insurance-related solutions to them, including workers compensation and employers liability insurance.
- Chapter 5 goes into detail regarding major topics in health insurance, including plan options for employer-sponsored groups.
- Chapter 6 summarizes the many facets of business interruption insurance, including coverage for lost income and coverage for extra expenses.
- Chapter 7 explores the positive aspects of group life insurance, including the potential for death benefits and tax savings.
- Chapter 8 briefs readers on commercial auto insurance, including coverage for businesses and coverage for employees.

Although the material as a whole is framed within the context of helping businesses, a significant amount of time is spent connecting commercial insurance to personal insurance. Students who are accustomed to assisting individuals and families will be able to see how the commercial versions of auto and life insurance, for example, are similar to or different from the versions they're familiar with.

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 businesses 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: FAIR CLAIMS PRACTICES

Insurance producers are taught to analyze people's needs, explain important policy provisions and engage in other ethical sales practices. But the well-intentioned efforts of an agent or broker at the front-end of an insurance transaction won't matter much if a policyholder ends up having a negative claims experience. Consumers who have just suffered a loss are unlikely to care how little they may have paid for coverage or how friendly an agent acted toward them when they purchased their policy. All they will want at that moment will be a quick, fair settlement from their insurance company.

Claimants who don't receive the kind of compensation they expect from their insurer are likely to take their business elsewhere. A survey released in 2016 by J.D. Power and Associates found that auto insurance claimants who reported low satisfaction with their insurer's claims process were seven times as likely to switch carriers than claimants who reported a high amount of satisfaction. The same survey also said lowly satisfied claimants were roughly 11 times less likely to recommend the insurer to others. Ultimately, negative claims experiences translate to low client retention and fewer referrals for salespeople.

As long as we assume a claimant is not engaging in fraud, it shouldn't be difficult to understand why a denied or held-up request for insurance money can provoke so much anger. An insurance policy is, after all, a contract between the entity paying for coverage and the company issuing it. The entity paying for coverage agrees to pay premiums on time and to not misrepresent material facts. In return, the company issuing the policy agrees to provide money after a loss in accordance with the policy's language. Rightly or wrongly, an insurer that denies a claim or waits a long time before paying it might appear to be breaching its contractual obligations to the consumer.

The Producer's Role in Claims

Although producers are paid mainly to market and sell insurance products, they may be called upon to assist with the handling of claims. In some cases, the producer might have direct involvement with a claim, including the ability to authorize small payments. At other times, the producer will have no authority to provide compensation but will be asked by a consumer to intervene in a claims dispute.

Producers who receive questions from claimants don't need to provide an opinion regarding whether a loss should be covered, but they should at least be able to provide a general explanation of what the claims process will entail. Once a claimant has been informed of what to expect, the producer can contact the adjuster assigned to the case and try to obtain some answers.

Producers should also keep in mind that the people who purchase insurance have invested some trust in them. Because they lack much insurance-related experience, typical consumers are likely to believe an agent or broker who oversells a positive policy feature and fails to mention contingencies or exclusions. For example, a first-time homeowner who is told she has replacement-cost coverage might not be aware that this kind of coverage, in and of itself, does not guarantee there will be enough money to completely rebuild a building. Similarly, she might not understand how losses from hurricanes might be

exempted from coverage on the basis of a flood exclusion. Unless she takes the time to carefully examine her policy (something consumers are not likely to do), she will only learn about these things if the person selling the insurance mentions them or if she actually experiences these kinds of losses.

Providing thorough and compassionate service during the claims process might not be enough to fully satisfy a confused policyholder, but it might reduce the producer's chances of being verbally attacked or even sued for allegedly poor disclosure.

The Claims Process

Because the claims process is designed to help policyholders receive the benefits they've been paying for, producers may find it helpful to explain ahead of time how the process works. At the very least, when an insurance policy is delivered to an insured, a producer can explain where information about claims can be found. Mentioning the process at that time might make it more likely that the insured will review those sections of the policy carefully and be more prepared if a loss ever arises.

Duties of the Insured

Consumers who experience a loss should report the situation to their insurance company as soon as possible. In most cases, this is accomplished by calling a toll-free number that is being staffed by customer service representatives. However, a policyholder who has a good relationship with an insurance agent or broker might turn to that particular producer first. An increasing number of companies are also letting their customers report claims online.

Once the loss is reported to the insurance company, the policyholder should receive a reference number for the claim and contact information for the insurer's claims department. Regardless of whether a loss is first reported to an agent, customer service representative or claims adjuster, the claimant should receive clear instructions regarding what to do next and what to expect. Providing detailed instructions to claimants as soon as possible is important because there are usually deadlines for submitting proof of a loss to the insurer.

The duties of the insured will depend in part on the nature of the insurance claim. A claim for a life insurance settlement might not be approved until the claimant has given the insurer a death certificate or other evidence of death. If the claim in question relates to casualty insurance, the insured might need to submit copies of any formal demands for money by third parties. For some health-related claims, including those for disability or workers compensation, a sick or injured person might need to consent to having his or her medical records examined by insurance representatives. Property insurance claimants will need to grant the insurer access to the damaged property and must take reasonable steps to keep the damage under control. These steps might include putting boards over broken windows or moving personal property away from a leaky ceiling.

The more information provided to the insurer at claim time, the faster the process will be. With this in mind, policyholders should be encouraged to keep good records long before they ever experience a loss. Detailed home inventories—whether written down or comprised of photographs—make it less likely that an insurance company will dispute ownership of damaged items. Meticulous accounting by business owners can minimize problems if a company ever needs to close due to a natural catastrophe and files a business interruption claim.

Careful recordkeeping should continue after the main loss has occurred and should include documentation of any loss-related expenses. For example, homeowners should keep receipts for hotel and restaurant bills if they have been displaced by a weather-related disaster. Extra expenses that businesses incur in order to begin operating soon after an interruption should be documented, too. Unless the homeowner or business is severely uninsured, reimbursement for at least some of these expenses is usually available.

The insurance policy itself will, of course, be another very important record during the claims process. In today's business world of comprehensive databases, a claimant who loses the policy or doesn't have the policy number readily available shouldn't experience major problems when reporting a loss. Still, the document can be an immeasurably helpful reference for someone who keeps it in a safe place. It may serve as a refresher to the claimant regarding his or her duties after a loss. And perhaps more importantly, it can help the claimant anticipate how a particular claim is likely to be treated by the insurance company.

Insurance Adjusters

After a claimant notifies the insurance company of a loss, the person's case will often be passed along to a specially trained "claims adjuster." A claims adjuster evaluates whether the loss should be covered at all and, if so, for how much. Good claims adjusters must have extensive knowledge of policy language, an up-to-date understanding of how value is measured, and an ability to make fair decisions in a reasonably quick amount of time. Adjusters can be involved in seemingly any kind of insurance, but they tend to be most commonly associated with property and casualty losses.

Adjusters can be classified by the kind of relationship they have with insurance companies. For instance, some adjusters are employees of a single insurance company. These adjusters may or may not need to be licensed, depending on the particulars of state law.

Adjusters known as "independent insurance adjusters" work on behalf of an independent "adjustment bureau" and are called into action when an insurance company either doesn't have enough of its own adjusters in an area or needs someone with special expertise. Many states require these adjusters to be licensed, but licensing rules are sometimes relaxed temporarily after a natural disaster.

Individuals known as "public adjusters" represent claimants during the claims process and do not work for or on behalf of an insurance company. Public adjusters typically must be licensed in their state of business and will earn a percentage of whatever settlement a claimant receives from the insurer.

An adjuster who is set to receive a percentage of a settlement might feel tempted to inflate loss estimates in order to make more money. Similarly, adjusters who receive bonuses from insurers might put pressure on themselves to keep the size of settlements down. Despite the loyalties adjusters might owe to insurers or claimants, they obviously shouldn't let compensation have an inappropriate influence on their valuations.

Communicating With Claimants

Insurance company representatives must communicate with claimants in a timely manner during various stages of the claims process. This duty, of course, includes paying valid claims soon after liability has been made clear to the insurer. It also exists in regard to returning messages left by claimants and making sure they receive the necessary paperwork to properly report a loss.

Even if the insurer's liability for a claim is uncertain, the claimant should be made aware of what's happening and the reason for it.

Many deadlines and other requirements for communicating with claimants are set by state law. Most states base the deadlines on model regulations created by the National Association of Insurance Commissioners (NAIC). The NAIC's Unfair Claims Settlement Practices Model Regulation is intended to apply to practically every insurance company and mentions the following deadlines and responsibilities:

- Within 10 days of receiving an inquiry from a claimant, the insurance company must respond.
- Within 10 days of being notified of a loss, the insurance company must provide necessary claim forms to the claimant.
- Within 30 days of being notified of a loss, the insurance company must complete its claim investigation.
- Within 15 days of receiving proof of loss forms from a first-party claimant (a claimant seeking coverage through his or her own policy), the insurance company must inform the claimant whether the claim has been approved or denied.

The model regulations provide some leeway when an insurer legitimately needs more time to make a claims decision. An insurer that can't easily determine its liability for a first-party claim can send the claimant an explanation within 15 days of receiving proof of loss forms instead of having to make a hasty decision. However, if the delay lasts another 45 days, a second notice with an explanation must be sent to the claimant.

Keep in mind, though, that the requirements mentioned here are merely model regulations. Each state has the authority to reject the NAIC's recommendations in their entirety or in part. Deadlines and other requirements tend to differ slightly from state to state.

Despite the importance of laws, obeying them right down to the letter won't guarantee a good relationship between an insurer and the public. Consider a situation in which a claimant has suffered a major loss and has contacted a claims adjuster or an insurance agent. If the adjuster or the agent assures the claimant that insurance money will be provided by a specific deadline, the claimant will treat this news like a promise. Even if there is a legally legitimate issue that delays payment beyond the provided deadline, the claimant may have a right to be angry and may complain. This sort of problem can easily be managed by not making promises that can't be guaranteed or by informing the claimant as soon as possible when promises need to be broken.

In cases where claims need to be delayed or denied, providing as much communication as possible is usually the best policy. In fact, claims rules in the United States typically say a notice of denial must include detailed information about the reason for the rejection. The required information for this type of notice includes references to the portion of the claimant's insurance policy on which the denial is based. First-party claimants who receive this notice and have kept a copy of their policy can then refer back to the whole document and determine whether their insurer is reading the contractual language fairly. Third-party claimants (such as an injured person making a claim against another driver's insurance) usually don't have the right to receive this specific information about other people's insurance policies.

Settling Disputes With Consumers

When consumers believe a claims decision is unfair or inappropriate, they often have the ability to appeal the decision through some kind of internal review board. A written explanation and other documents might need to be provided to the entity conducting the review. In many situations, this or another internal process is enough to settle the claim. In some cases, for example, the insurer might conclude that all or part of a claim was inappropriately handled because of a clerical error or an honest misunderstanding.

If disputes with an insurer can't be resolved internally, arbitration is another possibility. In arbitration, the carrier and the consumer both pay to have the matter settled by a third party. By engaging in arbitration, both sides agree to abide by whatever arrangement the arbitrator produces. In other cases, a similar process known as "mediation" will be followed, in which a third party will attempt to bring the two parties together but without the ability to force a resolution.

When disputes aren't settled through arbitration, mediation or internal reviews, consumers can file a complaint with their state's insurance department. A claimant might also take legal action in order to make sure that the contractual provisions of the insurance policy are enforced. In some jurisdictions, claimants can sue for bad faith and receive judgments beyond the amount of their insured losses. We'll go over this issue in greater detail later in this chapter.

Claims Issues in Specific Lines of Insurance

Many ethics-related claims issues touch professionals in all areas of insurance, but others are specific to certain products. Some concerns that are mainly relevant to particular corners of the business are addressed in the next several sections.

Property Insurance Claims

Small property insurance claims might be settled entirely through the sending and receiving of paperwork, but larger ones will require an onsite inspection by an adjuster. During an inspection, the adjuster might snap several photos and scribble several notes. Unless they are absolutely necessary, no repairs should be done until the inspector has viewed the damage.

Access to damaged property will be granted to the insurance company as part of the owner's policy. Consumers who deny access after a loss are in danger of not receiving the insurance money they might otherwise deserve. Still, the access required by the contract might not need to be unlimited. In fact, according to NAIC model regulations, insurers who deny claims because of a claimant's failure to provide access must prove the claimant was being unreasonable. Presumably, this could protect a claimant who denies access at a particular time for personal reasons but is very willing to reschedule.

Catastrophic Claims

A hurricane, tornado, terrorist attack or similarly major event can produce thousands of claims. Even if an insurance company pays a large percentage of them, the sheer number of claims makes it inevitable that a large number will be denied. Insurers who aren't proactive during the rebuilding of hard-hit communities will expose themselves to potentially unshakable public relations problems. Companies taking unreasonable positions toward claimants after a catastrophe are also at great risk of being named in a class-action lawsuit.

The importance of dealing with claims in as timely a manner as possible is at its greatest following a major or total loss. Dissatisfaction with an insurance company is certain to increase if a delay in the claims process means that a business can't re-

open its doors or that a family needs to remain in temporary housing.

Although insurers have the right and the obligation to ensure that money isn't provided to perpetrators of fraud, they should recognize that delays in providing legitimate compensation can ultimately lead to more losses. The sooner a family can start rebuilding their home, the less the insurer will have to pay for additional living expenses like hotel and restaurant bills. The quicker a business is able to get up and running with the help of insurance money, the smaller its business interruption claims will be.

One of the simplest yet most effective actions an insurer can take after a catastrophe is to be noticeably present in the affected area. These days, it's customary for companies to set up several mobile offices in damaged communities and bring in additional adjusters by the busload. In order to expedite claims processing, states will often loosen licensing requirements so that out-of-state adjusters can give quick service to residents.

Some ethics-based decisions might need to be made before adjusters arrive at a disaster area. Questions for managers and top-level insurance professionals to answer include the following:

- Should claims be processed on a first-come, first-served basis, or should a major loss take precedence over a comparatively minor one?
- Should grace periods be extended for disaster victims who are late in paying their premiums?
- How aggressively should the insurer enforce controversial exclusions, such as an anti-concurrent causation clause? (An anti-concurrent causation clause prevents a claim from being paid if damage was caused by both a covered peril and an excluded peril at the same time.)

The answers to those questions will need to be found very carefully, with attention paid to the concepts of fairness, good will and the insurer's financial stability.

Auto Insurance Claims

Disputes regarding auto insurance claims often involve replacement parts or the insurer's relationship with auto-related businesses. Arguments over replacement parts arise when an insurer initially offers to pay for parts that are inferior to what was originally in the vehicle. For example, the insurer might offer to pay for the poor-fitting part instead of the more appropriate part available through the vehicle's manufacturer. Some companies might not be totally opposed to replacing a part with a true replacement, but they might make the process difficult for the repair shop by requiring multiple approvals and inspections. The use of cheaper parts may save the insurer money in the short term, but it can lead to future losses if the cheaper part is truly inferior and breaks down.

Insurers may be accused of unethical behavior if they engage in a practice known as "steering" during the claims process. In the context of auto insurance, steering occurs when an insurance company refers claimants to other businesses with which it has a financial relationship. Examples of steering include cases where drivers are referred to body shops that will accept lower payments from the insurance company. A similar situation might occur in a rental scenario in which a claimant needing a replacement vehicle is referred to a rental company willing to take less money.

For many consumers, the ethical issues involved with steering relate to limited choices and potential conflicts of interest. Most claimants probably understand that an auto insurance company has well-established relationships with body shops and rental-car providers. As long as they receive good service at minimal or no cost, many claimants won't be opposed to working with an insurer's favored businesses. However, drivers who have a preference for a particular body shop or rental company shouldn't be misled into thinking they don't have other options.

In many states, it is illegal for an auto insurer to only cover repairs when they are completed at a favored shop. Even when insurers give the consumer the choice of going elsewhere, they shouldn't influence the claimant's decision by making potentially false statements. For example, it may be unethical (or even illegal) for the insurer to stress that repairs done by a different shop are unlikely to be completed properly or quickly.

Casualty Insurance Claims

Casualty insurance often calls on the insurer to cover the cost of defending the insured in a lawsuit. The insurer's duty to provide a defense is generally considered to be broader than its duty to pay for a settlement or court-awarded damages. In other words, unless it is already clear that the situation surrounding the claim is excluded from coverage, the insurance company is expected to pay for a defense. The insurer generally cannot refuse to defend an insured in a situation in which its liability is still uncertain.

Conflict often arises in casualty situations when the party taking legal action against the insured has proposed a settlement but the insured and the insurer can't agree about whether to provide it. In most of those cases, it is the insured who is hesitant and the insurer who wants to offer the settlement. A doctor being sued for malpractice, for instance, might not want to settle a case because a settlement is sometimes seen as an indirect admission of guilt.

But there have been instances in which the insurer has been the reluctant party and been convinced that a judge or jury will rule in the policyholder's favor. This stance must be analyzed with tremendous care. Again, suppose a doctor has been sued for malpractice. The plaintiff has offered a $500,000 settlement, but the doctor's insurer has rejected the offer because the case against the doctor seems frivolous. If the insurer misjudges the case and loses in court, the awarded damages are likely to be higher than the rejected $500,000 settlement and could even be greater than the doctor's insurance limits. In some cases like this one, courts have ordered casualty insurers to pay the entire amount of any judgments, including amounts beyond a policy's limit.

Third-Party Claimants

Casualty insurance claims might be made by the insured or by a "third-party claimant." A third-party claimant is a person or entity making a claim against somebody else's insurance. For example, a driver who is involved in an accident in which another driver was at fault might make a claim against the at-fault driver's insurance.

Situations involving third-party claimants can create ethics-related difficulties for insurers. If fault regarding an accident is in dispute, the insurance company might have to deal with a third party who wants his or her claim to be covered and a policyholder who wants the same claim to be denied. In auto insurance, for example, a third-party claimant who doesn't have collision coverage on his own vehicle might demand that another driver compensate him for property damage. At the same time, the

other driver might not believe she caused the accident and might worry that a successful claim against her insurance will boost her premiums.

Disputes with third-party claimants can be tricky, at least in part, due to contractual restrictions. As a reminder, the contractual relationship established through an insurance policy is generally between the insurance company and the policyholder. Since a third-party claimant lacks a contractual relationship with the policyholder's insurer, the third party might not be obligated to receive the same level of cooperation with the carrier. For example, although insurance companies often need to disclose which portion of a policy was used to deny a claim, this requirement typically doesn't apply to third-party claimants. In certain situations, the details of a policyholder's coverage might be privileged, and private information won't be disclosed to others without consent or unless state law specifically allows the sharing.

Still, the lack of a contractual relationship with a third-party claimant doesn't entirely excuse the insurer from certain requirements. In states where the NAIC's Unfair Claims Settlement Practices Model Regulation has been adopted, insurers might not be allowed to advise third-party claimants to make claims against their own insurance when the insurance company's customer is clearly the one at fault.. So, if it is reasonably clear that a homeowner suffered damage due to a neighbor's negligence, the neighbor's insurance might not be allowed to tell the homeowner to make a claim against his own insurance.

Options for dissatisfied third-party claimants differ from state to state. At the very least, a third-party claimant who is receiving unsatisfactory service from someone else's insurer can file a complaint with the state's insurance department. A minority of states let third-party claimants sue insurance companies for unfair claims practices.

Unclaimed Life Insurance

Life insurance claims tend to be significantly easier to settle than property or casualty insurance claims. Presumably, a lot of the relative ease involved with life insurance claims exists because the policies contain simple face values. Proof of death, such as a death certificate, makes it nearly certain that the insurance company will need to compensate a beneficiary, and the clearly defined face amount makes it obvious how much the compensation should be. Unless there is a dispute regarding a double-indemnity provision (in which the beneficiary may be entitled to double the death benefit if someone dies from an accident), there is usually little or no argument over the size of the settlement.

This assumes, of course, that the beneficiary is aware of the life insurance policy in the first place. Beneficiaries may be unaware of their right to life insurance benefits if they weren't closely involved in the deceased's finances or if the policy in question was purchased several years ago.

Traditionally, unclaimed life insurance benefits remained with the insurance company for at least a few years after a death. During that time, the insurance company was able to invest the money within reason and keep the resulting interest. At the end of this period, the money would usually be transferred to a state fund, and the state would earn interest on the death benefit until a beneficiary claimed it.

Critics of the life insurance industry sometimes wondered if the potential to earn interest on unclaimed death benefits discouraged companies from confirming deaths and contacting beneficiaries. Among other evidence, they cited cases in which insurers searched through death records from Social Security in order to cut off annuity payments but not to determine whether someone covered by life insurance had died.

In response to consumer concerns, the NAIC has created an online service for beneficiaries to locate possible death benefits owed to them. Upon receiving proof of death, the service will use industry databases to find applicable policies owned by the deceased. In addition, many states now require life insurance companies to conduct annual audits that identify policyholders who've passed away. In those states, the insurer might be required to contact beneficiaries by a certain deadline.

Regulation of Claims Practices

The options for consumers who believe an insurer hasn't handled claims fairly will depend on state law and related court decisions. However, the ability to file a complaint with a state insurance department exists across the country.

In accordance with the NAIC's Unfair Claims Settlement Model Regulation, insurance companies are expected to maintain detailed records. These records are meant to help the insurance department determine how a claim was handled and for what reasons. The model regulations also call for insurers to respond to inquiries from regulators as fully as possible and within 15 days of a request.

Some state insurance departments will only take disciplinary actions against an insurer for poor claims handling if they have received multiple complaints about the same carrier. If the department determines that an insurer's unfair response to a claim is a general business practice rather than an isolated incident, it may impose fines amounting to several thousands of dollars. Not all complaints will lead to fines, but even the threat of a state-conducted audit is sometimes enough to get a disputed claim paid.

The ability to take action against an insurer in a manner other than complaining to the insurance department can differ significantly by state. In general, policyholders have the right to sue the insurer for breach of contract, but this route has a few potential roadblocks to consider. For example, the amount awarded to the policyholder might be limited to the amount of the disputed claim. The party filing the lawsuit might not be allowed to receive compensation for punitive damages or pain and suffering. In cases where this kind of cap exists, a claimant might not be willing to take an insurer to court over a relatively small loss.

Third-party claimants—such as an accident victim making a claim against another driver's liability insurance—might not have the option of suing for breach of contract. After all, the contractual relationship established through an insurance policy is between the insurance company and the policyholder. In general, the contractual relationship isn't between the insurance company and someone who sues the policyholder.

Realizing how much a delayed or unpaid claim can impact consumers, several states have either written or interpreted unfair claims laws in a manner that lets policyholders seek damages beyond the contractually owed amount. Still, states don't always agree on the rights of third-party claimants in these situations. They also differ on whether a consumer needs to prove that the insurer acted unfairly as part of a general business practice as opposed to in a single, stand-alone incident.

Unfair Claims Settlement Practices

Claims-related penalties are more likely to be above and beyond the amount actually being disputed if the insurer is accused of an "unfair claims settlement practice." This kind of accusation can be made if an insurer unfairly denies a claim or in situations where the insurer makes a claimant wait an unreasonable amount of time before finally providing payment.

Many of the specific actions that rise to the level of an unfair claims settlement practice are set by state law or state rules. Several of the more commonly prohibited practices are mentioned in this section. Each mentioned practice is followed by a basic example:

- **Denying a claim without conducting an appropriate investigation:** Following a combination of an earthquake and a fire at his home, Joe files a property insurance claim. Joe has coverage for fire losses but not earthquake losses. Instead of sending an adjuster to determine how much each peril contributed to the damage, his insurance company denies his entire claim outright.
- **Failing to settle a claim when the insurer's liability is reasonably clear:** Wayne and Martina are involved in a car accident in separate vehicles. Although Wayne freely admits the accident was his fault, his insurance company delays compensating Martina for her losses and instructs its legal team to find a loophole in the policy so it can deny all claims.
- **Intentionally offering to settle for an amount below what the claimant actually deserves:** Laurie's home was broken into by robbers, who stole most of her personal possessions. She has kept good records of what she owned and was sure to purchase coverage that was in line with what her belongings were actually worth. However, her insurance company views the settlement process as a negotiation and decides to offer her a much smaller amount. (This practice is often referred to as "lowballing.")
- **Withholding money for a covered portion of a claim while disputing the rest of a claim:** Sandra's home was damaged by a hurricane. She and her insurer agree that at least a portion of her losses are covered. Coverage of her other losses are in dispute and depend on the wording of a flood exclusion. Rather than at least give her the money for the uncontested portion of her losses, her insurer decides to give her nothing until the flood-related dispute has been settled.
- **Requiring a deadline for providing proof of loss that isn't stated within the insurance policy:** Bengie was listed as a beneficiary on his father's life insurance policy. The policy wasn't discovered until nine months after the father's death. Although the policy lists no deadline for providing proof of a death, the insurance company denies Bengie's claim and says he should've provided a death certificate within six months of his father's passing.
- **Refusing to pay a claim because other sources of compensation may be possible:** George slips on a neighbor's steps and hurts his back. His health insurance company refuses to pay his medical bills because it holds the neighbor responsible for the accident. George's insurance policy makes no mention of this kind of situation, yet his insurer tells him he has no choice but to sue his neighbor.
- **Failing to make claimants aware of statutes of limitations:** Roberta has been fighting with her health insurance company over unpaid doctor bills for nearly two years. After those two years, she will not be allowed to take legal action against the insurer. The insurance company knows her deadline is approaching but doesn't disclose it in a timely manner. The deadline passes, and Roberta is left without the ability to have the matter settled in court.
- **Reducing or eliminating policy benefits in order to facilitate a quicker settlement:** Jasmine's home requires major repairs after a fire. The amount offered by the insurer won't be enough to restore the home to its prior condition. In order to convince Jasmine to accept this amount, the insurance company stops paying for the apartment where she and her family are temporarily residing.

Fraud and the Producer's Role

Some insurers believe an increasingly strict interpretation of claims laws might discourage adjusters from fighting fraud. If the cost of being sued is higher than the amount of a suspicious claim, it might make short-term economic sense to pay the claim and move on. The risk of an expensive lawsuit, along with the desire to avoid public relations disasters, creates an awkward situation for insurers. No matter what decision they make in regard to a claim that shouldn't be covered, the insurer's financial outlook may be damaged.

Whether they realize it or not, producers may have a few chances to reduce the stress felt by fraud-conscious adjusters. Since the producer is often the insurance representative who has had the most personal interactions with a consumer, the producer may be able to vouch for the person's character. Although a producer's positive opinion about a claimant might not be a good enough reason to abandon a fraud investigation, it may be one of many tools that can lead to a fair decision.

While meeting with applicants and noting their character, producers can explain and debunk many insurance myths. By reminding property insurance applicants that their policy won't cover losses from floods or earthquakes, producers reduce the chances of a flood-related or quake-related claim causing dissatisfaction. You can't force a consumer to read an insurance policy, but you can take time to judge the person's comprehension of the important points.

Finally, be aware that some states have passed laws to eliminate a producer's potential liability for reporting potential fraud in good faith. If you suspect fraud but are concerned about your legal liability in the event of being wrong, consult your carrier and/or a compliance expert in your community.

CHAPTER 2: INSURING COMMERCIAL PROPERTY

Running a business is difficult enough without having to worry about theft, accidents or natural disasters that could result in the loss of property. Good property insurance will not be able to stop those unfortunate events from occurring, but it can certainly help a business get back on its feet.

The most common kind of property insurance for businesses is based on contractual language from a document called the "Building and Personal Property Coverage Form." The form was created by the Insurance Services Office (ISO), a private company specializing in information about property and casualty insurance. This chapter contains explanations of the ISO form.

However, some companies use policy forms that are broader or more restrictive.

What Is Covered Property?

There are three basic kinds of covered property in commercial property insurance, with each one having its own dollar limit. These three are listed below and will be addressed one at a time in the next few sections:

- The business's building.
- The business's personal property.
- Personal property of others that is in the business's possession.

The Business's Building

The building is the place of business described on the policy's declarations page. Although we generally view buildings as singular structures, a "building" can mean any of the following things:

- The entire structure at a single address.
- Multiple structures described on the declarations page.
- A single unit in a multi-unit building.

Building coverage is for more than just walls, ceilings, windows and doors. It is broad enough to include additions the insured makes to the building and various fixtures, equipment and machinery that are permanently installed in the building. Depending on the carrier's interpretation of the term, "permanently installed property" might have any of the following definitions:

- Something merely attached to the building.
- Something that can't be removed without changing the building's structure.
- Something that was specifically listed in the real estate contract when the owner bought the building.

If a business rents space from a property owner, it might not be responsible for insuring the building. Tenants should review their leases carefully and discuss their insurance obligations with their landlord. Then they should determine what additional insurance ought to be purchased for their own protection.

The Business's Personal Property

Coverage for a business's personal property generally applies to any item inside the insured building or within 100 feet of the premises. More specifically, the typical policy states that the following items are insured:

- Office furniture and fixtures.
- Machinery and equipment used to conduct business.
- Property the insured owns and uses for business purposes.
- Outdoor signs (valued up to $2,500).
- If the insured is a tenant, any improvements the insured has made to the building that were not paid for by the owner.
- Leased property that the business agrees to insure.
- Improvements made to other people's property, such as replacement parts that are installed by the business.

Stock could also be part of the previous list. In regard to the Building and Personal Property Coverage Form, "stock" can be defined as follows:

- Items currently being sold by the business.
- Items the business plans on selling but is keeping in storage.
- Items the business is in the process of producing.
- Any raw materials the business uses to make its products.

Businesses are also covered for the materials they use to ship their stock, including padded envelopes and crates.

Property of Others

Commercial property insurance can cover other people's property while it is in the business's possession. For this kind of property to be covered under the Building and Personal Property Coverage Form, it must be either inside the insured building or within 100 feet of the building. If the property is outside the building, it can be either out in the open or in a vehicle.

The insurance for property of others is explained in an early portion of the Building and Personal Property Coverage Form and typically has its own dollar limit, as chosen by the business. It can be capped at any amount and is designed for businesses that commonly keep customers' property on their premises.

Alternatively, if a business doesn't normally take possession of other people's property and doesn't want to spend extra money to manage a comparatively small risk, it may be able to apply a small amount of its own personal property coverage to "personal effects" and "property of others." This option is available at no additional expense and reimburses the policyholder and various employees when their personal items are lost or damaged at the business premises. The coverage also applies to the property of others that is in the business's care. However, items pertaining to this optional, extended insurance are only covered for up to $2,500 at each premises.

Due to complex limits and restrictions on property of others (such as the requirement that the property be inside or within 100 feet of the premises), many businesses that routinely take possession of customers' property, including dry cleaners and repair shops, often go a step further and purchase an alternative type of property coverage known as "bailee insurance." This insurance might have higher limits and allow for broader protection, such as for losses that occur while customer property is in transit.

Replacement Cost v. Actual Cash Value

Property can be insured for either its "replacement cost" or its "actual cash value." A business that does not understand the difference between the two may be in for some unpleasant surprises after a loss.

Property's "replacement cost" is the amount it would take to rebuild or replace the property without taking depreciation into account. If the property is to be replaced, the replacement property and the old property must be of like kind and quality. When a building is to be replaced at its replacement cost, the new building and the old one might not need to be identical in every little way. However, the essential features must be the same.

An item's "actual cash value" is its replacement cost minus depreciation. The actual cash value may be determined by taking the replacement cost and multiplying it by the remaining amount of time the item would otherwise be expected to last. For the purpose of an example, pretend a new computer costs $800 and is expected to last 10 years. If the insured has owned a similar computer for five years (50 percent of 10 years) and loses it in a fire, the insurer might calculate the item's replacement cost as $400 ($800 multiplied by 50 percent).

By default, many kinds of commercial property (such as the business's personal property and the property of others) will only be covered up to their actual cash value. Replacement-cost insurance can be included for an additional price. Annual adjustments for inflation are also available.

Covered Perils

Along with choosing how much insurance to buy, a business needs to decide which "perils" or causes of loss should be covered. There are usually three options to choose from.

The most basic kind of property insurance will typically cover businesses against losses caused by the following perils:

- Fire.
- Lightning.
- Explosion.
- Windstorm or hail.
- Smoke.
- Aircraft or vehicles.
- Riot or civil commotion.
- Sinkhole collapse.
- Volcanic action.
- Vandalism.
- Sprinkler leakage.

An intermediate form of property insurance will also help pay for losses caused by four additional perils:

- Falling objects.
- Weight of snow, ice or sleet.
- Accidental discharge of water or steam (from a system or appliance).
- Sudden collapse.

Most businesses go a step further and purchase all-risk property insurance. This covers them against all perils other than those specifically excluded in their policy.

Excluded Perils

Even insurers offering all-risk commercial property insurance will exclude some perils from their policies. The next several sections address those commonly excluded risks. Businesses concerned about excluded losses might want to purchase another type of insurance.

Water Damage

Other than sprinkler leakage, the Building and Personal Property Coverage Form is generally not designed to cover water damage. This includes losses linked to any of the following causes:

- Floods.
- Waves.
- Mudslides.
- Seepage.
- Sewer backups.

Earth Movement

Significant kinds of earth movement can include earthquakes, landslides, volcanic eruptions and sinking. Separate insurance is necessary if a business is concerned about earth movement. However, a business can choose to insure against sinkhole collapse and volcanic action. Fire damage remains covered even if the fire is caused by earth movement.

Pollutants

Standard kinds of commercial property insurance do not cover pollution losses, other than the cost of cleanup. Furthermore, the cleanup is only covered when it results from a covered peril. Some substances that might qualify as pollutants are listed below:

- Smoke.
- Soot.
- Fumes.
- Acids.
- Chemicals.
- Waste (including waste being held for recycling).

The most the insurer will pay for cleanup of pollutants is often $10,000 per year. This is additional insurance and has no impact on the insurer's other limits of liability. To have a claim for cleanup covered, the business must report any cleanup expenses to the insurer within 180 days of the triggering loss.

Power Failures and Surges

Businesses receive no insurance benefits when a power failure can be traced back to problems at a utility company. There is also no coverage when artificial current does damage to personal property.

In general, some coverage remains intact when a power failure or power surge causes damage from a covered peril. In other words, if a business experiences a power surge, computers damaged by that surge will not be covered. But if that surge were to cause a fire, the business would still be covered for fire losses.

Theft

Losses from theft can often only be covered through all-risk insurance or crime insurance. If a business rejects both of those options and a burglary occurs, the insurer might only pay for repairs to the building. Replacing any stolen items will probably be the business's responsibility. Even if theft is a covered peril, the business will likely need to file a police report in order for the claim to be approved by the insurer.

Coinsurance

Most forms of commercial property insurance have "coinsurance requirements." A coinsurance requirement usually states that if property is not covered up to a certain percentage of its actual cash value (or, in some cases, its replacement cost), the insurance company will not fully compensate the business for a

loss. Instead, the insurer will pay a prorated amount based on how close the business was to meeting its coinsurance requirement. This includes scenarios in which only a portion of covered property is damaged.

Even for insurance veterans, coinsurance requirements can be confusing. Let's look at a few examples of how the requirements might affect a business. In all examples, let's assume there is an 80 percent coinsurance requirement.

A business owner purchased insurance that covers his property for up to $80,000. After a fire, it was determined that his property was actually worth $100,000. Since the policy limit ($80,000) was equal to 80 percent of the property's value ($100,000 × 80% = $80,000), the owner met his coinsurance requirement and his entire claim will be paid.

Another business owner purchased insurance in the amount of $90,000. After a windstorm damaged the business's roof, it was determined that the value of covered property was actually $100,000. Since the amount of coverage ($90,000) was greater than 80 percent of the property's value ($100,000 × 80% = $80,000), the owner met her coinsurance requirement and had her claim paid.

A third business owner purchased insurance in the amount of $60,000. After a major hailstorm, it was determined that the value of his property was $100,000. Since the amount of insurance ($60,000) was less than 80 percent of the property's value ($100,000 × 80% = $80,000), the business did not meet its coinsurance requirement and was only covered for a portion of its losses.

Conclusion

In printed form, a commercial property policy can amount to less than 30 pages. But each of those pages contains a significant amount of important information. Even if agents don't deal with it specifically on a daily basis, the Building and Personal Property Coverage Form can help them recognize various commercial risks. By applying their knowledge of risks to a business's specific situation, agents are more likely to keep policyholders satisfied and well-protected.

CHAPTER 3: COMMERCIAL LIABILITY

The most ethical business owners can still be kept up at night by fears of major lawsuits. Visitors to offices might slip on a wet floor. Purchasers of a product might become ill or injured while trying to use it. A traveling salesperson might knock down a fragile heirloom at a prospect's home. Even if a court determines that a business isn't responsible for these accidents, the cost of a good defense can be high.

Commercial liability insurance is beneficial both to businesses and their customers. Entrepreneurs who know they're at least partially protected against major mishaps are more likely to start new companies or offer new services. When members of the public are injured or suffer a property loss due to a company's negligence, insurance makes it easier to receive fair compensation.

Many common risks for businesses are managed through the purchase of "commercial general liability insurance." The insurance is relatively broad in scope and was designed to be adaptable for a wide variety of policyholders. Entities that provide services, build property or manufacture goods are all likely to either have it or need it in some form.

In today's market, commercial general liability insurance makes carriers responsible for covering losses related to property damage, bodily injury, medical payments, personal injury and advertising injury. The coverage, which will be described in greater detail over the next several pages, might be purchased independently of other insurance or as part of a multi-layered insurance package.

Commercial general liability insurance was introduced in the 1940s and was originally known as "comprehensive general liability insurance." With insurers adding more and more exclusions to their policies, the industry eventually decided the word "comprehensive" was too misleading. The name change and several other modifications were made in the 1986 edition of the standard coverage form, which was written and issued by the Insurance Services Office (ISO).

Most commercial general liability insurance policies are based in large part on ISO language. However, it would be incorrect to assume this insurance is essentially the same for everyone who buys it. Significant additional limits on coverage may be mandatory for certain kinds of businesses or for every applicant who wants insurance from a particular carrier. Some exclusions might be added at the policyholder's request as a way of lowering premiums, and others might even be deleted when the insured agrees to pay more. So although this chapter explains the basics of commercial general liability insurance, it shouldn't be used as a substitute for thorough knowledge of a carrier's specific products.

Producers who are unfamiliar with this insurance should also keep in mind that the best commercial general liability policy will still leave a business unprotected from some important risks. Injuries to employees, damage to an insured's own property, and lawsuits alleging unfair employment practices are all problems that should be addressed through other insurance or other risk-management strategies. Not surprisingly, even when it is purchased, commercial general liability insurance is rarely bought on its own and is instead included as part of a bigger package that aims to manage many other risks, too.

Basic Commercial Liability Concepts

Before going into detail about commercial general liability insurance, we should summarize some legal concepts that impact businesses. If you have a solid understanding of these ideas, you will probably have an easier time comprehending the intent and meaning of policy language. The important concepts covered in this section are as follows:

- Premises and operations liability.
- Product liability.
- Completed operations liability.
- Contractual liability.
- Vicarious liability.
- Compensatory damages.
- Punitive damages.

Premises and Operations Liability

Examples of premises and operations liability are probably what come to mind when the average person thinks about commercial liability risks. On a very simplistic level, this kind of liability can be described as liability that arises from accidents at the insured's place of business or while the insured is conducting business.

Liability related to the business premises might arise if the building, office or other space occupied by the insured somehow becomes unsafe. For instance, pretend that ice is allowed to form on the steps outside the insured's building. If a customer stumbles and suffers an injury, the insured might be held liable for it. For another example, imagine the insured has erected a sign over its place of business. If the sign falls and damages someone else's property, the business might be legally obligated to replace the broken item.

Liability related to operations occurs when the actions of the insured--not the condition of the premises—cause harm. Suppose a server at a restaurant trips and splatters hot food over a customer. In this case, the restaurant might be liable for any resulting medical expenses or dry-cleaning bills.

Product Liability

Product liability is a concern for businesses that manufacture or sell goods. The potential for product liability exists whenever a product leaves the business premises and causes harm to people or property. If a toy manufacturer sells products that turn out to be dangerous for children, the manufacturer might be liable for injuries, illnesses or deaths. Similarly, if an automotive product actually causes automobiles to break down, the manufacturer might be liable for the damage.

Note that product liability typically involves losses caused by a product after the product has left the business's location. Accidents that occur at the business's location, even if products are part of the cause, are generally considered premises and operations liability.

Completed Operations Liability

Liability for completed operations arises when work or a service has already been finished beyond the business premises and the business's poor performance causes harm.

Completed operations liability is a common concern among builders and practically anyone who provides skilled labor in homes or commercial buildings. Pretend an electrician has finished wiring several new circuits at an apartment building. A few months later, a fire destroys the building, and investigators determine that the electrician's use of inferior materials is to blame. If the fire had occurred while the electrician was still working on the circuits, the incident would involve the regular form of operations liability (the kind often paired with premises liability). But because the damage occurred after the work was finished, the liability in this example involves completed operations. This is an important distinction because insurers often treat accidents differently depending on whether work was finished by the time of an accident or was still in progress.

Be aware that although insurers might cover a business for competed operations liability, their general intent is to respond to accidents rather than unsatisfactory work. If a business does bad work but technically doesn't cause property damage or bodily injury, a resulting lawsuit from an angry customer won't always be insurable.

Contractual Liability

Contractual liability is liability that's accepted as part of an oral or written agreement. A common example of this acceptance of liability is a hold-harmless agreement that transfers liability from one party to another. Even though a restaurant that rents itself out for a wedding might ordinarily be liable for any injuries sustained at the premises by guests, the couple might sign a hold-harmless agreement in which they agree to accept liability for any accidents during the festivities.

Commercial general liability insurance will only cover contractual liability under certain circumstances. We'll review those circumstances later in this chapter.

Vicarious Liability

Vicarious liability exists when one party is held indirectly responsible for damage caused by someone else. It frequently becomes an issue for businesses when an employee or a subcontractor does bad work or causes an accident.

Compensatory and Punitive Damages

"Compensatory damages" and "punitive damages" are the two basic kinds of damages that can be awarded by the judicial system. Compensatory damages will result from the court's decision that the plaintiff lost an amount of money because of the party at fault and should be reimbursed for it. They are intended solely to repay or compensate the injured party for the loss incurred. Punitive damages, on the other hand, are meant to punish someone for an action. Instead of simply making the plaintiff whole again after a loss, they're designed to teach the guilty party a lesson.

Some states prohibit insurance companies from covering punitive damages. After all, if the risk of having to pay those damages can be transferred to an insurer, their intended impact as punishment could be minimal or nonexistent. Even if a state doesn't technically prohibit insurance money from being used to pay punitive damages, insurers might exclude these damages from their polices.

Who's Covered?

Commercial general liability insurance can be used to manage risks for a variety of people who may be affiliated with a business. But it's important not to make any assumptions about who's actually covered by it.

When the person named on the policy's declarations page is an individual instead of a business, the individual is covered along with his or her spouse. Coverage applies to activities involving any business of which the named insured is the sole owner. Liability in regard to personal accidents—such as a slip-and-fall at the couple's home—is excluded.

When the named insured is a partnership or joint venture, the insurance typically covers the business entity, the partners and the partners' spouses. Business partners and their spouses are only covered for liability in regard to the business named on the declarations page. Liability for personal activities or other business activities is excluded.

When the named insured is a limited liability company (LLC), commercial general liability insurance covers the company, its members and its managers. Again, individuals who have coverage in this setup are not covered for personal activities or other business activities.

When the named insured is another kind of business entity (such as a corporation), the insurance protects the business, its directors, its officers and its stockholders. Directors, officers and stockholders are not insured when they act in other capacities or are exposed to liability beyond the business.

Employees

Regardless of whether the named insured is an individual, a partnership, a corporation or some other entity, employees and

volunteers are usually also covered by the policy. Exceptions to this rule include cases in which employees harm each other or damage the business's own property. Employees will also lack coverage if they're sued for their role in providing or failing to provide medical care. Depending on the circumstances and state law, this exception can have a major impact on employees when a customer, client or visitor requires first aid.

Additional Insureds

Policyholders also have the option of adding a specific person or specific business entity to their general liability insurance as an "additional insured." This is especially common in the building trade, where contractors often insist on being added to a subcontractor's policy.

If a person or business is named as an additional insured on someone else's policy, that insurance will often be treated as primary coverage. Any other commercial general liability policies that the business might have will be treated as secondary insurance.

The additional insured will only be covered by someone else's policy when liability relates in some way to both the additional insured and the other party. For example, if the Brian Bricklaying Company adds the Barry Building Group to its general liability policy, the Barry Building Group would probably only be covered for projects involving both companies. For projects involving a different bricklaying company, the Barry Building Group would likely need insurance from some other source.

Bodily Injury and Property Damage

Commercial general liability insurance is used mainly to cover businesses when they're liable for bodily injury or property damage.

Bodily injury can include accidental cases of physical injury, illness or death. It usually doesn't include emotional stress, although some courts have ruled differently.

Property damage can include physical damage to property as well as the loss of use of undamaged property. For example, a business can be covered if it accidentally sets fire to another person's building. It might also be covered if it accidentally sets fire to its own premises and causes an otherwise unharmed neighbor to evacuate while the fire is put out.

Courts are likely to award money to harmed parties when injury or damage results from a business's "negligence." Negligence generally occurs when someone doesn't act with as much care as a reasonable person.

Be aware that liability can also be attached to a business by law rather than by anyone's negligence. Even court-awarded amounts that have nothing to do with a business's carelessness might be covered by commercial general liability insurance if they relate to bodily injury or property damage.

Many instances of accidental bodily injury or property damage will be sudden, but businesses can also be covered when the harm done to people or property is gradual and goes unnoticed for long periods of time. Investigating the circumstances of gradual damage is an especially important task when the date of an accident and the date when damage is actually noticed don't fall within the same policy period. If the policyholder either switched insurers or wasn't covered at all between those two dates, arguments might arise regarding who should pay for what. You'll read more about the timing of accidents and the timing of claims in the section "Occurrence and Claims-Made Policies."

Common Exclusions

At first glance, most of the wording in a commercial general liability coverage form seems to deal with the risks that are excluded from insurance rather than the ones that aren't. Exclusions are usually added or broadened when the ISO makes revisions to its standard policy form. Then, insurers who use the form are likely to include other exclusions by endorsement.

The increase in policy exclusions over the years is the main reason why the insurance had its name changed from "comprehensive general liability insurance" to "commercial general liability insurance." With so many exclusions capable of denying coverage to consumers, using the word "comprehensive" didn't seem fair anymore.

While reading about common exclusions over the next few pages, you should keep a few things in mind. We will focus our attention mainly on the exclusions with the greatest chances of being relevant to a typical business. So although the standard policy excludes liability related to wars, we will not discuss the particulars of that exclusion here. Secondly, as you may already know, the existence of an exclusion in a commercial general liability policy often just means a particular risk isn't covered by this particular brand of insurance. It doesn't necessarily mean coverage can't be secured at all. For example, despite the narrowness of pollution coverage in commercial general liability insurance, concerned businesses might be able to purchase separate insurance for pollution exposures or pay a bit more to have their policy's pollution exclusion changed.

Intangible Property

For property damage to be covered by commercial general liability insurance, it must have been done to something tangible. This means the property subjected to damage needs to be something you can actually touch. Computers, discs and flash drives can be touched, but the data stored on them can't. This might create a huge coverage gap when a business is held responsible for the loss or corruption of valuable electronic information. Separate "cyber insurance" products exist in today's market for liability related to electronic data.

Economic Losses

Property damage covered by commercial general liability insurance can't be purely economic. Giving bad financial advice to a client might lead to a lawsuit, but it's usually not the kind of suit in which coverage would be triggered. If a financial loss isn't linked directly to bodily injury or physical damage to tangible property, it might only be covered by other insurance, such as errors and omissions insurance.

The Business's Work and Items Being Worked On

A few of the more complex exclusions are designed to ensure that the business retains at least some of the risks involved with doing faulty work or making substandard products. For example, if a business is tasked with repairing or servicing property and damages it while performing work, the business will usually be uninsured for the damage. Similarly, if work has been finished somewhere other than the business premises (such as at a person's home) and is later found to be substandard, the business's insurance company typically won't pay to have the work redone. The insurance company can help with accidents, but it isn't interested in covering people who are simply bad at their jobs.

Pollution

Until the 1960s, pollution was an afterthought for most commercial liability insurers. But literal and figurative messes caused by oil spills in that era forced carriers to take a more cautious approach to the risk. Carriers' concerns were heightened even more in the 1980s, when insurers were faced with expensive asbestos-related claims.

The increased attention paid by regulators and the public to environmental hazards is at least partially responsible for the extremely strict pollution exclusions in the modern market. A liability insurer can refuse to be involved in claims related to practically any form of pollutant, including gasses, fumes, liquids, waste, smoke or chemicals.

In spite of the extensiveness of today's pollution exclusions, they do leave room for a few exceptions. For example, most insurers will cover a business when smoke or fumes from a fire cause bodily injury or property damage. Another exception provides coverage to businesses when the work materials they are using in a building expose inhabitants to fumes. This type of situation might arise when a company is painting a premises or using strong cleaning products. Exposure that occurs outside of the building remains excluded.

Electronic Data

As was mentioned earlier, loss of electronic data is usually excluded from commercial general liability insurance policies. This amounts to no coverage for nearly anything created, used or saved on computer systems or electronic media. Electronic data may be excluded because it can't be touched and, therefore, doesn't fall into the common definition of "tangible property." And just in case there's any argument about what constitutes tangible property, policies sold today will often also have a separate, specific exclusion for electronic data.

Property in the Business's Care, Custody or Control

Commercial general liability insurance often won't protect a business when it damages someone else's personal property within its care, custody or control. This is a significant coverage gap for repair shops, cleaning companies and just about any other entity that's entrusted with its customers' belongings. The exclusion can apply if damage is done to the property before, during or after it's been serviced by the insured.

The exclusion of personal property within the insured's care, custody or control raises several questions. For example, if a carpet cleaner is given keys to a customer's home and performs his work while the owner is out of town, would all of the home's contents be under his care, custody and control? Although most insurers would probably agree that he wouldn't be insured for damaging the carpet (which is clearly under his care, custody or control), there might be debate regarding whether he should be covered for accidental damage to other property in the rest of the house.

There's also the issue of who the exclusion actually applies to. Even if we assume a business's employee isn't covered for damage to property in his or her care, custody or control, what about the employer? Will the insurance company claim that property under an employee's care is, in effect, also under the employer's care? If the carpet cleaner in our previous example is sued for damaging the homeowner's property, would his employer's insurer cover the employer but refuse to cover the employee?

These uncertainties help explain why many businesses opt to cover property in their care with other insurance. Some coverage might be available as part of the business's own property insurance. Alternatively, companies that specialize in accepting other people's property for repairs or services are often good candidates for a "bailee" insurance policy, which is specifically designed to cover a customer's belongings.

Intentional Acts

Liability insurance is meant to cover the insured for accidents, not for intentional damage. Doing otherwise would have negative social consequences because it would give people an excuse to commit bad behavior.

When determining the applicability of the intentional acts exclusion, most courts look at the intent of the insured's actions and judge it against what resulted from them. Suppose a painter leaves a customer's front door open so she can go back and forth between her truck and her worksite. Because the door is left open, the customer's pet escapes and is hit by a car. In this case, the painter's intentional act (leaving the door open) produced unintentional results (the pet's escape). For many courts, having an unintentional result is enough for the intentional acts exclusion to be a non-factor.

It's less clear what would happen if the insured actually intended to cause some damage but ended up causing a lot more than expected. If a business owner intentionally punches someone and the victim hits his head on the ground and dies, would the incident be excluded as an intentional act? Or would it be covered because punching someone is usually not done with the intent of killing the person? Those are probably questions for a court to decide.

Vehicle Liability

Liability arising from the operation of cars and other vehicles is supposed to be covered by commercial auto insurance. With this in mind, commercial general liability policies usually won't cover businesses after accidents involving automobiles, planes or boats. This exclusion also extends to claims alleging that a business was negligent in hiring or supervising drivers or pilots.

Businesses offering delivery services should be aware that the typical vehicle liability exclusion leaves them uninsured while they're loading or unloading their vehicles. This part of the exclusion means businesses might not be covered from the time they pick up items with the intent of putting them in a vehicle to the point where the items have been handed off to their intended recipient. Consider a furniture manufacturer that is delivering a couch. If workers bump into a wall or drop the couch on someone's foot while loading or unloading it, commercial general liability insurance is unlikely to respond. Coverage might not be reactivated until the couch is placed in its proper spot inside the new owner's building.

A minor exception to the vehicle liability exclusion is made when businesses park other people's cars on or near their premises. However, this exception for valet service is only intended for damage to bodily injury or other vehicles. Damage to the car being parked might still be excluded because the vehicle would be under the business's care, custody or control.

Impaired Property

Most commercial general liability insurance policies contain an exclusion for "impaired property." In order to be impaired, the property must satisfy two requirements. First, it must be unusable or less useful as a result of either the insured's bad work or the

insured's defective product. Secondly, the property must be capable of being restored merely by replacing or repairing the bad work or defective product.

Since exclusions of impaired property can be hard to grasp, let's go over some examples.

In one famous case, nut clusters in a breakfast cereal were found to contain wood splinters. When the business that supplied the clusters to the cereal company made a claim, its insurance company argued that the incident shouldn't be covered because of an impaired property exclusion. However, a court disagreed, ruling that the tainted cereal couldn't be repaired by simply recalling the product and removing all the clusters. For all practical purposes, a box of cereal containing the splinters was not merely impaired. It was beyond repair.

For an alternate example, imagine a plane with defective navigational equipment. In this case, the manufacturer would typically not be covered if the pilot were to ground the aircraft for safety reasons and sue for loss of use. As long as the plane isn't actually damaged and can become usable again by replacing or repairing the manufacturer's equipment, it would probably be classified as impaired property.

Contractual Liability

Many people assume that contractual liability refers mainly to a business's failure to honor an agreement. But in the world of liability insurance, the term is typically used to describe a situation in which liability of one party is assumed by another. In an apartment lease, for example, the tenant might agree to accept liability for all instances of property damage or bodily injury occurring at the property. This includes accidents for which, in the absence of the lease, the landlord would legally be responsible.

Despite containing an exclusion of contractual liability, most commercial general liability policies apply several exceptions to the rule. Liability that's accepted by the insured for property damage or bodily injury can be covered if the other party to the contract would have otherwise been held liable for those things by law. So if a subcontractor agrees to accept liability from a general contractor for bodily injuries that occur during a construction project, the subcontractor's insurance might pay for bodily injuries that the general contractor would ordinarily be held liable for under the law. Defense costs for the other party can be covered, too, if this stipulation appears in the contract between the two parties.

The standard policy will continue to exclude damages that neither party would otherwise owe to someone under the law. In other words, even if a contractor agrees to cover the cost of any damage caused by a natural disaster until construction on a home is completed, the contractor's insurance won't absorb that risk. After all, in the absence of a contract, neither the contractor nor the property owner would owe anyone money because of the damage.

The contractual liability exclusion is also waived in situations where contractual language merely restates a kind of liability that the accepting party would still possess in the absence of any agreement. If the law says a bicycle repair shop is liable for damages to customers' bikes, the fact that this is stated in a contract between a repair shop and its customers won't have a negative impact on the shop's coverage.

Finally, there are a few specific kinds of contracts to which the contractual liability exclusion doesn't apply. These include leases for a business premises, easements and elevator maintenance agreements. Property damage or bodily injury liability assumed under these contracts will be covered unless they're subjected to a different exclusion.

Liquor Liability

Liquor liability can be a headache for restaurants, taverns and any business serving alcohol at a party or corporate event. If someone's intoxication results in property damage or bodily injury, the provider or server of alcoholic beverages might be blamed for the trouble.

Commercial general liability insurance won't be of any help when an entity in the business of serving or manufacturing alcohol is accused of contributing to someone's intoxication. Separate insurance is used for that purpose.

On the other hand, coverage for liquor liability often remains intact if an insured doesn't sell, provide or serve alcohol as part of its business. This exception to the rule is sometimes cited as a protection for employers who serve alcohol at office parties. It also helps property owners who lease space to bars or restaurants.

Workers Compensation and Disability Benefits

Commercial general liability insurance won't provide any benefits that employers are legally obligated to pay under workers compensation or disability laws. The insurance almost never responds to injuries suffered by employees or to physical damage to their own property.

Employment Practices

Commercial general liability insurance rarely covers businesses for employment practices liability. This form of liability usually involves cases in which workers are sexually harassed, discriminated against or wrongfully terminated. Separate insurance, known as "employment practices liability insurance," exists for some of those risks.

Even though a commercial general liability policy might not contain a specific exclusion regarding employment practices, multiple parts of the insuring agreement have often been used to deny a claim. As an example, think of a case in which a business is accused of wrongful termination. The act of firing someone is usually considered an intentional act, and intentional acts are excluded from coverage. Also, the losses suffered by a fired individual are usually economic, and purely economic losses are typically excluded, too. Even if the fired person claims to have suffered bodily injury on account of emotional distress, courts have generally said that emotional distress doesn't meet the definition of "bodily injury" found in the standard policy.

Professional Liability

Professional services are often defined as services requiring special skills that are intellectual rather than physical. Providers of these services include lawyers, doctors, financial planners and insurance producers.

Liability related to professional services is rarely covered by commercial general liability insurance because it hardly ever involves bodily injury or property damage. When a professional gives bad advice or fails to address a client's situation properly, the result is usually limited to economic losses rather than physical harm. Medical professionals are certainly capable of causing bodily injury, but an insurer will often wipe out coverage for that risk by adding an ISO-created endorsement to the standard policy form.

Risks associated with professional services can usually be managed more effectively by purchasing errors and omissions insurance or some specific type of malpractice coverage.

No-Fault Medical Coverage

A special section of a commercial general liability insurance policy deals with no-fault medical coverage. This portion of the policy exists so that there's a smaller chance of a lawsuit or costly settlement after an accident.

The no-fault portion of the policy usually has its own dollar limit. If the insured is accused of being at-fault for bodily injury and runs out of no-fault medical coverage, the main body of the policy (described in the previous sections of this chapter) will take over.

The no-fault medical portion of the commercial general liability insurance policy can cover anything from first aid and x-rays to doctor visits and funeral expenses. The insurer will cover bills for these treatments and services if they're needed within a year of the accident. To be eligible for payments, the injured person may need to agree to an examination by the insurer's chosen physician.

Exceptions to coverage for no-fault medical payments under the commercial general liability policy include injuries to employees and injuries suffered while engaged in athletics. (Think of a business with a company softball team.) Injuries for employees and other workers are meant to be addressed through workers compensation or other insurance.

The exclusions mentioned in previous sections of this material (intentional acts, liquor liability, contractual liability, etc.) are also generally applicable to the no-fault portion of the policy.

Personal and Advertising Injury

Despite our emphasis so far on property damage and bodily injury, commercial general liability insurance can cover other risks, too. Most notably, it's used to help businesses when they're accused of causing "personal injury" or "advertising injury." Since these terms usually aren't understood by the general public, we'll explain each of them in their own individual sections.

Personal Injury

In a very basic sense, personal injury occurs when people's rights or reputations are taken away from them.

Be careful not to confuse personal injury with bodily injury. As far as commercial general liability insurance is concerned, personal injury can occur even if the injured party suffers no bodily injuries or property damage.

The forms of personal injury covered by the typical commercial general liability policy are as follows:

- False arrest, detention or imprisonment. (**Example:** A business believes someone on its premises has broken a law and refuses to let the person leave.)
- Malicious prosecution. **(Example:** A business repeatedly takes unreasonable legal action against a competitor.)
- Wrongful entry. (**Example:** A business renting property to a tenant enters the property and uses it without the tenant's consent.)
- Wrongful eviction. (**Example:** A business changes the locks on rented property without informing a tenant and in violation of a lease.)
- Libel. (**Example:** A business publishes a damaging, untrue statement about a person or another business.)
- Slander. (**Example:** A business says a damaging, untrue statement about a person or other business.)
- Publication of private information. (**Example:** A business publishes something about a competitor's or customer's personal life.)

Advertising Injury

In regard to a commercial general liability policy, advertising injury occurs when a business commits an offense against someone in its promotional materials.

Advertising injury has become a more significant coverage issue in recent years thanks to the internet. Courts and insurers are confronted regularly with the issue of whether a particular feature on a website—such as a blog post or a comment on a message board—is a form of advertising.

Whether committed online, in print or in some other form, examples of advertising injury that are likely to be addressed by commercial general liability insurance include the following:

- Committing libel or slander in an advertisement.
- Disclosing private information about someone in an advertisement.
- Using copyrighted material in an advertisement without permission.
- Using another business's trademark or slogan without permission.
- Using another business's advertising idea without permission.

You may have noticed some overlap between the actions covered as personal injury and those covered as advertising injury. The overlap allows instances of libel, slander or disclosures of private information to be covered no matter if they are done in an advertisement or in some other form. However, be aware that the overlapping coverage of personal and advertising injury doesn't extend beyond libel, slander and disclosure of private information. For example, commercial general liability insurance covers businesses for copyright infringement, but only when the infringement occurs in an ad. Other instances of infringement are excluded from the standard policy form.

Personal and Advertising Injury Exclusions

The personal and advertising injury portion of a commercial general liability insurance policy has its own set of exclusions. Some of the most common exclusions are as follows:

- Copyright infringement in material other than an advertisement.
- Personal or advertising injury that occurs beyond the policy's coverage territory. (This exclusion is usually waived in the case of advertising injury committed over the internet.)
- Copyright infringement or libel committed in materials that were published before the policy period.
- Knowingly printing false information.
- Intentional acts. (Since certain acts, such as eviction or improper advertising, are almost never an accident, the insurer will often initially agree to at least cover the insured's defense in these cases. Then, if it is later determined that the business knowingly violated the law, the insurer might refuse to cover any judgments and ask to be reimbursed for the defense costs.)
- Libel, slander or any kind of advertising injury committed by advertising agencies, publishing companies, internet

service providers, web designers, broadcasters or search engine providers.
- Offenses committed on internet bulletin boards or in chat rooms.
- The use of someone else's name or product in a Web address, email address or metatag. (A metatag is essentially data used by search engines to organize online content.)
- False advertising of products or services.

Some of these excluded acts, such as libel committed by publishers or broadcasters, can be managed with the help of other insurance. Others, such as intentional acts, usually aren't meant to be covered by insurance at all.

Defense Costs

Even if a court finds that a business isn't liable for damage or injury, costs related to defending the matter can be high. The commercial general liability policy deals with this problem by making the insurer pay to defend the business in any situation in which the policy *might* be applicable. If there's at least some chance that the issue at hand is covered by the policy, the insurance company is typically required to pay for the insured's defense. In fact, the duty to defend the insured is usually broader than the duty to cover settlements or court-awarded damages.

Defense costs under the commercial general liability policy will continue to be covered until the amount paid by the insurer for settlements and court-awarded damages equals the policy's dollar limit. Money paid for defense purposes has no effect on the limit.

Let's demonstrate the points in the previous paragraph with an example. If a company has a policy with a $1 million limit, spends $50,000 on a defense team and is ultimately required to pay $1 million in damages to a plaintiff, the insurer will pay for the whole defense and all the damages. But if the same company is sued again during the same policy period, the insurer won't pay for a defense because the $1 million policy limit was reached in the first dispute.

Since it's responsible for handling defense costs, the insurer behind the commercial general liability policy can settle disputes without the insured's consent. Similarly, the insured is not allowed to settle disputes without the insurance company's permission. The assumption is the insurer has a better idea of how a court will rule and what kind of settlement (if any) is reasonable.

Occurrence and Claims-Made Policies

Commercial general liability insurance can be issued through the use of either an "occurrence" form or a "claims-made" form.

With an occurrence policy, coverage depends mainly on when an accident occurs. With a claims-made policy, coverage depends mainly on when a demand for money from an accident occurs. The distinction between the two forms can be extremely important when damage or injuries don't materialize at the same time as the accident that caused them.

Everything else being equal, coverage offered on an occurrence basis is usually preferred over claims-made coverage. With an occurrence policy, a business might remain insured for liability even if it cancels coverage before any demand for money is made.

With a claims-made policy, the opposite is often true. Regardless of when an accident actually happens, claims will usually be denied if they're not made during the policy period. Unlike an occurrence policy, a claims-made policy seemingly guarantees that an insurer will not be surprised by more claims after a certain date.

To better understand the difference between occurrence coverage and claims-made coverage, it may be helpful to know why claims-made forms were introduced. During the 1980s, many people who had occupied buildings with asbestos were experiencing serious health problems. Arguing that asbestos contributed to their conditions, they sued property owners and builders for millions of dollars. In turn, the owners and builders looked to their insurance companies to protect them. Even in cases where the plaintiffs had not occupied the properties in several years, and even in cases where the owners and builders had allowed their coverage to lapse 30 years earlier, the insurance companies were expected to pay. This encouraged insurers to stop issuing so many occurrence policies and to start issuing claims-made policies.

Retroactive Dates in Claims-Made Policies

A consumer who's considering claims-made insurance should be made clearly aware of the policy's "retroactive date." Even if a claim is made on a claims-made policy during the policy period, it will be denied if the accident associated with it occurred before the retroactive date.

Think of a claims-made policy that has a retroactive date of January 1, 2021, and is set to expire on December 31, 2021. If a claim is made on December 30, 2021 for an accident from 2020, the policy won't respond. It will only cover liability for accidents that happened from January 1, 2021, to December 31, 2021.

The retroactive date for a claims-made policy is usually the date when claims-made coverage from that carrier first went into effect. In other words, if a business purchases claims-made coverage from a carrier on January 1, 2021, and renews it on January 1, 2022, the retroactive date for the renewed policy should continue to be January 1, 2021. If the retroactive date is moved up to a more recent date, the business could be left with a major insurance gap.

It's also possible (though unlikely) for a claims-made policy to be issued without a retroactive date. In this case, the business would be insured for claims made during the policy period regardless of when an accident occurs.

Extended Reporting Periods for Claims-Made Policies

Much to the benefit of business owners, claims-made policies typically include an "extended reporting period" at no extra charge. The extended reporting period provides temporary coverage when commercial general liability insurance is cancelled, replaced or not renewed. Sometimes known as "tail coverage," It can be particularly helpful when a company goes out of business or switches from one insurance carrier to another.

Having a claims-made policy with an extended reporting period is similar to having a very limited and temporary occurrence policy. The extended reporting period puts great importance on the date of an accident and deemphasizes the date of an actual claim.

The basic extended reporting period gives the business 60 days after the end of the policy period to report accidents and have them covered by a claims-made policy. If those accidents are reported in time, claims stemming from them will be covered for five years, up to the policy's dollar limits. For example, if a shopkeeper is scheduled to have her insurance cancelled but

knows a customer slipped at her premises just prior to the policy's cancellation date, she can report the incident to her insurer and be covered for it for the next five years. However, if the shopkeeper is not aware of the incident and therefore doesn't report it within 60 days of the policy's cancellation date, she won't be protected by insurance. Although coverage is often available for businesses that want more than 60 days to report accidents or more than five years of protection from those accidents, it isn't included in the typical policy free of charge.

For an incident to be covered as part of the extended reporting period, it still needs to have occurred during the policy period. So if the policy covering the shopkeeper in our previous example expires on January 1, she won't be covered at all for accidents occurring on January 2. It makes no difference whether she reports the accident within 60 days of her policy's cancellation date.

Conclusion

Commercial general liability insurance is something practically any insurance professional should know about. Almost every business will have a use for it, yet it has many nuances that should be explained by a knowledgeable agent or broker. Demonstrating an awareness of how the typical policy works can create trust with business owners and give them a clearer idea of what other risks are worth managing.

CHAPTER 4: WORKERS COMPENSATION AND EMPLOYERS LIABILTY INSURANCE

By the late 1800s, the Industrial Revolution had put the United States on a new path. Railroads were being built, factories were replacing farms, and heavy-duty machinery was being utilized in new ways to increase productivity. With those changes came new risks for the average laborer. Older people from agrarian backgrounds and younger people just entering the workforce had to adapt to perilous manufacturing jobs with little or no training. Safety standards were either very basic or nonexistent, and labor laws that could have cut down on major accidents were years away from being passed.

Thanks to a growing pool of people who were willing to do hazardous work for little money, employers had few incentives to reduce their employees' exposure to danger. And with no social insurance in place for the poor or the disabled, breadwinners who exposed themselves to possible injuries or occupational death were also exposing their family to financial devastation.

Unlike such major European powers as Germany and Great Britain, the United States lacked a workers compensation system and relied on tort law to determine whether injured workers were entitled to reparations. If a worker was injured during the course of employment, he could only receive compensation if he took his employer to court and proved the employer had been negligent. Meeting those requirements was expensive and difficult for most plaintiffs. One study, cited in the government periodical Social Security Bulletin, found that employers from the era were judged to be at fault for less than 20 percent of workplace accidents.

Part of the problem for workers in those situations related to the multi-faceted power of the employer. From a financial perspective, the employer was more likely than the employee to be capable of affording talented legal counsel. Also, on a psychological level, the employer's ability to retaliate against its workers was an intimidating weapon that kept witnesses from testifying against a negligent company. Similar concerns often dissuaded injured people from pursuing any kind of legal action in the first place. If a worker believed recovery from an injury was at all possible, he didn't want to get into a dispute with his employer and hurt his chances of getting his job back.

Those workers who dared to push their way into court were often sent home without compensation because of three popular legal defenses favoring businesses:

- Under the "contributory negligence defense," an employer could avoid liability for an accidental injury if the employee in any way caused or helped cause the accident.
- Under the "fellow servant defense," an employer could avoid liability for an accidental injury if the accident was caused by a coworker or some other person besides the employer.
- Under the "assumption of risk defense," an employer could avoid liability for an accidental injury if the nature of the injury was considered common in that line of work. So, hypothetically, a firefighter who was harmed by fire in the line of duty could have been denied compensation because coming into contact with flames was part of the job.

In many cases, these defenses were absolute. (A contributory negligence defense, for example, could shield an employer from all liability even if the employee was only partially responsible for his own injury.) But they became less iron-clad over time, and other developments helped reduce the legal challenges for workers. Instead of holding an employer entirely blameless on account of a worker's contributory negligence, courts started employing the concept of "comparative negligence" and awarded compensation to workers in an amount that was proportionate to the employer's role in an accident. Instead of accepting the fellow servant defense in nearly all cases, some courts determined the employer could be held liable if an injury was caused by a worker's supervisor. Flexibility also extended to spouses, who eventually won the right to continue a suit against an employer after a worker's death.

The Beginning of Workers Compensation Laws

Workers compensation received federal attention in 1908 when Congress passed the Federal Employers Liability Act, a law that created a procedure whereby injured railroad workers could make claims for damages. Another law—the Federal Employees' Compensation Act—followed a few years later and provided compensation to an assortment of injured government workers.

In between the passage of the two federal acts, Wisconsin became the first state to develop a constitutionally viable workers compensation system of its own. By 1950, every state had instituted a similar system and allowed injured employees and families to collect compensation from employers regardless of fault.

Understanding No-Fault Insurance

Legislators in every state have made workers compensation a no-fault system. In practical terms, this means an injured employee does not need to prove negligence by the employer in order to collect benefits. As long as claimants were engaged in work-related tasks at the time of an accident, they can be harmed by the actions of coworkers, bosses, customers or themselves and still have their losses covered. In most cases, the contributory negligence defense, fellow servant defense and assumption of risk defense cannot prevent them from receiving compensation.

In exchange for not having to prove negligence by their employer, people who are covered by workers compensation laws forfeit

their ability to sue their employer after an accident. Employers must provide compensation in the amount prescribed by state law, but they are not liable for pain, suffering or punitive damages.

Different Laws for Different States

No-fault workers compensation systems exist in all U.S. states and territories, including Washington D.C., Puerto Rico and the Virgin Islands. But it must be stressed that no two systems are exactly alike. An absolute expert on workers compensation has more than 50 sets of laws and regulations to deal with, and the assorted differences among states can be significant.

As a way of demonstrating this point, let's go over the insurance-related requirements employers must follow. At the time this course was being written, laws in 49 states required employers to have some kind of workers compensation insurance. Depending on the state in question, the coverage could be purchased from a government entity, bought from a private company or created through some kind of state-approved self-insurance arrangement.

Yet in the state of Texas, employers could choose between obtaining coverage and not purchasing insurance. If an uninsured Texas employer happened to be sued by an injured worker, the employer could not use the contributory negligence defense, fellow servant defense or assumption of risk defense, and its liability for pain, suffering and other damages could have been unlimited.

People who specialize in workers compensation coverage should also understand that some state laws, which have a direct impact on insurance coverage, have changed frequently and dramatically in the last few years. In all likelihood, states will continue to change and refine their workers compensation systems as a way of promoting fairness and managing the economy.

Please keep the issues of change and non-uniformity in mind while you read the remainder of this chapter. Although you will find occasional references to specific states in the text, the information is provided for general purposes. It might not reflect all the particulars of your state's workers compensation system, and it is not a substitute for advice from licensed legal professionals. Producers who assist businesses in the purchasing of workers compensation insurance are strongly encouraged to review current statutes from their respective states.

Who's Exempt From Workers Compensation?

As evidenced by the railroad-specific Federal Employers Liability Act of 1908, workers compensation laws of the past were sometimes geared specifically toward people with highly hazardous jobs. Employers are in a very different situation today and are generally required to purchase insurance covering all workers regardless of risk.

Exceptions to this rule exist in every part of the country and are listed in workers compensation statutes. If a certain kind of worker is specifically not protected under state statute, an employer does not need to obtain insurance to cover the worker's injuries. Therefore, if all of an employer's workers fall outside of the state statute, the employer is allowed to conduct business without insurance. If some but not all of the employer's workers are not covered by the statute, coverage must still be obtained for the other employees.

The next several sections mention classes of people who are often excluded from workers compensation systems. Exclusions differ among states and might not apply to businesses in all industries. Companies involved in accident-prone fields (such as construction and food services) might be required to insure their employees under every circumstance.

Small Businesses

Some states will exempt a business from workers compensation requirements if it only employs a few workers. Cutoff points for this exemption might be as high as five employees or as low as three employees.

Domestic Employees

Because most people don't view their residence as a place of business, many households that employ maids, nannies and other domestic workers don't think about workers compensation requirements. While many domestic employees operate outside the workers compensation system, a family may need to cover an employee if work is done on a regular basis for an extended period of time.

If employers of domestic workers believe they are covered for liability through their homeowners insurance policy, they might be in for an unpleasant surprise. Although the liability side of a homeowners insurance policy can help pay medical costs incurred by injured workers, the coverage is subject to a dollar limit and cannot be utilized in every situation. When an injured domestic worker is supposed to have been covered through a state's workers compensation statute, the issuer of the homeowners policy can deny liability claims.

Independent Contractors

Workers compensation is for employees, not independent contractors. The exact meaning of "independent contractor" will depend on state and federal law and is generally based on the relationship between the worker and the business. If several of the following statements are true, the worker might qualify as an independent contractor. If several of them are false, the worker is more likely to qualify as an employee:

- The tasks performed by the worker do not relate to the specific nature of the business.
- The business does not have the right to determine the worker's schedule.
- The business does not have the right to determine where tasks should be performed.
- The worker openly performs similar tasks for other businesses.
- The duration of the relationship between the business and the worker is predefined, rather than indefinite.
- The worker is responsible for providing his or her own tools and supplies.
- The worker does not receive employee benefits, such as health insurance or paid vacation days.
- The business provides no training to the worker and does not dictate how tasks are to be performed.
- The worker is compensated via a flat fee rather than a regular wage.

Workplace Injuries

A person may be eligible for workers compensation after suffering a workplace injury. In order for the individual to be covered for any resulting medical expenses and receive other benefits, the following three facts must be established:

- The person was an employee of the business at the time of the injury.
- The injury was accidental.
- The person suffered the injury in connection with his or her job duties.

Occupational Diseases

When workers compensation laws first emerged in the early 20th century, they catered only to employees who experienced workplace injuries. By the 1920s, some statutes had expanded to include a limited amount of coverage for occupational diseases. If a worker suffered a scratch that resulted in the transmission of harmful bacteria, medical expenses and lost wages were handled by either the employer or the employer's insurer.

These days, a broader assortment of diseases can lead to workers compensation claims. In general, a person who contracts a disease is covered for workers compensation if either of the following statements is true:

- The person's assigned tasks or work environment are responsible for causing the illness.
- The person's assigned tasks or work environment are responsible for worsening a pre-existing medical condition.

Medical Coverage

When an employee is injured or contracts a disease at work, workers compensation pays for the person's medical expenses. Unlike reimbursement for lost income, this coverage begins immediately after an accident and is not limited to a particular dollar amount. There is no deductible for the employee to worry about, and there are no co-payments for medical services. Even when an employee suffers an injury without missing a single minute of work, this nearly unlimited coverage can be utilized to pay for all reasonable medical care.

When employees request workers compensation for medical care but not for lost income, they make what is known as a "medical-only claim." Because they do not involve lost wages, medical-only claims can be relatively inexpensive. Contrary to popular belief, the majority of workers compensation claims are medical-only claims.

Wage Replacement

When an injury causes an employee to miss work for more than a few days, the person will probably make a "lost-time claim." Lost-time claims are not as common as medical-only claims, but they tend to be much more expensive because they involve payment of lost wages.

For a lost-time claim to be valid, an employee must first miss a certain number of workdays. If the employee comes back to work without having missed the specified number of days, that person will not be compensated for lost wages. The employer or the insurer will only need to pay for the person's medical expenses.

Though some states have required at least a week-long absence, employees are usually eligible for lost-income benefits if an accident has kept them out of work for three days. If absenteeism lasts for a longer period of time (typically two weeks or more), lost wages from those first three days will be provided to the worker. If absenteeism lasts longer than three days but less than two weeks, wages from the first three days will usually be treated like an uninsured loss for the worker.

The amount received for lost wages will depend on the worker's financial situation, as well as on the provisions in the state statute. For most claimants in the United States, the amount will be based on roughly 66 percent of their regular income over the past year. If the person does not do any work while recuperating, the entire 66 percent will probably be available to the employee on a weekly, prorated and tax-free basis. If the person does some work while recuperating, wage replacement might be equal to approximately two-thirds of the difference between the employee's pre-accident salary and the employee's post-accident salary. Alternative or additional amounts of compensation may be available if a person is permanently disabled but not unable to work.

Injured workers who are reasonably wealthy might find that their compensation for lost wages is based on less than two-thirds of their salary. Maximum weekly benefits are likely to be equal to some percentage of the average wages for workers in the area. There are also some predetermined amounts of compensation for people with specific conditions and certain levels of disability.

Death Benefits

When workers die as a result of a workplace accident, their family members and dependents are likely to receive a death benefit from the employer's insurance company. The death benefit will usually be provided on a weekly basis and will be based on roughly 66 percent of the worker's wages. It generally will be close to the amount the worker would have received for a permanent total disability. Like disability payments, death benefits may be capped at a certain percentage of the state's average weekly income.

A family member's right to a workers compensation death benefit will depend on the person's relationship to the deceased and the number of people who had the same relationship. Some states will lower the death benefit if the recipient was not significantly dependent upon the worker for money.

The most common beneficiaries of workers compensation death benefits are spouses. A widow or widower is likely to receive compensation on a regular basis until death, unless he or she remarries. Upon remarriage, the deceased's husband or wife typically is given a one-time lump sum from the insurance company in an amount equal to one or two years of benefits.

The deceased's children, whether biological or adopted, are also eligible for death benefits. These benefits last until a child turns 18, but they can be extended under some common circumstances. If a son or daughter remains a full-time student, benefits can continue during early adulthood. If a son or daughter is incapacitated at the time of the worker's fatal accident, the child may be able to receive death benefits throughout his or her incapacitation.

Funeral Expenses

Survivors of deceased workers receive a few thousand dollars for funeral, burial and other end-of-life expenses. The employer or insurer provides this money even if the worker had no dependents.

What's in the Standard Policy?

Workers compensation insurance is almost always paired with employers liability insurance. Workers compensation insurance covers employers for the medical costs and lost wages they must pay to employees in accordance with state statutes. Employers liability insurance covers the employer for damages and defense costs when an employer is believed to be liable for an occupational injury that is not covered by workers compensation insurance. The coverage provided by most insurers in the United States is based on NCCI's Workers Compensation and Employers Liability Insurance Policy.

A workers compensation insurance policy serves as a contract between the insurance company and the employer. Although the policy makes the insurer responsible for providing money to injured employees, the phrase "the insured" refers, in general, to the business paying for the policy.

The policy itself is divided between a workers compensation section, an employers liability section and several other sections. We'll spend the next few pages summarizing the important points of those sections.

Workers Compensation Insurance

The workers compensation portion of the policy is relatively short. It covers the employer for nearly every medical expense and wage reimbursement that must be paid to employees in accordance with state statutes. If an employee is entitled to workers compensation, the insurance company must provide it. If an employee or an injury is excluded from state workers compensation laws, this portion of the policy does not force the insurer to pay anything.

Workers compensation insurance was designed to be flexible and easily adaptable to laws in different states. If anything in this portion of the policy differs with the kind of compensation that must be paid in accordance with state workers compensation laws, the wording in the policy can be disregarded. As long as a business has purchased insurance, its out-of-pocket expenses for workers compensation will almost always be limited to its insurance premium and any applicable deductible.

The workers compensation portion of the policy is not subject to any dollar limit. This is different from the second portion of the policy, which addresses employers liability insurance.

Employers Liability Insurance

Employers liability insurance covers an employer when a worker is injured but is not protected by workers compensation laws. It also can be utilized in situations where a worker's injury leads to legal action by a third party, such as the worker's family.

Like workers compensation insurance, employers liability insurance pays claims that are related to occupational injury, occupational disease or occupational death. The injury or death must have occurred during the policy period. Claims related to occupational diseases are only covered if the worker's last exposure to the disease or harmful work environment took place during the policy period.

Employers liability insurance does not make the insurer responsible for paying benefits that are required by workers compensation laws. Nor does it make the insurer responsible for paying damages when an employee's lawsuit is not related to a workplace injury, illness or death.

Unlike workers compensation insurance, employers liability insurance has dollar limits. Unless the employer agrees to pay more for additional insurance, coverage is usually provided in the following amounts:

- Up to $100,000 for each event causing an occupational injury (no matter how many people are injured in the event).
- Up to $100,000 for each employee who suffers an occupational disease.
- Up to $500,000 total for all instances of occupational disease arising during the policy period.

Policy Exclusions

Sometimes, even insurance is not enough to keep an employer from having to pay for work-related injuries. Situations in which liability is not entirely transferable from employer to insurer are summarized in the next few sections.

Intentional Injuries by Employers

When an employer does intentional harm to a worker, the worker can sue for damages. Defense costs, settlements and damages that are related to intentional harm are not covered by insurance.

Willful Misconduct

Workers compensation insurance does not cover any extra benefits or fines that employers must provide due to willful misconduct. This exclusion might be cited in cases where the employer did not specifically intend to injure someone but willfully engaged in unsafe behavior.

Multi-State Coverage

When employees suffer an occupational injury, their benefits might be based on the workers compensation laws in any one of the following states:

- The state where the injury occurred.
- The state where the employee resides.
- The state of the employer.

Most of the time, the injury, the employer and the employee's residence will all be in the same state. But when business trips are made or when a company expands, the employer might need coverage that can be used in other parts of the country. The appropriate kind of multi-state insurance can exist within a single policy if application forms are filled out properly and if multi-state activities are communicated promptly to the insurer.

The policy's "information page" has two important places where multi-state coverage may be indicated. The first place lists all the states where the coverage will apply at the time the policy first goes into effect. If an employer is doing business in additional states at the start of the policy period and those states are not listed in the appropriate place, coverage will only apply in the additional states if the insurer is notified within 30 days of the issue date.

Another portion of the information page allows employers to list the states where no business is currently being conducted but where coverage might be needed at a later date. When business is about to be done in one of these states, the employer must contact the insurer. The policy then goes into effect in that state.

If a business wants coverage to extend to multiple states, it might be a good idea for an insurance professional to examine workers compensation laws in those states. Some states might not allow an employer to use workers compensation insurance that was purchased in another state.

Defense Costs

When an employer is sued in connection with a worker's injury or disease, the insurance company pays for the employer's defense. Defense costs do not affect the amount of money available to cover the employer's liability. The insurer must pay defense costs until the damages paid for bodily injury, disease or death have reached their dollar limit.

In exchange for paying defense costs and damages, the insurance company is allowed to settle with the plaintiff without the employer's consent. Upon paying benefits under any part of the policy, the insurer has the right to sue any third party who it believes is actually responsible for the injury. After an injury involving a machine, for example, the insurer might try to recoup its losses by suing the manufacturer on the employer's behalf.

Conclusion

Workers compensation has clearly come a long way over the past century. The system's no-fault features have made it easier for employees to receive valuable assistance, and insurance has played a major role in limiting an employer's liabilities. By becoming knowledgeable about workers compensation, an insurance professional can help businesses protect themselves and put them in position to fulfill legal, financial and ethical obligations.

CHAPTER 5: HEALTH INSURANCE OPTIONS

Many insurance producers won't want to admit it, but the average person has a relatively decent chance of avoiding many of the problems insurance was designed to manage. Most homeowners, for example, insure their homes against fire even though their property is unlikely to ever burn down. Similarly, they have liability insurance at a time when being sued by someone—even in our increasingly litigious society—isn't a guarantee. In many cases, they also have permanent life insurance when the need to provide financial stability for their beneficiaries is only temporary.

None of those statements is intended as an attack on insurance products or on the people who sell them. Indeed, fires, lawsuits, deaths and other causes of loss can produce financial ruin. Taking steps to minimize their negative impact is an inarguably smart thing to do, and purchasing adequate insurance is often the most important step in the process.

Still, the chances of losing lots of money on account of those problems seem significantly smaller than the likelihood of needing expensive medical care. There are plenty of people who never have a fire, never get sued and end up dying without leaving a financially needy dependant behind. Yet expecting those people to also go through life without eventually having a chronic or serious illness or injury is extremely unrealistic.

The near-inevitability of needing health care is a major reason why more than 250 million Americans had health insurance in 2010 (according to numbers from the U.S. Census Bureau) and why laws were passed during that year to extend coverage to 32 million more citizens. The enacted reforms sparked considerable debate among lawmakers and taxpayers. But hardly anyone disagreed with the basic premise that having a well-insured population is good for society.

Since so many people either already have the insurance or at least realize its importance, health coverage shouldn't be such a mystery to the public. Yet one of the most important kinds of insurance is also one of the least understood. Applicants tend to shop for it based mainly on price or by what's available through their employer. Important limits placed on benefits or on access to physicians often aren't noticed until care is actually needed.

One of the barriers to understanding health insurance is the lack of uniformity among plans and policies. Whereas most property and casualty insurers utilize standard coverage forms from the Insurance Services Office (ISO), health insurance contracts might only match one another to the extent that certain benefits have been mandated by law. Although the controversial Patient Protection and Affordable Care Act created greater standardization of benefits and aimed to simplify comparison shopping, it's too early to tell whether the law has helped consumers understand what they're buying.

Oddly enough, the confusion surrounding health insurance may have been nurtured by the industry's desire to satisfy consumer demand. In order to meet the needs of a diverse customer base, health insurance carriers developed a wide variety of coverage options. They introduced managed care to applicants for whom traditional reimbursement policies had become unaffordable. They added PPOs when consumers complained about HMOs not letting them see favored physicians. In time, they even cycled back to HMOs and reduced some restrictions as a way of regaining subscribers. The assortment of choices makes it more likely that careful shoppers will find something suitable for them, but it also means there are more variations to analyze. Someone who believes all health plans work the same way is making a serious mistake.

With all this in mind, any text attempting to explain health insurance should probably contain a statement like, "This is how health insurance works, except when it doesn't." We can't tell you exactly how a particular health insurance product will respond to any situation. However, we will spend the next several pages giving you the tools to compare and contrast plans and policies on your own. You'll learn what to look for, as well as the reasons why various health insurance configurations were created in the first place. Even if it serves mainly as a reminder to an experienced producer, we hope this chapter helps you guide people through the health insurance maze.

The Individual Market

To understand modern health insurance, we should start by reviewing what's known as the "individual market." In the individual market, people purchase an insurance policy issued solely for themselves and perhaps for a spouse or child. The applicant arranges coverage by personally contacting either an insurance company or a health insurance agent.

Most people with health insurance don't obtain it through the individual market. Instead, they become insured through an employer-sponsored plan in what's known as the "group market." In the group market, one person or entity (such as a business or union) purchases insurance to cover several non-family members under the same policy. Although an individual who wants to be covered by a group plan needs to complete an application and often must pay some of the costs, he or she doesn't personally contact the insurance company in order to initiate coverage. Administrative tasks—such as delivering enrollment forms and monthly premiums to the insurer—are usually handled by the sponsoring employer or union.

One positive of the individual market is that it puts applicants in control of their insurance decisions. Unlike members of most group plans, someone shopping for an individual policy tends to have several types of coverage to choose from. Buyers interested mainly in the comprehensiveness of coverage can gravitate toward policies with few exclusions and high benefit

limits. Shoppers who place greater importance on out-of-pocket expenses can opt for insurance with low deductibles and minimal cost-sharing requirements. Individuals who already feel comfortable with a particular physician can choose a plan that already has a business relationship with their doctor. Cost, comprehensiveness and access will be different from policy to policy. Savvy consumers can browse through the market until they find a suitable mix.

Another benefit of purchasing health insurance in the individual market is portability. Covered members in a group plan risk losing their insurance when they change jobs or become unemployed. A policy bought in the individual market won't be impacted by changes in employment and can remain in force until the policyholder stops paying premiums or commits fraud.

Before getting too excited about the freedoms built into it, consumers should realize the individual market isn't everyone's best source for insurance. Applicants are often subjected to vigorous underwriting standards, which might result in them being denied a policy for medical reasons. Even healthy people who have a choice between individual coverage and group coverage tend to prefer the latter because the cost is usually shared with an employer. For these and other reasons, the individual market is filled almost exclusively with the following kinds of customers:

- Individuals who are self-employed.
- Individuals with part-time or temporary jobs.
- Individuals with full-time jobs at businesses without an employer-sponsored health plan.
- Individuals who retired before becoming eligible for Medicare.
- Individuals who are unemployed and have used up their COBRA rights or similar continuation coverage.

Applying for Individual Health Insurance

For most of the time that health insurance has been sold in the Untied States, qualifying for health insurance in the individual market has involved a relatively thorough process. This was particularly true in states where "medical underwriting" was allowed. In medical underwriting, an applicant will only be deemed eligible for insurance after the carrier has evaluated the person's medical history and deemed him or her an acceptable risk. At the very least, applicants who are subjected to medical underwriting will need to complete a health-related questionnaire and disclose whether they have been diagnosed with particular illnesses or injuries. They will also be asked about any habits—such as tobacco use—linked to poor health.

Questions on health insurance applications should be answered honestly. Applicants who intentionally misrepresent information to an insurer can have their policy rescinded and may face additional penalties. The Patient Protection and Affordable Care Act made it illegal to cancel someone's insurance based on incomplete information on an application, but this prohibition generally extends to cases of reasonable or innocent omissions. It doesn't protect people who intentionally withhold important information. However, in rules finalized in February 2013, the Department of Health and Human Services clarified that misrepresentation of a person's tobacco use is not an acceptable reason for rescinding health insurance. However, the same rules created a process whereby individuals who misrepresent their tobacco use can be required to pay penalties, including additional premiums.

Some applicants will also need to complete a physical examination and give the insurer access to their medical records. The extent of the examination and the need to review medical documents will be based—at least in part—on the answers indicated on the questionnaire and the comprehensiveness of the desired policy.

Traditionally, after an applicant provided sufficient medical information and had been evaluated by underwriters, the insurance company would usually respond by taking any one of the following actions:

- If the applicant was in decent health, the insurer would offer the desired coverage at its normal price. (Applicants in this scenario were known as "standard risks.")
- If the applicant was a moderate amount of health problems, the insurer might've offered the desired coverage for an extra cost. Alternatively, the insurer might've charged the applicant the same amount as a standard risk but offered less coverage. (Applicants in either of these scenarios were known as "substandard risks.")
- If an applicant had serious health problems, the insurer might not have offered any insurance to the individual at all.

The major criticism of medical underwriting is that it makes health insurance inaccessible or unaffordable for people with serious medical conditions. For example, consumers who were subjected to medical underwriting in past decades were unlikely to qualify for a policy in the individual market if they had any of the following health problems:

- Cancer.
- Sleep apnea.
- Major depression, bipolar disorder or schizophrenia.
- Kidney failure.
- Diabetes.
- Heart disease.
- Cirrhosis.
- Multiple sclerosis.
- Muscular dystrophy.
- Lupus.
- Hepatitis.
- Lymphedema.
- History of organ transplants.
- AIDS.

If an applicant who had recovered from one of the conditions mentioned above or had other major medical problems, desired coverage might've only been available at a higher price.

Non-Medical Underwriting

As a way of making health insurance more widely available, medical underwriting has been replaced in many cases by "community rating" or "modified community rating." Community rating serves as a pooling mechanism, whereby the risk of insuring high-risk applicants is shared from a cost perspective by everyone who purchases the same coverage. When modified community rating is performed, some factors will still make insurance cost differently from person to person, but health status generally isn't one of them.

The non-medical factors commonly used in community rating are as follows:

- **Age:** Since the body deteriorates over time, older applicants are charged more than younger applicants. Even after they've obtained insurance, policyholders in the individual market are likely to experience periodic rate increases as they age.
- **Geography:** Health statistics and the cost of medical care are unlikely to be the same across the country or even across ZIP codes. Someone in an urban area might pay a different amount than someone in a rural area.
- **Family composition:** According to a 2008 report from the Department of Health and Human Services, family coverage for one adult and one child might be cheaper than a similar policy for two adults.

The non-health factors listed above are also important to insurers doing medical underwriting. However, they take on greater importance when community rating is used.

No matter if it is medical or non-medical, information about an applicant is used to put the person in a "rate class." The rate class is made up of similar people with the same insurance. Usually, when a policy comes up for renewal, changes in price are applied to everyone in the class.

Medical Underwriting and Health Care Reform

The Patient Protection and Affordable Care Act made sweeping changes to health insurance in the United States. Beginning in 2010, a health insurer in the individual market could no longer deny insurance to people under 19 because of their medical history. A similar ban went into effect in 2014 for adults.

Changes in 2014 also changed the way an insurer could set its rates. Instead of basing prices on an applicant's health status, insurers in every state needed to use either modified community rating or a less stringent system. Gender-based pricing also become illegal. (In the past, women typically paid more for health insurance than men based in part on pregnancy and on their tendency to utilize more care than males.). Beginning in 2014, when two people (or two small groups) purchased exactly the same kind of health insurance from the same company, only the following factors could be used to charge them different amounts:

- Age (with the cost for one age group equaling no more than three times the cost for any other age group).
- Tobacco use (with the cost for smokers equaling no more than 1.5 times the cost for non-smokers).
- Geography (as determined by each state).
- Family composition.

In order to dilute the risks involved with offering insurance regardless of health, the new rules about eligibility and pricing were initially coupled with an "individual mandate." Under the mandate, most Americans—including healthy, low-risk consumers—needed to obtain insurance or be fined by the Internal Revenue Service. Subsequent changes to tax laws effectively waived the individual mandate by the time this material was being written. However, be aware that the mandate's status (as well as all information related to the Affordable Care Act) remains a hotly contested issue in Congress and in the courts. For the most up to date information about this particular law, you are strongly advised to review any recent updates from the federal government and consider advice from legal counsel.

Insurance Options

You're now aware of whom the individual market is for and how those customers are evaluated by insurance companies. But what kinds of policies are actually available for the purpose of managing medical expenses?

Medical insurance has traditionally been broken down into two broad groups. One group consists of "basic" coverage and is filled with products featuring relatively modest benefits. Another group is for "major medical" and "comprehensive" products, which aim to address a wider range of health costs. Admittedly, some of the policies within those groups—particularly in the "basic" category—have become very uncommon or practically nonexistent. Still, it's important for you to have a background in them because they all contributed to the health insurance market we have today.

Basic Health Insurance

When available, basic health insurance policies can be purchased to help pay for hospital expenses, surgical expenses, physician expenses or a combination of the three. Historically, they have been made available as "first-dollar coverage." Policyholders with first-dollar coverage can be reimbursed for medical expenses without having to pay any deductible out of their own pockets. They might also be spared from "coinsurance fees," which require a patient to pay a specified percentage of otherwise coverable medical bills. However, in what might qualify as one of this chapter's recurring themes, what was once a distinguishing characteristic of this insurance can no longer be considered a certainty. Many of today's insurers have incorporated modest deductibles and other cost-sharing mechanisms into their basic policies.

In exchange for being subjected to little or no cost-sharing, patients with basic health insurance generally need to deal with relatively low benefit limits. Whereas patients who undergo brief hospitalization could conceivably have their entire stay covered in full, someone who needs extended care for a chronic condition might run out of insurance quickly. More commonly, these policies will pay up to a specified amount per day or per procedure but can be capped at a figure far below a provider's actual charge. Also, depending on the chosen coverage, benefits might be limited to care received in a specified kind of facility (such as a hospital).

Since it may be inadequate for people who either have catastrophic ailments or need care in a variety of settings, basic health insurance is often supplemented by other insurance. You'll read more about how basic policies can fit into a broader insurance plan in the section "Major Medical/Comprehensive Insurance."

Hospital Expense Insurance

As its name probably makes clear, hospital expense insurance reimburses patients for care received in a hospital. The insurance tends to have at least two main parts. The first part applies to charges for room and board. The second pertains to other hospital expenses.

Coverage of room and board is based on the cost of a semi-private room. Meals are included, but non-essential services like the use of a television or phone are the patient's responsibility. Benefits can apply while the patient is hospitalized on an inpatient basis and can last anywhere from a few weeks to a year. (Many states have their own minimum requirements.) The insurer will either pay up to a flat amount per day of hospitalization (such as $100) or a stated amount of the rooming charges (such as 100 percent or 80 percent).

Covered services besides room and board commonly include general nursing care, blood transfusions, medicine, medical

tests, x-rays and supplies. Expenses for these services are usually covered up to a multiple of the dollar limit for room and board. For example, a policy with a $100-per-day limit for room and board might cap coverage of other services at 10 times that amount ($1,000).

In general, benefits from hospital expense coverage (including those not related to room and board) will only be provided if the patient has actually been hospitalized. Therefore, someone who goes to the emergency room but is never formally admitted to the hospital might not be able to utilize this insurance. Most policies make an exception if the trip to the emergency room relates to an accidental injury (not sickness) and occurs within a few days of the accident.

It's important to note that the charges picked up by hospital expense insurance are limited to the ones billed by the hospital. Very often, physicians, surgeons and other medical professionals charge their own additional fees when treating hospital patients. In these cases, the facility's charges will be reimbursable under the hospital expense contract. Charges from other parties will need to be paid out of pocket or with other insurance.

Surgical Expense Insurance

Surgical expense insurance reimburses the policyholder for fees paid to surgeons or anesthesiologists. The amount of covered expenses depends on the surgery being performed. Another important factor is whether reimbursement is based on a "fee schedule" a "relative value" point system or on what's considered a "reasonable and customary" amount. In fact, these three methods of determining reimbursement are used to varying degrees in many other areas of health insurance.

Fee Schedules
Insurers using a fee schedule will have already developed a list of surgical procedures and a maximum dollar limit for each of them. If a medical provider decides to charge more than the listed amount, the patient might be fully responsible for the difference.

Relative Value Systems
Rather than using flat dollar amounts, some insurers calculate surgical benefits through a "relative value" point system. In this method, the insurance company gives each surgical procedure a number of points. Simple procedures are usually worth few points, while complicated procedures are usually worth many points. Each point is worth a specific dollar amount, which is disclosed somewhere in the policy.

Reasonable and Customary Charges
Reimbursement based on what's "reasonable and customary" is potentially more responsive to medical inflation because it considers what many physicians actually charge. The insurer first attempts to find an accurate price range for a given service in the patient's geographic area. Then statistical analysis is performed on the price range to determine how much is both reasonable and customary. For example, an insurer might determine that a reasonable and customary charge is equal to what roughly 80 percent of local doctors charge.

Unless they've entered into an agreement to accept a certain amount as full payment, physicians are allowed to charge more than what's reasonable and customary. Patients will be responsible for any excess charges, as well as for any deductibles, copayments or coinsurance fees.

If a policy bases coverage on what's reasonable and customary and also has a coinsurance requirement, the coinsurance calculation will utilize the reasonable and customary charge rather than the actual charge. In other words, let's pretend a patient underwent a procedure and was charged $1,000 by a surgeon. Based on its statistical analysis, the patient's insurance company believes the reasonable and customary charge for the procedure is actually $750. If the policy contains a coinsurance provision whereby the insurer agrees to pay only 80 percent of medical costs, the insurer will pay 80 percent of $750 (the reasonable and customary charge). It won't pay 80 percent of $1,000 (the actual charge). In this scenario, the patient expecting to only pay 20 percent of the bill would actually need to pay 40 percent.

Physicians Expense Insurance

You read earlier about how hospital expense insurance doesn't cover physician charges unless they're built into the facility's fees. Physicians expense insurance fills in this gap and might also help pay for office visits and house calls. The policy might have a cap on the dollar amount or on the number of visits.

Health-Related Indemnity Policies

While reviewing the three major kinds of basic coverage, you may have noticed the word "expense" in their names. Expense policies provide compensation based on the actual costs of received medical care. By contrast, an "indemnity policy" doesn't consider actual costs of services. It pays a specified dollar amount to the policyholder no matter how much care is actually received. An indemnity policy can even provide more money than what's actually spent on medical care, and the recipient can use it as he or she pleases.

Health-related indemnity policies are often marketed to consumers through television, print advertisements and mailings. They usually require no medical underwriting and are pitched at what first might seem like an attractively low price. They're likely to only pay benefits under limited circumstances. For example, a hospital indemnity policy will only provide money for a patient while he or she is hospitalized and will only do so for a limited time, such as a month.

"Dread-disease" or "critical illness" policies are another form of health-related indemnity insurance. These policies are only triggered when a patient is diagnosed with one of the few diseases listed in them. (Cancer is probably the most commonly listed ailment.)

Indemnity policies might qualify for an exemption from many of the requirements of the Patient Protection and Affordable Care Act. Since exemptions for these plans are only available under special circumstances, you should contact the Department of Health and Human Services or speak with an attorney if you have questions about them.

Major Medical Insurance

Several decades ago, insurance companies decided that basic health insurance was inefficient. Since it was typically offered with no deductible or coinsurance requirement, the probability of an insurer having to pay for at least some of a policyholder's medical expenses was high. Meanwhile, the dollar and time limits attached to it meant someone who suffered an extremely serious health problem had a fair chance of running out of insurance. In short, basic policies did the opposite of what good risk management is supposed to do. They paid for losses people could have absorbed on their own but left people unprotected from catastrophic situations that could have crippled their finances.

Insurers attempted to solve some of the problems of basic coverage by introducing "major medical insurance." Major medical insurance pays for a combination of the services we've already mentioned, including those in the hospital expense, surgical expense and physician expense categories. And at least in the beginning, they were more likely to cover treatments and services that were excluded under basic contracts. For example, major medical insurance was more likely to compensate patients or providers for prescription drugs, mental health care, physical therapy and outpatient trips to the emergency room. (Basic plans, if sold today, might cover some of these on a limited basis.)

For many years, arguably the greatest distinction between basic coverage and major medical coverage related to cost-sharing. Basic policies have historically offered first-dollar coverage with no deductible or coinsurance fees. As long as the cost of rendered care was within a policy's limits, the entire amount was reimbursable to the insured. Modern offerings of basic coverage sometimes contain deductibles or coinsurance requirements, but they both appeared in major medical policies first. We'll explain each of them in greater detail in a few moments.

In exchange for sharing some of the cost for their health care, patients with major medical insurance get high benefit limits. Instead of the few thousand dollars of coverage available from a basic policy, some purchasers of a major medical health plan have remained covered even after receiving care worth millions of dollars.

Deductibles

A policy's deductible is the amount of otherwise coverable medical costs a patient must pay out of pocket before insurance benefits become available. The purpose of the deductible is to make the patient responsible for at least some medical costs and to spare the insurer from having to process so many small claims.

There might be a single deductible that applies cumulatively to practically all kinds of care, or there might be a "per-cause" deductible, which would need to be satisfied for each of a patient's medical conditions. When a single deductible is used, it usually must be satisfied once per calendar year. If a per-cause deductible is used, it might need to be satisfied whenever the insured has gone a specified period of time (such as 90 days) without needing treatment for the same ailment. In either case, a policy can waive the deductible requirement for certain kinds of treatment. Some health insurance products don't apply a deductible to hospital care. Others might enforce a hospital-related deductible but not one for visits to physicians' offices.

If a policy calls for a deductible to be satisfied every calendar year, a "carryover provision" usually protects patients whose medical expenses are incurred near year's end in late autumn and early winter. Under the carryover provision, the insurance company looks at the amount of out-of-pocket expenses that were applied to the patient's deductible during the last three months of the previous year. Then, those amounts are used to reduce the deductible for the new calendar year on a dollar-for-dollar basis. To better understand this concept, suppose an insured must satisfy a $500 deductible each year and needs no care until November. In November, she undergoes a $400 procedure, all of which is paid out of pocket and credited toward her deductible. If she needs care in January, she can have the $400 applied to the new year's deductible and have her coverage begin after spending only $100 more. She won't have to satisfy the same deductible twice.

A few deductible-related consumer protections are commonly built into policies for families. A "common accident provision" generally states that if two or more people who are covered by the same policy are hurt in the same accident, the deductible only needs to be met once. For instance, think of a father and son who are injured in a car crash and have a family policy with a $500 deductible. If post-accident care ends up costing $500 for the father and $300 for the son, the family will only need to spend $500 to satisfy the deductible. The fact that the son's $300 of care is below the $500 deductible amount is irrelevant.

Families covered under one policy also sometimes benefit from there being a "family deductible" in addition to a deductible for each individual. With a family deductible in place, individual deductibles are waived once a certain number of family members have satisfied their own deductible. This feature of family policies can be especially helpful to couples with several children. Let's pretend a family of five has a policy with a $500 individual deductible and a family deductible that is met when two members have satisfied the $500 deductible. If both parents have already satisfied their $500 deductible, individual deductibles will be waived for their three children.

Finally, a "corridor deductible" is common when major medical insurance is used as a supplement to a separate, basic policy. Medical bills that aren't covered by the basic policy but would otherwise be covered by major medical insurance are applied to the corridor deductible. Until the corridor deductible is satisfied, the insured will have no coverage under the major medical portion of a plan.

The presence of a corridor deductible essentially creates a temporary insurance gap for patients who exceed their basic policy's limits. In many ways, this gap mirrors the so-called "doughnut hole" that often existed within several Medicare Part D prescription-drug plans until recently. Many Part D plans provided initial coverage up to a certain amount. Then, if a senior's drugs ended up costing more than this amount, the insured paid out of pocket until "catastrophic coverage" from the federal government kicked in. Under the Patient Protection and Affordable Care Act, the doughnut hole was eliminated in 2020.

Coinsurance Fees

Once the deductible is out of the way, people with major medical insurance may still need to pay for a portion of their care in the form of "coinsurance fees." Coinsurance provisions in health insurance contracts explain how the cost of covered services will be split on a percentage basis between the patient and the insurance company. The most common coinsurance provision calls for an "80/20" split. In other words, once the deductible has been met, the insurer will pay 80 percent of costs (often based on a fee schedule or on reasonable and customary charges), and the patient will pay 20 percent. This approach differs from the one found in many basic policies, which often cover 100 percent of expenses up to a certain dollar amount.

To demonstrate how coinsurance works, let's imagine a man who undergoes back surgery costing $10,000. If his major medical policy has a $500 deductible and an 80/20 coinsurance arrangement, his bills will be handled in the following manner:

- $500 will be paid by him in accordance with the deductible.
- 80 percent of the remaining $9,500 ($7,600) will be paid by his insurance company in accordance with the coinsurance arrangement.
- 20 percent of the remaining $9,500 ($1,900) will be paid by him in accordance with the coinsurance arrangement.

The introduction of coinsurance fees was one of the insurance industry's earliest attempts at controlling the utilization of medical services. Presumably, the more patients are required to contribute toward their care, the more likely they'll be to only see a doctor when it's truly necessary. Many forms of managed care—such as some PPOs—will waive coinsurance requirements under some circumstances but will still enforce them when patients use out-of-network providers.

Copayments

They're often confused with one another, but a coinsurance fee and a copayment have some significant differences. Unlike percentage-based coinsurance fees, copayments are expressed as flat dollar amounts per medical visit. Also, whereas coinsurance fees might not be billed to the patient until after an insurance claim has been made, copayments are usually due at the time of service. Even if a policy doesn't require payment of a deductible or coinsurance fees—as is sometimes the case with an HMO plan—a copayment will usually be charged.

Like coinsurance fees, copayments are meant to make patients more responsible for the cost of care and to discourage unnecessary medical visits. The size of a copayment is usually not enough to discourage visits to a primary care physician, but it tends to be bigger for higher levels of care. For instance, a policy calling for a $10 copayment to see a family physician might have a $30 copayment to see a specialist and a $100 copayment to go to the emergency room.

Out-of-Pocket Limits

An insured who has to pay out of pocket in the form of deductibles, coinsurance fees and copayments can end up paying a lot of money for health care despite having insurance. Major medical insurance policies attempt to take some of the unpredictability out of the equation by including an "out-of-pocket limit." The out-of-pocket limit caps how much an insured will have to pay for otherwise covered care during a calendar year. Money spent on insurance premiums is always excluded from this amount, and coinsurance fees are always included. Whether the out-of-pocket maximum includes the deductible and copayments will depend on the policy.

Health insurance that is meant to comply with the Patient Protection and Affordable Care Act must have an out-of-pocket limit for "essential health benefits." The limit includes any combination of deductibles, co-payments and coinsurance fees (but not premiums). At first, the required limits were roughly $6,000 for an individual and approximately $11,000 for a family, with annual adjustments allowed for inflation. Households whose incomes are within 400 percent of the poverty line might qualify for cost-sharing subsidies, which will push their out-of-pocket limits below those amounts. The broad categories of "essential health benefits" to which the Affordable Care Act's out-of-pocket limit might apply are listed below. Each state is allowed some leeway in setting the specific requirements:

- 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.

Renewability

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), major medical insurance policies sold in the individual market are "guaranteed renewable." Guaranteed renewable insurance must remain in force at the policyholder's option regardless of the person's claims history or risk potential. It cannot be cancelled or non-renewed by the insurer simply because the insured has become too sick. Some of the few circumstances under which a guaranteed renewable policy can be cancelled or non-renewed are listed below:

- The policyholder had stopped paying premiums.
- The policyholder has committed fraud.
- The policyholder has moved out of the insurance company's service area. (This circumstance is especially relevant for people in HMOs or other managed-care plans.)

Health insurance premiums for a guaranteed-renewable policy can still rise at renewal time. Companies generally can't increase their price for current policyholders on a case-by-case basis, but they can require higher premiums from broad classes of people who have purchased the same insurance.

It's important not to confuse a guaranteed-renewable policy with a non-cancellable policy. Non-cancellable policies guarantee that premiums won't rise above amounts that have already been agreed to. They are very rare in today's insurance market and are practically unheard of in regard to major medical insurance. Assuming they can be found at all, these policies are more common in the market for life, long-term care and disability insurance.

Important Limits and Exclusions

The best health insurance policies can still have significant limits and exclusions. Many of the most important limits and exclusions will be summarized in the next several sections.

Pre-Existing Conditions

A medical problem experienced prior to an insurance policy's effective date is known as a "pre-existing condition." Throughout most of modern times, policies with an exclusion for pre-existing conditions would have a "look-back" period, such as one or two years. If treatment for the condition was received during the look-back period, the condition would be temporarily excluded. In some jurisdictions, a temporary exclusion would also be enforced if treatment wasn't received but would've been sought by a reasonably prudent person.

Even when such care was excluded from health insurance, denial of coverage on the basis of a pre-existing condition exclusion was temporary. After a waiting period of anywhere from several months to a few years, treatment for pre-existing conditions would be covered unless the condition was excluded for all policyholders with the same insurance.

For the sake of an example, think of a man who was diagnosed with diabetes three months ago. If he applied for insurance in the individual market, an insurer could have refused to cover any diabetes-related treatment because the problem was diagnosed so close to the policy's issue date. However, the man would have been covered for any new medical problems arising after the effective date, and his diabetes would have been covered, too, after a lengthy waiting period.

In 2014, the Affordable Care Act generally allowed adults to avoid exclusions or waiting periods pertaining to pre-existing conditions. Exclusions and waiting periods were banned for children with pre-existing conditions in 2010. Again, the long-term applicability of the Affordable Care Act remains uncertain at the time of this writing as the law continues its way through the federal court system.

Skilled vs. Custodial Care

We've focused thus far on care received in hospitals, doctors' offices and outpatient centers. But as practically anyone with an elderly or disabled family member already knows, varying levels of care can also be provided in private residences, nursing homes and assisted-living facilities. Whether care in those settings will ultimately be covered by health insurance can be difficult to determine.

Major medical insurance will usually pay for "skilled care" at either a nursing facility or a patient's home. Skilled care is care that can only be performed by a trained medical professional. It doesn't include "custodial care," which can often be performed by non-medical professionals. Examples of custodial care include housekeeping chores like cooking, cleaning and doing laundry. Other examples are more personal forms of assistance, such as help with getting dressed, bathing, eating, moving to and from a chair and using the bathroom. Help with these tasks is sometimes paid for when a patient is also in need of skilled care, but custodial care on its own will need to be funded via some other means.

Many health insurance policies make coverage of skilled care contingent upon prior hospitalization. If the patient wasn't hospitalized for a minimum amount of time prior to needing care at home or in another facility (three days is a common requirement), claims might be denied. Once skilled care has been authorized, it might only last for a certain number of days.

The limits and exclusions involving skilled and custodial care tend to become more important for consumers as they age. Many people who are nearing or already in retirement erroneously think these kinds of care are covered in large part by the federal Medicare program. In fact, Medicare's position on skilled and custodial care is very similar to the limits and exclusions we've mentioned here.

Medicare shouldn't be confused with Medicaid. Medicaid is the top payer for nursing home care in the United States. Unfortunately, most seniors aren't eligible for the needs-based program until they have spent down most of their assets. Individuals who are concerned about needing long-term skilled or custodial care and don't want to rely on Medicaid may want to consider buying long-term care insurance.

Maternity Care

The high cost of childbirth has been a problem for many women, including some who already have insurance. Historically, policies purchased in the individual market didn't need to cover maternity care, and those offering some coverage would limit it to certain circumstances. Women who delivered via a non-elective caesarian section might have had some insurance protection, but those who had normal vaginal births often had to pay thousands of dollars completely out of pocket. In either case, there frequently were no benefits pertaining to prenatal tests and treatments unless special financial arrangements were made.

Coverage for maternity care has been much more widely available to women in group health insurance plans. In 1978, Congress enacted the Pregnancy Discrimination Act, which clarified that discrimination against pregnant women was an illegal form of gender discrimination under the Civil Rights Act of 1964. As a result, health insurance plans for businesses with more 15 employees must cover maternity care and must do so on a level equal to other medical services. The requirement provides pregnancy coverage to enrolled employees and to their enrolled spouses. The plan doesn't need to provide pregnancy coverage to other dependants, such as children.

Be aware, too, that even group plans with an exemption from the Pregnancy Discrimination Act must abide by the Health Insurance Portability and Accountability Act and cannot treat pregnancy as a pre-existing condition. Under HIPAA, maternity benefits available in a group plan must be available at the same time as the plan's other benefits.

The passage of the Pregnancy Discrimination Act has often left employers wondering whether the law requires them to cover some controversial kinds of care. Abortion coverage must be provided, but only to the extent that the procedure is necessary to preserve the life of the mother. Regulators and courts have gone back and forth regarding whether the law requires plans to cover contraception. In 2000, the Equal Employment Opportunity Commission—which enforces several labor-related laws on the federal government's behalf—ruled a plan covering other preventive services (such as screenings, immunizations and physicals) must also cover medically prescribed contraception. Similarly, some courts have argued that excluding prescribed contraception is discriminatory because it is used entirely by women and because the health-related effects of contraception disproportionately impact females. More recently, some judges have ruled otherwise, arguing that as long as a plan doesn't cover male-targeted contraception, it doesn't need to cover female-targeted contraception.

The Patient Protection and Affordable Care Act addressed pregnancy issues in several ways. In 2014, the requirement to include coverage of maternity care was extended to smaller group plans and to policies in the individual market. Federal regulations also now require non-"grandfathered" health plans (including group plans and policies in the individual market) to cover certain kinds of preventive care without applying copayments, deductibles or coinsurance fees to them. (Grandfathered plans, in general, are individual and group health plans that already existed on March 23, 2010, and that haven't undergone significant changes since then.) FDA-approved contraceptive services for women are considered a form of covered preventive care under the regulations. A limited exemption allows some religious organizations to avoid paying for contraception coverage, but their impacted employees must still be offered the coverage at no cost by their insurance company.

Plans and policies offering maternity-related benefits must also comply with the Newborns' and Mothers' Health Protection Act of 1996. This federal law was enacted to eliminate "drive-through deliveries," in which new mothers and their infants were discharged prematurely from hospitals for insurance reasons. The law applies to practically all kinds of health insurance, including group plans from an insurance company, self-insured plans created by employers, and policies offered to applicants in the individual market.

The Newborns' and Mothers' Health Protection Act doesn't require all plans to cover maternity care, but those choosing to cover it can't limit benefits beyond the standards set by the law. Insurers covering vaginal births must pay for at least two days of hospitalization for the mother and child. For caesarian births, the

requirement is three days. An insurer can still impose deductibles, copayments and coinsurance fees, but cost-sharing can't differ from day to day. For example, if a policy requires a 20 percent coinsurance fee for the first day of hospitalization for a vaginal birth, the fee can't increase for the second day. Mothers are entitled to the coverage regardless of whether they've had their hospital stay certified or approved in advance by their insurer. However, the insurer is allowed to impose higher cost-sharing requirements if certification or approval is not obtained.

By the time the Newborns' and Mothers' Health Protection Act went into effect, most states had already passed similar legislation. Depending on where they live, mothers and their babies might be entitled to additional insurance-related rights.

Other Exclusions

There are many other coverage exclusions deserving of attention in this chapter. Here are some other kinds of care that might be limited or completely not covered by even a fairly comprehensive policy:

- **Cosmetic surgery:** Cosmetic surgery is usually only covered by health insurance when it is performed in connection with treating an injury or illness. For example, a woman will probably be covered for breast reconstruction following a mastectomy, but a claim for elective breast augmentation would probably be denied.
- **Dental care:** Dental insurance is usually purchased separately from major medical insurance. The major medical plan might still cover necessary dental care after an accident.
- **Eye exams and glasses:** Like dental insurance, vision coverage is usually purchased separately. A major medical insurance policy might still cover treatment for eye-related diseases.
- **War injuries:** Injuries sustained in war are usually covered under a government health plan for veterans.
- **Experimental treatments:** New forms of treatment that have undergone little or no testing often won't be covered by insurance.
- **Alternative medicine:** Non-traditional forms of treatment, such as herbal remedies and chiropractic care, might require special authorization or not be covered at all.
- **Injuries or illnesses from the workplace:** Health insurance doesn't pay for treatment if it should be paid for by an employer's workers compensation insurance. If a health insurer ends up paying a claim that should've been paid by the employer's insurance company, it will request reimbursement from the other carrier.
- **Preventive care:** The Patient Protection and Affordable Care Act generally requires preventive care to be covered, but exemptions exist for many plans already in existence on September 23, 2010. Among older plans, preventive care (such as physicals, immunizations and screenings) might not be covered unless the plan is from an HMO.

Health Insurance Claims

The party responsible for filing a claim with the health insurance company will depend, in part, on the kind of policy involved. "Service contracts"—including policies issued by Blue Cross/Blue Shield organizations and managed-care entities like HMOs and PPOs—usually pay medical providers directly. Patients with these kinds of policies typically won't need to fill out claim forms unless they want to be reimbursed for a payment they made in error. If the patient has a "reimbursement policy," (a form of insurance much more common among private insurance companies in previous decades), the patient might need to be the one to initiate the claims process and fill out forms. However, many people with reimbursement policies can "assign" their claims-related responsibilities to their doctor by signing the appropriate paperwork at the medical office, thereby allowing the doctor to receive direct payment. In fact, it is common for patients to be asked to sign these forms regardless of whether their policy is considered a service contract or a reimbursement contract.

Insuring Children and Families

Consumers who want to insure their spouse, children or other family members typically can do it through either the individual or group market. If an adult has a policy from the individual market, the insurance can be converted to a family policy by notifying the carrier soon after having a child or getting married. Likewise, if the new parent or the newly married person has group insurance, the spouse or child can be added to the group plan if proper notification is given.

Under HIPAA, an employee's dependents and spouse can also be added to a group plan during annual open-enrollment periods and when they lose other health insurance.

Most workers with group coverage probably assume it's best to cover their entire family with the same plan. Taking this position can make a family's insurance situation simpler, but it doesn't always translate to savings on premiums. Although employers often pay for a portion of their employees' health insurance, employer contributions for an employee's family members are usually smaller or not available. If a spouse or child is relatively healthy, it might be a good idea to look into an individual policy for the person before adding him or her to a group.

The Patient Protection and Affordable Care Act contains many important provisions pertaining to children. Under the law, insurers can no longer deny or limit coverage for someone under 19 because of pre-existing health conditions. Also, adult children can now remain on their parents' health insurance plan until age 26. 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.

Sources of Insurance

We've touched on the differences between individual policies and group plans, and we've gone into detail about the characteristics of basic and major medical insurance products. But the categorization of health insurance options doesn't end there.

Even if we assume the vast majority of people with health insurance have major medical or comprehensive coverage through a group plan (as is indeed the case), there are still several different options to choose from. These options include reimbursement policies from private insurance companies, service plans from Blue Cross/Blue Shield organizations, and myriad types of managed-care arrangements from many different entities. Each option has its own set of positives and negatives for patients, although the distinctions among them are becoming increasingly blurry. The basics of each will be explained over the next several pages.

Reimbursement Policies

Arguably the most traditional form of major medical insurance is a reimbursement policy. Reimbursement policies have been sold

mainly by for-profit insurance companies rather than by Blue Cross/Blue Shield or independent managed-care organizations. Many for-profit insurers selling life insurance also sell health reimbursement policies.

Reimbursement policies tend to give policyholders the greatest level of choice regarding which medical providers they can see. Patients aren't limited to an insurer-approved network of physicians, and they don't need a referral to see specialists. What matters is that the kind of care received from a provider isn't excluded from the policy. The freedom to go to practically any doctor might help explain why these policies tend to be more expensive than other insurance options. The higher cost might explain why they usually aren't the first option for the average consumer or small businesses.

Since reimbursement policies lack an organized network of providers, patients might need to pay their doctor for services themselves and then personally file a claim for reimbursement. Still, as was mentioned previously, it's possible for the patient to complete necessary paperwork at the physician's office and allow the provider to make a claim on the patient's behalf. Through this process, known as "assignment," money normally sent to the insured will instead be sent directly to the provider.

As a side note, be aware that some people use the term "indemnity" instead of "reimbursement" when discussing these classic kinds of health insurance contracts. We have chosen not to do so in order to distinguish them from the basic policies that don't take the cost of received care into account (hospital indemnity, dread-disease, etc.). For a review of these basic policies, refer back to the section "Health-Related Indemnity Policies."

Service Plans

Most major medical insurance policies covering groups or individuals today have at least some elements of a "service plan" in them. In a service plan, insured individuals don't pay premiums in exchange for future reimbursement. Instead, they pay premiums in exchange for future medical services. This difference helps explain why patients in service plans are often called "subscribers" instead of "policyholders."

The seemingly subtle distinction between reimbursement plans and service plans impacts how insurance claims are handled. Unlike situations involving reimbursement policies, patients in service plans generally don't need to pay doctors on their own and then wait to be paid back by their insurer. Instead, claims are usually handled automatically by the health care provider, and the insurer pays the provider directly. A patient with a reimbursement policy can sign forms to make sure a provider is paid directly, but this extra step of written authorization usually isn't necessary in a service plan. Direct payment from the insurer to the provider will have already been agreed to as part of a contract. So, by default, reimbursement policies reimburse the patient, and service plans reimburse providers.

Medical providers who have contracted with insurers to treat subscribers are part of a plan's "network." In exchange for direct payments and other incentives, providers in a network typically agree to bill for no more than what's in the plan's fee schedule or what the plan believes is "reasonable and customary." Patients who see network providers might still have to pay deductibles, coinsurance fees and copayments, but they won't need to pay any additional fee just because the insurer and the provider don't agree on what something should cost.

Telling the difference between reimbursement plans and service plans can be difficult and, frankly, unimportant to a certain extent. Today, it's common for a health insurance product to feature characteristics of both a reimbursement policy and a service plan. For example, a service plan might act more like a reimbursement policy when a patient sees a doctor who isn't in the plan's network.

The classic example of a service plan is a Blue Cross/Blue Shield plan. At a basic level, the many kinds of managed-care plans (HMOs, PPOs, etc.) can be considered service plans as well.

Blue Cross/Blue Shield

Blue Cross/Blue Shield plans have been leaders in the market for service plans for several decades. Originally, these plans were separate, with Blue Cross plans handling hospital expenses and Blue Shield plans handling physician expenses. Eventually, it became more practical for the two types of plans to merge. Each Blue Cross/Blue Shield plan serves its own geographic area and is run by its own set of directors, but they all follow standards from the same national association.

Historically, one of the distinguishing characteristics of Blue Cross/ Blue Shield entities has been their non-profit status. That reputation, though, has become somewhat diluted over the years. Many Blue Cross/Blue Shield plans have re-organized themselves as for-profit entities. Meanwhile, some of the consumer protections offered originally by Blue Cross/Blue Shield plans have since become mandatory for for-profit insurers.

Managed Care

Since you now have an understanding of service plans and Blue Cross/Blue Shield, we can address the important issue of "managed care." Managed care has many definitions, with its meaning dependent upon who is using the term and in which context. Many people assume managed care is synonymous with an HMO or that it's completely separate from the kinds of insurance available from major insurance companies. In fact, managed care can be viewed more as an approach to health insurance rather than an alternative to it. It's been adopted to varying degrees by private insurance companies, Blue Cross/Blue Shield plans, service plans and (to a lesser extent) providers of reimbursement policies.

For our purposes here, we'll define managed care as an approach to health insurance that attempts to control how covered care is actually provided. Examples of managed care in action include instances in which an insurer requires pre-authorization for an operation and cases in which an insurer limits a patient's choice of physicians. If a patient is asked to choose among the physicians in an insurer's network, at least some level of managed care is being practiced.

The amount of managed care in a health insurance plan can be anywhere from relatively minor to very high. An insurer practicing a relatively minor amount of managed care might simply try to influence patient behavior by offering certain financial incentives. For instance, it might cover 50 percent of services received from out-of-network providers, but offer to pay 80 percent if the patient gets care within the network. Conversely, an insurer practicing a lot of managed care might essentially force a patient to receive care from a network provider by refusing to cover any out-of-network treatment.

If a patient stays in network, access to providers can be restricted in other ways. A strict approach to managed care might require a referral from a primary care physician before a patient is allowed to visit a specialist. A more flexible approach might waive the

referral requirement but impose smaller copayments if treatment is received from the primary doctor instead of a specialist.

Proponents of managed care believe it can be an effective way of controlling health-care costs. Because of the disincentives to go out of their network, patients have good reasons to only seek treatment from providers who have already agreed to accept pre-negotiated payment amounts from the insurance company. The restrictions relating to specialists can sometimes make care more efficient. Depending on a primary care physician's expertise, he or she might be able to solve a patient's problem and thereby eliminate the need to see a usually more expensive specialist. If the primary care doctor can't solve a problem, he or she can usually guide an uninformed patient to the appropriate expert. For these and other reasons, consumers who are willing to accept a higher level of managed care usually pay less for their insurance.

Still, managed care is routinely criticized for its influence on choice and the doctor-patient relationship. Managed care attempts to make comprehensive health services available to patients, but a patient's favored physician isn't always part of an insurer's network. And even if a patient is satisfied with his or her current doctors, there's no guarantee those doctors will remain in the network forever. Meanwhile, doctors in an insurer's network sometimes complain that rules regarding insurer authorization are too narrow and prevent them from implementing patient-specific treatment plans.

Over the last few decades, insurers have tried to find ways to balance cost against freedom of choice and have come up with several different managed-care arrangements. Among the most recognized arrangements are HMO plans, PPO plans, and POS plans.

HMOs

An HMO (or "health maintenance organization") is probably what most people think of when the term "managed care" is used. This makes sense because even though many other sources of health insurance have elements of managed care in them, the use of managed care within HMOs is especially high.

Compared to other health insurance arrangements, an HMO features a relatively tight relationship between the physician and the insurer. The closeness of the relationship can be reflected in several ways, including how medical providers are paid, who physicians work for, and how carefully a physician's procedures are monitored.

In perhaps the closest kind of relationship, individual physicians can be employed on an exclusive basis by the HMO to staff its own medical facilities. Alternatively, an HMO can contract with one or more medical groups, and the groups' employed physicians will serve the HMO's patients. An HMO also has the option of contracting with individual physicians who will treat the HMO's subscribers in addition to treating other patients.

Compared to other examples of managed care, an HMO is less likely to compensate medical providers through a "fee-for-service" arrangement. In a fee-for-service system, compensation for providers is based on the number and type of specific services they actually perform. By contrast, providers in an HMO are often paid a pre-determined amount every year or every month based on their total number of patients. This pre-determined amount might be paid directly to a physician, or it might be paid to the physician's medical group, which will have its own method of compensating individual doctors. Either way, the movement away from a fee-for-service system is meant to eliminate financial incentives for providing supposedly unnecessary treatment. Of course, whether certain services are truly unnecessary is often a serious area of disagreement between doctors and insurers.

Even in cases where an HMO uses a fee-for-service model, it will monitor a provider's decisions to make sure care is being provided in a cost-effective manner. For example, if a provider orders tests at an unusually high rate, the HMO might request clarification or a change in behavior.

Primary Care Physicians

A patient in an HMO will have all of his or her care coordinated by a "primary care physician." A primary care physician is the patient's first point of contact for help with a medical problem. The physician might be a general practitioner, a family practitioner, an internist (if the patient is an adult) or a pediatrician (if the patient is a child). Each HMO will have a list of eligible primary care physicians for patients within a designated geographic area. A patient who has a bad experience with a primary care physician can switch to another provider on the list. If a primary care doctor leaves the HMO, patients might be able to continue seeing the doctor for a short period of time.

In an HMO, the primary care physician acts as a "gatekeeper" who controls a patient's access to specialists. Before a patient can receive covered care from a specialist, the primary care physician must be consulted to determine if a specialist is actually necessary. If the patient's problems aren't treatable by the primary care physician, a formal referral often must be made to the specialist.

Preventive Care

One of the attractive features of an HMO is its emphasis on preventive care. HMOs have long believed that addressing health issues as soon as possible ends up saving them money over the long run. As a result, they've typically covered physicals, screenings, immunizations and other forms of preventive medicine at a higher rate than other kinds of health insurance. This is likely to become less of a distinguishing characteristic as more health plans become compliant with the Patient Protection and Affordable Care Act. Through the law, non-grandfathered plans must cover certain forms of government-recommended preventive care without imposing a deductible or requiring any additional copayments or coinsurance fees.

Cost Sharing in an HMO

Another attractive feature of an HMO is cost. Since there are more restrictions on access to providers, subscribers tend to pay comparatively lower premiums. The cost of receiving covered care is usually lower, too. Patients usually don't need to satisfy a deductible before their benefits kick in, and they tend to only be responsible for a small copayment for each medical visit. Coinsurance fees are usually not required.

PPOs

Consumers who want insurance with more flexibility than an HMO and are willing to pay a little more might be interested in a "PPO." A PPO (or "preferred provider organization") has contracts with a wide variety of medical providers and pays those providers on a fee-for-service basis. The size of the fee might be pre-determined as part of a fee schedule or might be based on what's reasonable and customary in the area.

In exchange for accepting pre-negotiated fees from the PPO, affiliated providers are more likely to receive business from the PPO's subscribers. Patients in a PPO aren't prohibited from receiving care beyond the insurer's network, but financial incentives exist to keep them from going elsewhere. For

example, while a PPO might cover 60 percent of care received beyond the insurer's network, care inside the network might be covered up to 80 percent. Similarly, a PPO might reduce the deductible (or waive it entirely) if care is received from network providers.

Unlike an HMO, PPOs generally don't require the use of primary care physicians as gatekeepers. If they want to see a specialist, patients can do so without first receiving a referral. There will be financial incentives to choose a specialist within the PPO's network, but seeing an out-of-network specialist is still permissible.

POS Plans
A "point of service" (POS) plan is commonly considered a combination of an HMO and a PPO. Just as they would in an HMO, patients choose a primary care physician, who will coordinate their care and issue the necessary referrals. Just as they would in a PPO, patients have the option of going out of network. But compared to a PPO, the difference in coverage for in-network care vs. out-of-network care in a POS plan tends to be more significant.

HSAs, MSAs and FSAs

Managed care isn't the only popular method of controlling costs in the health insurance community. Many health policy experts believe certain ways of paying for care—when coupled with favorable tax treatment—can make insurance affordable and reduce unnecessary treatment. Proponents of this idea often encourage broader use of "health savings accounts" (HSAs)

A health savings account is an individually owned tax-favored account containing money for medical expenses. The account can be offered in conjunction with an individual health insurance policy or a group plan, and it can be for the benefit of one person or a family. Contributions—which are capped by the Internal Revenue Service at a certain dollar amount each year—can come from the account holder or from an employer.

A health savings account must be paired with a high-deductible health insurance plan. The deductible can be anywhere from roughly a few thousand dollars for an individual to several thousand dollars more for a family. Until the deductible has been satisfied, a patient's medical expenses can be paid with money from the person's account. In fact, money from the account can sometimes be used to fund medical expenses not covered by the high-deductible insurance plan. Examples might include the cost of eyeglasses, preventive dental services and custodial care. While making an exception for insulin, the Patent Protection and Affordable Care Act eliminated over-the-counter medicines from the list of eligible expenses. (For an in-depth look at eligible expenses, see IRS Publication 502.)

In general, contributions to health savings accounts are tax-deductible and can grow on a tax-deferred basis. Withdrawals for payment of eligible medical expenses are free from federal taxation, but money spent for other purposes will be taxed as income. Barring special circumstances, such as a disability, withdrawals made prior to age 65 for non-medical purposes will also be subjected to a flat, percentage-based penalty.

The push for greater use of health savings accounts is based partially on the theory that the high deductible in the accompanying plan will force people to make responsible decisions about their health care. It's also been argued that the high deductible can make insurance an option for people who wouldn't otherwise be able to afford it. On the other hand, some critics believe a movement toward more health savings accounts wouldn't benefit households in low tax brackets and would discourage unhealthy people from seeking important treatment.

Be careful not to confuse a health savings account with a "flexible spending account" (FSA) or a "medical savings account" (MSA). A flexible spending account lets employees use pre-tax dollars to pay for various medical expenses. Unlike money in a health savings account, unused funds in a flexible spending account generally cannot be carried over from one plan year to the next.

A medical savings account is very similar to a health savings account but is only available to self-employed people and employees of small businesses. Since health savings accounts are available to a broader portion of the population, they've essentially replaced medical savings accounts in today's market.

Group Health Insurance

Most people who have health insurance didn't get it in the individual market. Instead, they receive group coverage as an employee benefit through their job. The use of health insurance as an important employee benefit grew out of the World War II era. Labor shortages caused businesses to compete for the best workers, but government freezes on wages meant those companies often couldn't attract new employees by simply offering more money. Since the freezes weren't applicable to fringe benefits, group health insurance was used as a recruiting tool and as a way to satisfy organized labor. The wage freezes eventually ended, but the popularity of employer-sponsored health insurance continued to grow.

We'll conclude our study of health insurance by reviewing topics specific to group health plans. But despite a few significant differences, the majority of the information already provided in this chapter is relevant on a nearly equal basis to the individual market and the group market. Like most policyholders in the individual market, enrolled group members almost always have a form of major medical insurance covering hospital expenses, surgical expenses and physician expenses. Like shoppers in the individual market, covered employees often must accept a certain level of managed care. And like applicants who get their insurance outside of work, members of group plans might have coverage through a for-profit insurer, Blue Cross/Blue Shield, an HMO, a PPO or some combination of those sources.

Applying for Group Health Insurance

Group health insurance covers several people through a single insurance policy. In most cases, the link between all members in the group is their employer. Employer-sponsored group health insurance is usually available to all of a company's full-time employees. Most plans will also insure an enrolled employee's spouse and children. Although the Patient Protection and Affordable Care Act doesn't force all group plans to cover employees' children, those already covering children must continue to do so until a child turns 26. Eliminating coverage for children because they are no longer students, no longer single or no longer dependents on an employee's tax returns is prohibited until they reach this age.

Insurance options in group plans tend to be less clear for retirees, working senior citizens and same-sex partners. Health insurance for retirees used to be a popular benefit, but it's become increasingly uncommon as businesses have tried to reduce costs. Working people who are nearing Medicare eligibility should contact their insurer to see how their current plan coordinates with the federal plan. This is especially important for people at companies with less than 20 employees because those businesses sometimes have the right to offer reduced coverage

to workers over 65. Same-sex couples who are married generally have the same federally imposed insurance rights as married opposite-sex couples. Similarly, same-sex couples in civil unions generally have the same state-level insurance rights as married couples in their state. An increasing number of employers are also making enrollment an option for unmarried couples in domestic partnerships.

The option to enroll in an employer-sponsored group plan typically exists when the employee is hired or during a month-long "open-enrollment" period each year. Under HIPAA, employees, spouses and dependents who initially declined group coverage don't need to wait for an open-enrollment period following marriage, the birth or adoption of a child or the loss of other health insurance.

Circumstances in which an employee, a spouse and dependents can bypass a group plan's open-enrollment period because of a loss of other coverage include the following:

- Coverage existed under a spouse's or dependent's plan, and the spouse or dependent has become unemployed.
- Coverage existed under a spouse's or dependent's plan, and the spouse's or dependent's employer has discontinued the plan.
- Coverage existed under a spouse's or dependent's plan, but the spouse's or dependent's employer has shifted the cost of the plan entirely to employees.
- Coverage existed under a spouse's or dependent's plan, and the plan's lifetime benefit limit has been reached.
- Coverage existed under a spouse's or dependent's plan, but the spouse or dependent has lost coverage due to a reduction in work hours.
- Coverage existed under a spouse's or dependent's plan, and the spouse or dependent has died.
- Coverage existed under a spouse's or dependent's plan, but the spousal or dependent relationship has ended. (This includes cases of spouses getting divorced and children reaching adulthood.)

Marriage is one of the few events that lets families bypass an open-enrollment period and join a group plan without needing to have lost other coverage. An employee who is already covered by a group can add his or her spouse within 30 days of marriage. If the employee hasn't enrolled, he or she can join within those same 30 days.

Birth or adoption is another event that lets families join group plans outside of normal open enrollment. Children can join within 30 days of being born or adopted. When they do, coverage is retroactive and dates back to their date of birth or adoption. Parents to the child who haven't enrolled can do so during those same 30 days.

One drawback to group coverage is that eligible employees are limited to the options presented to them by the sponsoring employer. For example, if the employer only offers insurance through an HMO, the employee must decide whether to accept it or go without group coverage. If the employer offers multiple options but the employee is still unhappy with a particular aspect of a plan, the employee can't negotiate a change with the insurance company.

Despite allowing for less personal choice than the individual market, group insurance is usually preferred by eligible employees. The main reasons for this pertain to access and affordability. Although a group as a whole might be charged more because of the overall health status of its members, group plans can't deny enrollment to a particular person because of health or charge the person more for being a higher risk. And although most employers won't help pay premiums for spouses or dependents, many businesses continue to pay for at least a portion of the insurance covering their employees.

Pricing Group Health Insurance

Since insurance companies can't discriminate against a particular person in a group plan, characteristics of the group as a whole can be very important. The composition of the group and the amount charged per member will need to be enough to balance out the risk of insuring unhealthy members. In most cases, the insurance company will be more confident (and more willing to offer affordable coverage) when enrollment in the group is high and when the average age of the members is low.

If the number of people in a group is very large, the group might be viewed as its own pool for the purpose of pricing and will be subjected to "experience rating." Experience rating is a method of calculating the cost of insurance in which emphasis is placed on the applicant's previous losses. If claims made by an experience-rated group are relatively high, the group should expect to pay a relatively high amount for its insurance. If an experience-rated group has a major shift in its claims history from one year to the next, the amount charged by the insurer for the following year will reflect the change.

Due to their size, smaller groups either aren't subjected to experience rating or are only impacted by it to a limited extent. Instead, greater emphasis is put on community rating. Community-rated groups can still experience significant increases in the cost of their insurance, but it won't be because claims for the group are especially large. Rather, it will be influenced more by changes in the group's demographics and the overall claims history of all similarly insured businesses in the area.

As was mentioned earlier, the Patient Protect and Affordable Care Act began requiring insurers to engage in a modified form of community rating in 2014 when pricing coverage for small groups. The law also called for community rating among larger groups, depending on how other portions of the law are implemented at the state level.

Self-Insured Plans

Over the past few decades, many employers have abandoned traditional relationships with insurance companies and covered their employees through a "self-insured plan." In a self-insured plan, the money for an enrolled person's medical treatment comes out of an employer's own funds. This differs from a "fully insured plan," in which insurance for employees is funded entirely by paying premiums to an insurance company. Both types of plans can require financial contributions from enrollees, but the difference relates to how much responsibility an employer must accept when those contributions are too small to pay claims. In a fully insured plan, the employer is not financially liable if premiums from group members aren't enough to pay claims. In a self-insured plan, claims exceeding collected premiums will need to be paid by the employer unless special legal arrangements have been made.

For a self-insured plan to be successful, the employer's annual health care costs need to be steady or, at least, predictable. To an extent, this helps explain why self-insured plans are more commonly implemented by companies with several hundred

workers than by smaller businesses. Whereas a few employees having catastrophic health problems are unlikely to skew a large employer's annual costs very much, having the same thing happen at a small company could bankrupt the business.

The financial responsibilities involved with a self-insured plan are sometimes worth taking if the employer wants to customize its health plan to make it more efficient and less costly than a fully insured plan. Unlike fully insured plans, self-insured plans generally aren't regulated by state insurance departments and can therefore ignore many of the mandatory benefits insurance companies must provide. However, self-insured plans generally must comply with the majority of the federal requirements mentioned in this chapter, including most of those pertaining to HIPAA and the Patient Protection and Affordable Care Act.

Since health plans can be very complex, an employer with a self-insured plan will usually still maintain some kind of relationship with a health insurance company or another business specializing in employee benefits. For example, an employer might provide all the money needed to pay claims but contract with a third-party administrator (TPA) to handle enrollment, billing and other administrative tasks. When these tasks are offered to self-insured plans by a health insurance company, the acronym "ASO" (for "administrative services only") is sometimes used.

If a self-insured plan wants to manage the risk of unexpectedly large claims, it can purchase "stop-loss insurance." Stop-loss insurance will reimburse the self-insured employer for medical payments above a set amount. It might go into effect when claims for an individual reach the amount or when claims for the group as a whole have reached it. A similar arrangement known as a "minimum premium plan" is sometimes used by fully insured plans that are willing to share some medical bills with insurers in exchange for lower premiums.

Coordination of Benefits

It's possible for people to be covered by more than one health insurance plan. This might occur if an employee works for multiple employers, each of which has its own plan. More commonly, it happens when both members of a married couple have insurance through their employers and decide to cover each other or their children under both plans.

If someone has health insurance from multiple sources, it's important to examine a plan's "coordination of benefits provision." The coordination of benefits provision serves two important purposes. First, it stops someone who is covered by multiple insurance policies from "double-dipping" and being compensated for more than the cost of their care. Second, it explains how the cost of care will be shared among the different insurance plans. Usually, one plan is "primary" and pays for care as if the patient were covered under no other plans. Then, the other plan (considered "secondary") pays for some or all of the costs not covered by the primary plan. In general, the rules about which plan is primary and which one is secondary are as follows:

- If someone is covered as an employee in one plan and as a spouse in another, the employee coverage is primary.
- If a child is covered by plans from two parents who have joint custody, the coverage from the parent whose birthday falls earliest in the calendar year is primary.
- If a child is covered by plans from two parents who don't have joint custody, the coverage from the parent with custody is primary.
- If a divorce decree specifies which parent will be responsible for a child's health insurance, the insurance arranged by that parent will be primary.
- If someone is covered by an employer-sponsored group plan and Medicare, several factors (including the size of the employer and whether the person is retired) will determine which insurance is primary. Interested readers should contact the Department of Health and Human Services or visit the department online for details.

Mental Health Parity

As mental health has become less of a stigmatized topic, the insurance-related rights for individuals with mental health problems have grown. In 1996, Congress passed the Mental Health Parity Act, which required lifetime and annual dollar limits for mental health care to be equal to the dollar limits for physical health care. The law didn't require coverage for mental health care, and those providing such coverage could still have different limits for mental health if they weren't based on annual or lifetime dollar limits. For example, a plan could still have different copayments or coinsurance fees for mental health and could put different limits on the number of covered visits. The law applies to group plans with more than 50 members.

The Mental Health Parity and Addiction Equity Act of 2008 expanded upon the requirements of the earlier law. Under the act from 2008, plans covering mental health care must have substantially the same limits for mental health care and physical health care in regard to most aspects of coverage, including deductibles, coinsurance fees, copayments and number of visits. As with the earlier law, it doesn't force plans to cover mental health care in the first place, and it only applies to group plans for more than 50 people.

Many states require coverage of mental care in some plans. For example, Illinois requires group plans for more than 50 employees to cover "serious mental illnesses." Insurers offering plans to smaller groups in the state must offer mental health coverage to the employer, but the employer can decline it.

The Family and Medical Leave Act

The Family and Medical Leave Act preserves employees' jobs and their health insurance when they take a leave of absence to care for themselves or a family member. Employees covered by the law are entitled to 12 weeks of unpaid leave (and continued health insurance) per year under any of the following circumstances:

- They need time off to become acquainted with a newborn, a newly adopted child or a newly placed foster child. (Men who take leave for this reason are entitled to the same rights as women.)
- They need time off to care for a seriously ill child. (The child doesn't need to legally or biologically be their son or daughter. However, an employee must have assumed some kind of parental role.)
- They need time off to take care of a seriously ill spouse.
- They need time off to take care of a seriously ill parent or guardian. (The parent or guardian doesn't need to legally or biologically be their mother or father. However, the ill person must have assumed some kind of parental role when the employee was a minor.)
- They need time off to manage their own serious illness.
- They need time off for reasons relating to a family member's membership in the National Guard or

Reserves. (In addition, family members may take 26 weeks of unpaid leave to care for a seriously ill service member.)

Serious medical conditions that would trigger an employee's rights under the Family and Medical Leave Act generally include a sudden medical problem requiring hospitalization or a chronic condition that prevents a person from working. Requests for medical leave generally must be granted, but an employer can require medical proof before authorizing an absence.

Not all businesses are impacted by the Family and Medical Leave Act. For the law to apply, all of the following statements must be true:

- The employee has worked for the employer for at least a year.
- The employee has worked at least 1,250 hours for the employer over the past 12 months.
- The employer employs at least 50 people within 75 miles of the employee's workplace. (This requirement attempts to address situations in which an employer has multiple offices.)

The insurance-related rights under the Family and Medical Leave Act don't excuse employees from having to pay their portion of insurance premiums. Also, if an employee takes leave and never returns to work, the employer might be able to recoup any premiums it paid toward the person's coverage during the absence.

Continuation Coverage

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) gives people who would otherwise lose group coverage a chance to maintain their insurance. Circumstances under which COBRA rights can be triggered are as follows:

- An employee, the employee's spouse and the employee's children can keep their group coverage for 18 months if the employee leaves the employer. (This includes being laid off or leaving voluntarily, but it doesn't include cases in which someone is fired for gross negligence.)
- An employee, the employee's spouse and the employee's children can keep their group coverage for 18 months if the employee loses coverage because of a reduction in work hours.
- An employee, the employee's spouse and the employee's children can keep their group coverage for 29 months if the employee becomes disabled within 60 days of the events listed above.
- An employee's spouse can keep his or her group coverage for 36 months following a divorce or separation.
- An employee's spouse and children can keep their group coverage for 36 months following the employee's death.
- An employee's spouse and children can keep their group coverage for 36 months if the employee's coverage is cancelled because of Medicare eligibility.
- An employee's children can keep their group coverage for 36 months if they become too old for the plan or become ineligible for other reasons.

COBRA rights apply to group health insurance, group dental insurance and group vision insurance. They don't apply to group life insurance, group disability insurance or group long-term care insurance. Regardless of the timeframes mentioned above, coverage extended through COBRA can end prematurely if any of the following events occur:

- The employer ends the group plan.
- The insured stops paying premiums.
- The insured joins another group plan. (Someone who becomes eligible for another group plan can decline enrollment in it and continue COBRA benefits.)

Although COBRA allows eligible employers and their families to temporarily keep their insurance, those who exercise their COBRA rights will usually end up paying more than what they're accustomed to. An employer who pays for a portion of an employee's insurance is not required to do the same for people on COBRA. In fact, an individual can be charged the same amount as current employees, plus the amount normally paid by the employer, plus an extra 2 percent to cover administrative costs. If COBRA rights are extended because of disability, the extra 2 percent can be increased to 50 percent for months 19 through 29.

The aforementioned federal rules about COBRA are for group plans at businesses with more than 20 employees. Some states (including California, Illinois and several others) give similar rights to workers at smaller businesses.

Conclusion

Health insurance is an incredibly important topic for consumers and for the producers who help them. The next several years will feature several important changes in the way this insurance is offered. Undoubtedly, other major changes will occur in later years as society tries to deal with evolving health-related concerns. Keeping up with all the changes will be a challenge for anyone connected to the health insurance industry. Still, the task is likely to be less burdensome on professionals who have a firm grasp on the way coverage currently works.

CHAPTER 6: RECOVERING FROM SHUTDOWNS

Pretend for a moment that you are a business owner who receives a phone call earlier than usual one morning. The frantic voice on the other end of the line belongs to your office manager, who hurriedly informs you there is a fire ripping through your premises. As you arrive on site, you're relieved to learn no one was hurt. Your building, though, wasn't nearly as lucky. A bustling fire crew blocks you from inspecting the damage up close, but you could tell all the way from the road this wasn't just a small fire that relegated itself to your company's small kitchen. Based on what you see, getting your business back to where it was will require several months of rebuilding. Your property insurance will help pay for repairs to the building and for replacement of contents, but what about your income? How will you pay bills while your doors are closed? How will you continue to pay your workers? What you do while you wait for your post-fire income to catch up with your pre-fire income?

While business owners can't control the forces of nature or prevent all serious accidents from happening, they can cushion the financial blow of a possible shutdown by purchasing adequate "business interruption insurance." This kind of insurance typically reimburses policyholders for lost income and any expenses they incur during a break in normal business operations.

Kinds of Insurable Properties

Although business interruption insurance reimburses policyholders for lost income and not for property damage, coverage is still usually linked to an insured's physical place of

business. In order for an interruption at a particular business property to be covered, the property often must be named in the insurance contract.

The kinds of properties that can be named in a business interruption contract are seemingly unlimited. A policy might name one building, an entire industrial complex, a rental property or a single office within a bigger building. A single policy form can be made to cover interruptions at one location, or it can be made to cover multiple properties regardless of their proximity to one another.

Coverage is available to businesses renting their commercial space, as well as to those who own and operate their own buildings. Business tenants can insure themselves against interruptions that are caused by damage to their section of a building or to any public area that is used to access that part of a building.

Coverage also extends to interruptions caused by damage to personal property, such as important equipment or machinery. In these situations, the damaged personal property usually needs to have been within 100 feet of the named premises.

ISO forms permit owners of commercial properties to choose among three kinds of business interruption coverage. Those who operate a business out of their property but do not rent out space to tenants will probably opt for "non-rental value only" coverage. Owners who rent out space to tenants but do not operate their own business out of their property will probably opt for "rental value only" coverage. Owners who operate a business out of their property and rent out space to tenants will probably opt for "business income with rental value" coverage.

In the context of the three preceding terms, "rental value" means the amount of money commercial tenants pay to building owners, plus any operating expenses that are normally paid by tenants but would be incurred by owners during an interruption.

Tenants should keep in mind that they are probably not covered by their landlord's business interruption insurance, assuming such coverage has even been purchased by the property owner.

Regardless of the location, business interruption insurance is a combination of "business income insurance" and coverage of assorted business expenses. Let's look at the kinds of benefits that are commonly available.

Business Income Insurance

Business income insurance pays business owners the amount of money they would have earned if a covered peril had not forced them to suspend normal operations. It reimburses business owners for their lost net profits before taxes. Not surprisingly, since these insurance benefits are meant to replace lost taxable income, they must be declared as income for tax purposes.

Business income payouts are determined by the actual loss a business has suffered during an interruption. Essentially, benefits are calculated by estimating the profits that would have been produced without the interruption and by subtracting the company's actual income from that hypothetical figure. Income sources not affected by the interruption, such as investment income, will also be deducted.

Continuing Expenses

If a business owner plans on ever reopening after an interruption, there will be several bills and other financial obligations to take care of in the meantime. Luckily for that business owner, business interruption insurance includes coverage of "continuing normal operating expenses." Continuing normal operating expenses are those expenses the insured would face regardless of damage to named property. Examples of these expenses include rent, commercial mortgage payments, commercial insurance premiums, utility bills and some taxes. If the insured wishes to lower premiums, the cost of heat, power and refrigeration can be excluded by means of an endorsement.

A normal continuing operating expense is not covered if the interruption has eliminated it. The cost of electricity, for example, is usually considered a normal continuing operating expense, but it would not be covered if business is interrupted by a blackout. After all, the business would not be using any power during that kind of interruption.

Payroll Coverage

Choosing to pay employees during a business interruption does more than create good will between labor and management. It helps the business owner by making it less likely that valuable workers will leave the company out of financial necessity.

By keeping their experienced employees on the payroll during a suspension of operations, businesses set themselves up for quicker recovery. Their reopening will not be delayed by a shortage of staff, and their productivity will not be hampered by newly hired personnel with inadequate training.

Insurers understand how employee continuity can reduce business interruption losses, and they make it a point to list payroll as a covered continuing expense. Along with wages and salaries, business interruption insurance pays for union dues, workers compensation premiums, some employee benefits and the business's required contributions to Social Security and Medicare under the Federal Insurance Contribution Act (FICA). Insurance benefits will be reduced appropriately if an employee is laid off during an interruption.

Extra Expenses

Most but not all forms of business interruption insurance reimburse businesses for the extra expenses they incur during a suspension of normal operations. In order to be covered by an insurer, these costs must, in some way, either reduce the duration of the interruption or help eliminate the interruption altogether.

Each insurer may have its own idea of what constitutes a legitimate extra expense. That said, the insured could probably make a strong case for coverage of the following expenses:

- The cost of renting a temporary place of business.
- The cost of equipping a temporary place of business with necessary machinery and supplies.
- The cost of making a temporary place of business physically presentable to the public and serviceable for business operations.
- Expedited shipping costs for necessary machinery and supplies.
- Moving costs.
- Overtime pay for employees who assist in the relocation process.

Unlike business income insurance, which usually features a three-day waiting period before coverage can begin, coverage of extra expenses starts at the very beginning of an interruption.

Benefits can continue throughout the "period of restoration," which will be the subject of the next section.

In spite of the difference in waiting periods, insurance for extra expenses and coverage of business income are linked to each other in several ways. They are often both subject to the same benefit limit, which means any claim made for an extra expense is likely to reduce the amount of money that will be available for a business income claim.

There is no difference between the perils covered by the business income side of a policy and the perils covered by the extra-expense side of a policy. Both parts of the contract require that all claims relate to physical damage at a named property. Therefore, a business will not be covered for the extra expenses it incurs when it loses its lease and must relocate, and it will rarely be covered for the expenses it incurs during a strike.

Period of Restoration

Coverage of business income and expenses lasts until insured losses exceed the policy's dollar limit or until the end of the "period of restoration," whichever occurs sooner. In the case of business income, the period of restoration usually begins a few days after the start of an interruption. In the case of extra expenses, it starts at the same time as the interruption. In both cases, the period of restoration ends on the earlier of the following dates:

- The day when the damaged premises should have reasonably been repaired, rebuilt or restored.
- The day when the business has reopened at a different, permanent location.

A business interruption coverage form may also feature a chronological limit of liability that caps the period of restoration at a year. But since interrupted businesses rarely take longer than one year to resume normal operations, the cap is often not a factor at claim time and was often absent from insurance contracts prior to 9/11.

Limits to the Period of Restoration

While a business technically has the right to suspend operations and take all the time in the world to reopen, the insurance company will only pay benefits during what it believes to be a reasonable timeframe for repairs and rebuilding projects. This reasonable timeframe lasts only as long as it would take to make the property as serviceable as it was before the interruption. If business owners decide they want to expand their property as part of their rebuilding plans, lost business income and extra expenses will not be covered during the expansion.

Covered Perils and Benefit Triggers

For a loss to be covered, operations usually need to have been interrupted at a covered premises by a covered peril. We already know a "covered premises" can be seemingly any building, complex or office named in the insurance policy. But we have not yet specifically explained the perils that can lead to a valid claim.

The perils covered by business interruption insurance should usually be identical to the perils in the business's commercial property insurance policy. This link between property insurance and business interruption insurance usually ensures that interruptions are covered when they are caused by fire, wind, lightning, burst pipes, vandalism and explosions, among other perils. In most cases, it also ensures that interruptions are not automatically covered when they are caused by a flood or an earthquake. An insurer might agree to cover those commonly excluded perils for an additional premium.

With a few possible exceptions, an interruption will only be covered if a peril has done physical damage to a business's premises. In practical terms, this means a restaurant would not be covered if it shuts down temporarily because of a food-poisoning scare. It also means a business would not be covered if it voluntarily closed its doors in anticipation of a covered peril (such as a windstorm) without sustaining any actual damage to its property.

Waiting Periods

Even if a covered peril has clearly caused an interruption, the insured will still have to endure a waiting period before coverage of business income and continuing expenses can apply. Typically, this waiting period ends when a business has been interrupted for 48 or 72 hours. Though not mentioned in all policies, it is assumed that these hours must occur consecutively. So if a business closes, briefly reopens and then shuts down again, it will probably be subjected to a new waiting period. Waiting periods tend not to apply to coverage of extra expenses.

Excluded Perils

Perils commonly excluded from business interruption coverage include earthquakes, floods, radiation and acts of war. However, exceptions are possible. Insurers did not invoke the war exclusion after the events of 9/11, and the subsequent Terrorism Risk Insurance Act ensured that any business owner who was willing to pay a premium could be covered for similar kinds of attacks.

At the time this course material was written, interruptions prompted by pandemics were commonly excluded from coverage, but such losses were being debated fiercely by courts, insurers and regulators after COVID-19.

Loss-of-Market Exclusion

Claims may also be denied on the basis of a "loss-of-market exclusion." In general terms, this exclusion prohibits coverage when demand for a business's goods or services is reduced or becomes non-existent. For the purpose of an example, consider a business impacted by a hurricane in a coastal community. Suppose the business avoided significant damage during the hurricane but had to close when most its customers in the area evacuated. Depending on the language of the business's insurance policy, claims for this kind of interruption may be denied.

It is worth noting, however, that the loss-of-market exclusion can be one of the most ambiguous elements in a business interruption contract. To a court or even to an insurance company, the exclusion might not apply when the loss of market is caused by a covered peril.

Computer Interruptions

The basic business interruption form authored by the Insurance Services Office specifically excludes coverage of computer interruptions. In this context, a computer interruption means a break in operations that is caused by "destruction or corruption of electronic data, or any loss or damage to electronic data."

Additional coverage is available that reimburses policyholders for income and expenses when a virus or some other pest is introduced into a network or computer system. The additional coverage excludes cases in which the damage has been inflicted

by an employee or by any third party who has been entrusted with the computer system.

Power Outages and Service Interruptions

Power outages and service interruptions used to be commonly covered under commercial insurance policies, but that has changed as businesses have become more and more dependent upon their phones, fax machines, email accounts and Web sites. A basic business interruption contract offers no benefits when businesses are shut down by a failure at a utility company, a breakdown of an offsite transformer or deterioration of power lines.

Benefit Limits

No matter how well a business has documented its earnings, policyholders can never know for certain how much they might lose during a suspension of their operations. Even if they could arrive at a solid figure that represents the expected loss for a typical day, they would still lack the ability to conclusively determine how long an interruption might last. While there have been plenty of cases in which businesses reopened quickly and didn't come close to using up all their insurance benefits, events like 9/11 and Hurricane Katrina brought about instances in which businesses were closed for a year or more and lacked enough coverage to survive.

In the next several sections, we will note one method that businesses and insurance professionals have used to quantify adequate coverage. We will also explore various clauses in business interruption contracts and go into detail about how dollar limits are impacted by them at claim time.

Probable Maximum Loss

Though buyers may choose to over-insure or underinsure themselves for various reasons, they are probably best served by a dollar limit that is at least somewhat comparable to their "probable maximum loss." Often, this number is calculated by determining a business's probable income for a 12-month period and then estimating the length of an interruption in a worst-case scenario.

Suppose, for example, that a business expects to bring in $12 million over the next year and believes that in a worst-case scenario (usually thought of as the total destruction of the business premises), it will need no more than nine months to reopen. In this case, the probable maximum loss can be calculated by multiplying the expected yearly income by the expected length of the interruption. By multiplying $12 million by 0.75 years (or nine months), we arrive at a probable maximum loss of $9 million.

To arrive at a suitable dollar limit for business interruption insurance, the business must then develop an estimate of probable extra expenses and add that number to the probable maximum loss. So, if the aforementioned business expects to incur up to $1 million in extra expenses during its nine-month interruption and wants losses to be covered in full, the dollar limit for its business interruption insurance should probably be at least somewhere around $10 million.

We must state, however, that all of these calculations have been simplified. In a real-life situation that requires more than a ballpark figure, readers are strongly advised to use a more exact method of calculating probable maximum loss. Many insurers have developed a multi-page "business interruption worksheet" in order to help their producers determine probable maximum losses.

Coinsurance Clauses

Pretend a business purchased $50,000 of business interruption insurance and has lost $45,000 during a suspension of operations. Waiting periods aside, that means the business ought to be reimbursed for the entire loss, right? Well, maybe. Then again, maybe not. The answer will depend on whether the business's policy contains a "coinsurance clause" and whether the business bought enough insurance to overcome the impact of this clause.

The coinsurance clause can make a business responsible for a portion of any business interruption loss, even when the loss is far smaller than the policy's dollar limit. The clause exists to protect the insurance company in cases where a business has underreported or underestimated its expected "net income" (net profit or loss before taxes) and operating expenses. It ensures that the insurance company will be paid fairly for absorbing risks and that a short interruption will not come close to exceeding the policy's dollar limit.

The coinsurance clause states that the insurer will not honor a claim in its entirety if the policy's dollar limit is less than the policy's coinsurance percentage, multiplied by the business's expected net income and operating expenses for the 12 months following the policy's inception. When the insurance is renewed, its anniversary date will serve as the beginning of a new 12-month period.

The applicability of the coinsurance clause will be determined at the time of a loss. If, for example, insurance is purchased in January and an interruption occurs at the end of September, the insurance company will look at the business's actual net income and operating expenses from January through September and will estimate the net income and operating expenses that would have been expected for the rest of the year. The hard numbers and the hypothetical numbers are then added together and multiplied by the coinsurance amount, which can be as low as 50 percent and as high as 125 percent. The result is then compared to the policy's dollar limit.

Coinsurance Examples

The coinsurance clause and its corresponding formulas are probably best understood when they are accompanied by some concrete numbers. With this in mind, let's look at three examples.

Company A chose to purchase business interruption insurance with a $100,000 limit and a 50 percent coinsurance requirement. After a loss, it was determined that the company's net income and operating expenses for the year following the policy's inception was going to equal $200,000. Since the policy's dollar limit ($100,000) was equal to 50 percent of expected net income and operating expenses ($200,000 × 50% = $100,000), the coinsurance requirement was met. Therefore, after any applicable waiting period, Company A was entitled to full coverage up to the policy's dollar limit.

Company B purchased business interruption insurance with a $100,000 limit and an 80 percent coinsurance requirement. After a loss, the company's expected net income and operating expenses for the year following the policy's inception was going to equal $100,000. Since the policy's dollar limit ($100,000) was greater than 80 percent of net income and operating expenses ($100,000 × 80% = $80,000), the coinsurance requirement was met. Therefore, after any applicable waiting period, Company B was entitled to full coverage up to the dollar limit.

Company C bought business interruption insurance with a $200,000 limit and a 50 percent coinsurance requirement. After

a loss, the company's expected net income and operating expenses for the year following the policy's inception was going to equal $600,000. Since the policy's dollar limit ($200,000) did not equal or exceed 50 percent of the expected net income and operating expenses ($600,000 × 50% = $300,000), the coinsurance requirement was not met. Therefore, Company C was only covered for a portion of all its claims.

The following two tables list the minimum amount of coverage that a business would need to purchase if it wanted to comply with an insurer's coinsurance requirement. The first table assumes a 50 percent coinsurance requirement. The second one assumes an 80 percent requirement.

With 50% Coinsurance Requirement	
Expected Net Income and Operating Expenses	*Minimum Coverage Needed*
$100,000	$50,000
$200,000	$100,000
$300,000	$150,000
$400,000	$200,000
$500,000	$250,000

With 80% Coinsurance Requirement	
Expected Net Income and Operating Expenses	*Minimum Coverage Needed*
$100,000	$80,000
$200,000	$160,000
$300,000	$240,000
$400,000	$320,000
$500,000	$400,000

Figuring the Covered Portion of a Claim

When a business has not satisfied its coinsurance requirement, an insurance professional can look at the coinsurance clause and—using the appropriate numbers—determine the amount the insurer will actually pay to the policyholder.

To determine the covered portion of a loss, we must first determine the size, in dollars, of the coinsurance requirement. As shown in the two preceding tables, this is accomplished by multiplying the coinsurance percentage by the business's expected net income and operating expenses for the year following the policy's inception. For the aforementioned Company C, we would multiply 50 percent by $600,000 and get a result of $300,000.

In the next step, we need to divide the policy's dollar limit by the size of the coinsurance requirement in dollars. For Company C, we would divide $200,000 by $300,000 and get a result of 0.66. That means a business like Company C would be covered for no more than 66 percent of each business interruption loss.

Now all we have to do is multiply our answer from the previous step by the actual loss. If a business like Company C were to lose $30,000 due to an interruption, the insurer would multiply $30,000 by 66 percent and get a result of $20,000. This result would be the amount that the business would receive from the insurance company. The remaining $10,000 would go down as an uninsured loss.

If company C were to lose $100,000 due to an interruption, we would generally follow the same steps. However, instead of multiplying 66 percent by $30,000, we would multiply 66 percent by $100,000. The result ($66,000) would be covered by the insurance company, and the rest would be considered an uninsured loss.

No matter the actual size of a loss and a policy's actual coinsurance requirement, the preceding steps can be summarized in the form of the following equation:

- Covered Portion of Loss = [Policy Limit ÷ (Coinsurance Percentage × Expected Net Income and Operating Expenses)] × Actual Loss

Conclusion

Business interruptions can create major problems for owners and their employees. Along with other forms of risk management, business interruption insurance may minimize some of those problems. While not as popular or as widely understood as coverage for tangible property, it is a product that can be useful to all kinds of companies, regardless of their size or specialty.

CHAPTER 7: GROUP LIFE INSURANCE

Although discussions of employee benefits tend to focus on health coverage and retirement plans, employer-paid group life insurance actually came first. Even in the first few decades of the twentieth century, businesses understood that providing life insurance could be an inexpensive way to attract and keep good workers. When a job applicant has to choose between two similar employment opportunities, an offer of free life insurance might put one suitor over the top. When an employer can't afford to give dedicated staff members a raise, implementing a group life insurance plan can boost company morale.

In some cases, having a group life insurance plan might simply seem like the decent thing to do. Workers are likely to mention their spouses, children or other family members to their bosses at some point and may even invite members of their household to company functions. If management gets to know these family members, the employer may develop deep sympathy for them after an employee's death. The feeling can be even more intense if the company knows that the family was living paycheck to paycheck and relied on the deceased to pay the bills. The money made possible through group life insurance is rarely enough to eliminate anyone's long-term financial concerns, but it's usually capable of covering immediate expenses while survivors take a deep breath. It's a great way to express appreciation for the employee's loyalty.

The right plan can even create tangible financial benefits for the affiliated employer. Dollars spent on life insurance for employees can be deducted from an employer's taxable income within certain limits. More complicated plans might let the employer recoup paid premiums after a death or receive a large lump sum when an especially important employee passes away.

Group Plan Basics

Group life insurance involves the use of a single insurance policy to insure the lives of several people. The specifics of the policy are negotiated and agreed to by the insurance company and the policyholder. In most cases, the policyholder is an employer that

wishes to provide insurance to its employees. Alternatively, the policyholder can be an association, a union or a creditor. For the sake of simplicity, the examples and terminology used in our explanation of group life insurance will be based on plans from employers.

While playing the role of policyholder and plan sponsor, the employer often chooses a death benefit to serve as a base amount for all of the plan's participants. The base amount is typically either a flat dollar amount (such as $50,000) or a multiple of the participant's annual salary. Many employers go a step further and give enrollees the chance to purchase additional coverage beyond the base amount with their own money. We'll go into further detail about the size of death benefits a little later in this chapter.

The person or entity who will ultimately receive death benefits through the group plan is typically decided by the employee. This party, known as the "beneficiary," is usually a close family member, but it isn't uncommon for employees to designate a charitable organization to receive the money.

The manner in which the beneficiary receives death benefits can be left up to the beneficiary or can be chosen in advance by the employee. The method of receiving life insurance money from the insurer is known as a "settlement option" and may involve one lump sum or several smaller payments over a number of years.

Group Underwriting and Premiums

Premiums for group life insurance are typically paid monthly to the insurer by the employer. When the cost of the insurance is shared by employer and employee, the employee's share will come out of a payroll deduction and be delivered to the insurer on the employee's behalf. A common policy provision known as a "waiver of premium" can excuse an employee from having to pay his or her portion of premiums while the person is too disabled to work.

The cost of group life insurance will depend on several characteristics of the group's members. Companies underwriting group life insurance might be interested in a group's average age, its average salary and the number of male employees versus female employees. The insurer might also be concerned about the kind of business being covered, the number of employees who have recently died and the cumulative health history of group members.

Plans requiring premium contributions from participants sometimes charge employees more as they age, but the individual's personal health history will either be irrelevant or a minimal factor. The minimal or lack of emphasis on a participant's own medical history is made possible by the concept of "pooling." In pooling, risks are shared among all group members in a way that is meant to keep premiums relatively stable for everyone. The bigger the pool of participants, the less likely it will be that a particular employee's health status will impact everyone else's costs.

At large employers, covered employees might represent the entire pool that will be used to set premiums. Smaller companies, on the other hand, are often added to a pool of several similarly sized businesses and charged an amount based on the characteristics of the larger pool. Depending on the insurer's preference and state law, a group might be subjected to only one or a combination of these pooling methods. For example, a small employer might be pooled together with similar businesses for the purpose of determining an initial price and then have the price lowered or increased based on the particular employer's loss history.

Terms and Renewals

The most traditional form of group life insurance covers enrollees for guaranteed-renewable, one-year terms. As long as the employer satisfies certain enrollment requirements (such as having at least a minimum number of enrolled employees), the policy can be renewed each year at the employer's option. The insurance company can't refuse to renew coverage simply because the group has become riskier to insure, but an increase in risk can be reflected in higher premiums for the new term.

Even if an insurer keeps premiums stable, there is always the risk that an employer will cut back on its share of costs and require higher contributions from employees. Workers who want to lock in their premiums over several years (or think they might benefit from not being part of a pool) may want to consider individual life insurance rather than group coverage.

Eligibility and Enrollment

For an employer to have its own group life insurance plan, it may need to satisfy various participation requirements. Most insurers prefer to only sell plans to businesses with at least 10 employees. Businesses with fewer workers will often work around this requirement by banding together and becoming part of a "multiple employer trust."

Additional participation rules are likely to apply depending on how premiums are paid. If premiums are paid entirely by the employer, participation usually needs to be automatic for all employees within a particular class. For example, depending on how the plan is structured, participation might need to be automatic for all full-time employees or for all workers who have been with the employer for a particular number of years. If premiums are paid totally or in part by employees, participation must be voluntary and might need to be exercised by a certain number of eligible workers. For instance, a group plan involving employee contributions might be discontinued if fewer than 75 percent of eligible employees opt into it. Regardless of whether these requirements are imposed by the insurance company or by law, they are intended to ensure that risks are spread across an adequately sized pool of people.

The pooling of risks makes group life insurance accessible to practically all of a business's employees, but there are a few important exceptions to this rule. Before employees can join their plan, they must be "actively at work." In general, being actively at work means working 30 hours per week for the employer. Although this requirement creates an obvious coverage exclusion for many part-time workers, its main purpose is to excuse the insurer from having to cover people with serious disabilities. The exclusion doesn't apply if the disability occurs after the person's enrollment in the plan, but it can be a problem if the company switches plans or is implementing one for the first time. Beyond this exclusion, group life insurance is almost always available to eligible members regardless of their individual health histories.

Benefits provided under a group life plan will occasionally be different for employees beyond a certain age or for high-ranking executives. For instance, death benefits might decrease once a participant turns 65, or they might have a higher dollar limit or other more favorable characteristics if the insured holds an especially important position. However, any aspects of a plan that favor some employees over others need to be analyzed with care. When it is poorly executed, age discrimination can easily

violate state or federal labor laws like the Age Discrimination in Employment Act. And even when they're legal, plans that discriminate against employees on the basis of salary can produce unfavorable tax consequences. Some tax-related rules for discriminatory plans will be summarized later in this chapter.

In a voluntary group plan, eligible employees will have a chance to enroll when they're hired (following any applicable probationary period) or during an annual open enrollment period. If employees want to enroll at some other point, they might need to undergo a medical exam or have their health records analyzed by the insurance company.

The limit on enrollment periods exists to prevent a problem known as "adverse selection," in which insurance is purchased disproportionately by people who put the carrier at greater risk. Similar enrollment rules are typically enforced to minimize adverse selection in the market for group health insurance. In fact, the enrollment periods for group life and group health insurance are often identical.

Common Death Benefits

Death benefits from group life insurance will equal a flat dollar amount, a multiple of an employee's salary or a combination of the two. For instance, a policy might provide that a beneficiary will be given one year's worth of the deceased salary or $50,000, whichever is less. Amounts might vary on the basis of age, hours worked or years of service. Again, differences in benefits among workers need to be constructed carefully in order to avoid illegal discriminatory conduct.

Coverage purchased entirely by an employer is often capped at $50,000 in order to simplify compliance with the federal tax code. Unfortunately, this amount of money is rarely enough to satisfy a beneficiary's needs for long. Enrollees who believe the death benefit is inadequate can often raise it at their own expense.

Analyzing Needs

Employees who can sign up for even a small amount of entirely employer-paid life insurance are practically being offered free money. But even if decisions regarding whether to take free coverage are obvious, plan participants still have an important question to ask themselves: "Is this the right amount of life insurance for me?"

The death benefits provided through group life insurance don't take each individual employee's financial needs into account. Instead, the death benefits made possible by the plan are, in a sense, a compromise designed to satisfy several criteria. As the policyholder, the employer may want to offer free or inexpensive coverage as a sign of generosity, while at the same time keeping costs low and maximizing tax advantages for itself. Meanwhile, the insurance company may want to structure death benefits in a way that simplifies the administration of the plan while also shielding itself from overly large risks within a large and diverse pool of participants. These desires inevitably create scenarios in which group members don't have enough insurance to match their situation.

To estimate an appropriate amount of life insurance, employees should ask themselves the following questions:

- How much money will my dependents need in order to maintain their current standard of living and keep up with inflation?
- How much money will my children need for school tuition and basic necessities?
- How long will my dependents need financial assistance?
- How much money should beneficiaries receive—regardless of need—as a gift from me?
- How much money should beneficiaries receive in order to offset debts (such as a mortgage loan) that I 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 my death?
- How much money should be reserved for a favorite charity or some other non-traditional beneficiary?

Believe it or not, there are cases in which the answers to those questions suggest that someone's current level of life insurance is already appropriate or unnecessary. Several financial advisers believe someone who is single and has no debts or dependents doesn't need life insurance. Many people who fit this description might not have a good enough reason to join a voluntary group life plan or to purchase more coverage than what's provided for free.

For the majority of workers, though, the amount calculated by answering those questions will be greater than $50,000 or a year's worth of salary. Upon coming to that conclusion, employees need to think about how to make up the difference. The most common options for them will be to either voluntarily purchase more coverage through their group plan or shop around for their own policy.

Is Group Coverage the Best Deal?

Again, there ought to be little or no debate regarding whether free life insurance from an employer is a good thing. But if employees are required to pay for even a portion of their coverage, they shouldn't automatically assume that buying through their group is their best option.

The cost differential between group life insurance and life insurance for one person will depend greatly on the individual's health. Unhealthier people tend to save money with group life insurance because it puts little or no emphasis on their personal medical history. In fact, when employees have serious medical conditions, group life insurance might be the only form of life insurance available to them. Healthier people, on the other hand, tend to benefit less from group life insurance because their higher life expectancy is used against them in order to make coverage available to high-risk participants. They might end up paying less if they opt for an individual policy outside of the group.

Despite the general rule about group life not favoring healthy employees, health shouldn't be the only factor used to compare costs in the group and individual markets. Group plans can still be cheaper for healthy employees if the employer is paying a significant portion of the premiums. Costs can also be lower in a group plan because the employer and the insurer share administrative tasks.

Portability and Conversion

Some employees may prefer to buy insurance outside of their group because they want portable coverage. When employees leave or lose their jobs, federal and state law usually lets them keep their group health insurance for several months if they're willing to pay for it. This portability usually doesn't extend to group life insurance unless the employer opts to include it as part of the

plan. In general, group life insurance is considered "convertible" but not portable.

The main distinction between portable coverage and convertible coverage is that portable coverage essentially lets former employees keep what they already have. If an employee worked at a company that offered portable term life insurance with premiums that could change every year, that's basically the kind of insurance the former employee can opt to keep. The former employee with portable coverage will be able to keep the insurance regardless of his or her health.

A former employee with convertible coverage can still be covered regardless of health, but the person's group insurance will often be replaced by a very different kind of life insurance. Instead of being entitled to essentially the same kind of coverage as the group, a former employee with convertible term insurance will only have the right to obtain "permanent life insurance."

Unlike term life insurance, permanent life insurance is designed to keep somebody insured for the rest of their lifetime. It also has an investment feature that gives the policy a "cash value." A policy's cash value grows over time and can be used in a number of ways. The policyholder can borrow money against it, use it to offset future premiums or even receive a portion of it in a lump sum if coverage is ever cancelled. In many cases, term life insurance that's converted to permanent coverage will have level premiums that are based on the person's age at the point of conversion.

The longevity and versatility of permanent life insurance can be very attractive, but they help explain why these policies are often significantly more expensive than term insurance. Healthy people who were satisfied with term insurance through a former employer should be able to qualify for term insurance of their own instead of converting to a permanent policy. Even people with health problems might opt against converting to a permanent policy because of the extra cost.

Interested workers generally have the right to convert their group coverage dollar-for–dollar to an individual permanent policy within a month of leaving their employer. Benefit managers need to be aware of specific deadlines and options in their state so that they can inform personnel who are leaving the company. If a former employee dies without having known about conversion rights, survivors might take legal action against the business.

Tax Issues for Group Life Insurance

Life insurance can produce positive tax-related outcomes for businesses, beneficiaries and covered employees. Death benefits are often exempt from income taxes, and money spent on insurance within a group plan can sometimes be exempted or deducted from federal tax bills. Still, as is usually the case with rules from the Internal Revenue Service, the eligibility requirements for tax benefits can be very complex.

Many of the general tax rules for group life insurance will be summarized in the next few paragraphs, but specific tax advice should only be provided by a qualified tax professional. Tax rules change frequently, and competent tax planning can only be done after considering the specifics of a situation.

Taxation of Death Benefits

Life insurance death benefits are usually not taxable as income to beneficiaries. A rare exception to this rule might be a case in which the beneficiary became entitled to death benefits after paying money to the policy's previous owner. In this scenario, the amount beyond what was paid to the policy's previous owner might be taxed as income. The selling of life insurance from one owner to another is known as either a "viatical settlement" or a "life settlement." These settlements occur in the individual market for life insurance but not in the group market.

Life insurance beneficiaries may also need to pay some income taxes depending on how they receive death benefits. The most popular life insurance settlement option delivers death benefits in a lump sum, but some beneficiaries prefer to receive their money in installments. One positive of choosing the installment option is that money can be kept with the insurance company and earn interest. Interest earned on death benefits will be taxed in a way that impacts a portion of all the received installments. IRS formulas determine how much of each installment will count as income.

On occasion, businesses purchase life insurance on their employees and name themselves as beneficiaries. This kind of insurance, known as "corporate-owned life insurance," is commonly intended to help a company cope with the financial fallout of losing a key executive or owner. Companies usually can't deduct the premiums they pay for corporate-owned life insurance from their taxes, but they can still receive the policy's death benefits on a tax-free basis. For death benefits to be tax-free to the business, the following conditions must have been met:

- The covered person consented in writing to the corporate-owned life insurance before it was issued.
- The covered person was either an employee of the business within a year prior to death OR was considered a director or highly compensated employee of the business.

If those two requirements aren't satisfied, the business will have to pay income taxes on the difference between the death benefit it receives and the premiums paid to the insurance company.

Estate Taxes

Although death benefits are generally exempt from income taxation, the value of a life insurance policy can sometimes be included as part of the deceased's estate. This is important to some families because estates valued at more than an amount set by law will be subjected to federal estate taxes within nine months of the person's death.

Life insurance will be considered part of the deceased's estate for tax purposes if the estate was listed as a beneficiary or if the deceased had any ownership rights in regard to the policy. Ownership rights include the right to transfer the policy to someone else, the right to use the policy as collateral for a loan and the right to choose the beneficiary. As long as the estate is not listed as the beneficiary, the owner can avoid having the insurance included as part of his or her estate by transferring all ownership rights at least three years before dying.

Since they usually can pick their own beneficiaries, people who die with group life insurance will have the insurance's death benefits included as part of their estate. However, most estates aren't worth enough for the estate tax to apply to them. The 2021 exemption for estates worth less than $11.7 million means the tax is usually only a concern for people with very valuable assets. One group of employees who are often more susceptible to estate taxes are "key employees." You'll read more about these highly compensated individuals in a later section.

IRS Rules for Group Term Life Plans

In general, businesses that don't list themselves as beneficiaries can receive tax deductions for paying group life insurance premiums. However, a business that is overly eager to find tax advantages for itself might inadvertently create tax problems for its employees. Unless group life insurance is of a certain variety and below a certain amount, covered employees might owe money to the IRS.

Depending on the type and amount of coverage, participants in group life insurance plans might be taxed on "imputed income." Within our discussion of life insurance, imputed income can be defined as something of financial value that is provided in the form of an employee benefit rather than in the form of money. An example of imputed income for an employee would be the portion of life insurance premiums paid by an employer. Even if employees pay all premiums, they might be receiving imputed income if their plan lets them buy insurance at rates below IRS standards.

According to IRS rules, benefits that would otherwise be considered imputed income don't apply to group term life insurance if the death benefit doesn't exceed $50,000. This exemption is intended mainly for groups with at least 10 people in them, but smaller groups are eligible if they follow certain guidelines.

If death benefits in a group term life insurance plan exceed $50,000, some imputed income might be produced and be taxable to the employee. (The $50,000 cap on death benefits can be waived if the sole beneficiary is the employer or a charity.) To figure out the amount of imputed income for an employee who has been covered for the entire tax year, follow the instructions below:

1. Subtract $50,000 from the insurance's death benefit.
2. Divide the amount obtained in Step 1 by 1,000.
3. Look up the monthly cost per $1,000 of coverage, as determined by the IRS. (At the time this course was being written, the cost could be found in a table in the "Group Term Life Insurance Coverage" section in the IRS's "Publication 15-B." Costs appear in a table format and depend on the employee's age.)
4. Multiply the amount obtained in Step 2 by the amount obtained in Step 3.
5. Multiply the amount obtained in Step 4 by 12. (For employees who haven't been covered for the full tax year, use the number of months they've been covered instead of 12.)
6. Subtract any premiums that have been paid by the employee with after-tax dollars from the amount obtained in Step 5.

Voluntary Group Plans and the $50,000 Rule

The limited tax exemption for group term life insurance can be difficult to work around in voluntary group plans because participants often increase their death benefit beyond $50,000. Even if employer-paid coverage is non-existent or is capped at the $50,000 threshold, additional coverage that's purchased voluntarily by a plan participant can still result in imputed income under IRS rules.

In order to avoid taxation of imputed income in a voluntary group plan for term life insurance, a number of rules must be obeyed. According to various tax advisors, some of the more important rules and recommendations to follow include the following:

- Voluntary portions of the group plan should be addressed in a policy that is separate from any portions that are automatically provided to all eligible employees.
- Premiums for voluntary coverage should be paid entirely by employees.
- Rates for voluntary coverage cannot "straddle" the rates found in the aforementioned table from the IRS. (Straddling occurs when the age-based rates in the plan are higher for at least one age group than they are in the IRS's table and lower for at least one other age group than in the table.)

The three items mentioned here are presented only as a general summary. Any kind of layering of plan options that is designed to avoid taxation should be done with a professional who understands all the details.

Key Employees and the $50,000 Rule

The $50,000 exemption for imputed income and group term life insurance doesn't extend to key employees when a plan favors them on a discriminatory basis. According to rules from 2012 by the IRS, a key employee is any of the following individuals:

- An officer of the employer whose annual pay exceeds $165,000.
- An owner of at least 5 percent of the business.
- An owner of at least 1 percent of the business whose annual pay exceeds $150,000.

In order to preserve the $50,000 exemption for key employees, the group term life plan must be non-discriminatory toward other employees in regard to participation and benefits. To be non-discriminatory in regard to participation, a group term life insurance plan must satisfy at least one of the following requirements:

- At least 70 percent of employees are part of the plan.
- At least 85 percent of participants aren't key employees.
- Eligibility doesn't favor key employees, as determined by the Secretary of the Treasury.

To be non-discriminatory in regard to benefits, the plan must offer the same benefits to key employees and other participants. This rule doesn't prevent a plan from basing death benefits on a multiple of a participant's income. In other words, a plan that offers a death benefit equal to two years of salary to someone making $160,000 and someone making $50,000 isn't necessarily a discriminatory plan.

Other rules apply to cafeteria plans and insurance for shareholders at S corporations. They are beyond the scope of this course.

Taxation of Permanent Life Insurance

The $50,000 exemption on imputed income is for group term life insurance and not for permanent life insurance. However, some group plans will preserve part of the exemption by layering a permanent life insurance policy on top of a $50,000 term policy.

Tax issues for permanent life insurance are more complex, mainly because parts of the premiums are applied to the coverage's cash value. Money applied to the cash value can be invested and grow on a tax-deferred basis. If an employee has access to the cash value and decides to surrender the insurance or borrow from it, a portion of the money will probably be taxed as income. Death benefits, in most cases, will still be tax-free to the beneficiary, and the aforementioned rules for estate taxes will apply.

Permanent life insurance is sometimes a component within a "split-dollar" policy. In a typical split-dollar arrangement, the cost is shared between the employer and the employee. When the employee passes away, the employer receives a refund of its premiums or the policy's cash value, whichever is greater. Any remaining death benefits go to the employee's chosen beneficiary. Tax implications for all parties will depend on how the arrangement is structured. Split-dollar policies deserve to be mentioned in this chapter because of their connection to employers and employees, but be aware that they are generally considered a form of individual life insurance rather than a type of group coverage.

Conclusion

Group life insurance can be a valuable employee benefit, but it shouldn't be offered or accepted without some careful planning. While you encourage an employer to implement a plan, you'll want to make sure the right tax questions are asked and that administrative requirements are considered. While marketing a plan to eligible employees, you'll want to stress the ways in which the death benefit might fit into their financial goals. By knowing what's available and analyzing the group's situation, you should be able to help people find attractive coverage at an affordable cost.

CHAPTER 8: COVERING VEHICLES

The need for auto insurance should be examined carefully by every business. This basic yet important advice applies to commercial entities that have their own vehicles and even to businesses that don't have any autos in their name.

Many companies decide to purchase their own cars for tax reasons, as employee perks or as a way of simplifying matters for workers who are constantly on the road. In these cases, the need for insurance will be absolute. In order to be operated on public roads, company cars will need to at least be covered by the minimum amount of liability insurance set by state law.

Businesses that don't own any vehicles might not need auto insurance as a matter of law, but they should at least consider the amount of auto-related risks they are willing to absorb. If an employee is sent out on a company errand in his own car and causes an accident, there is at least a chance that his employer will be sued. The employee's personal auto insurance will usually cover him in this scenario, but determining whether there is any or enough coverage under that same policy for the employer can be tricky.

Unfortunately for business owners, auto risks are almost never covered by other kinds of commercial insurance. The standard commercial general liability policy has an auto exclusion that usually prevents it from paying damages to victims when an accident involves a vehicle that's owned, hired, borrowed or leased by a business. Meanwhile, the typical commercial property policy won't cover damage to a policyholder's own vehicle. If a business wants to prepare itself financially for losses caused by auto accidents, its options are generally limited to buying commercial auto insurance or following a self-insurance strategy.

The most popular variety of commercial auto insurance is based on a document called the "Business Auto Coverage Form." The document was created in the late 1970s by Insurance Services Office, Inc. and has been revised several times since then. Policies based on that document are known as "Business Auto Policies," BAPs" or "BACs." For simplicity's sake, we'll use the term "BAP" from this point forward.

Because BAPs are so common and applicable to most businesses, we will use them as the main reference point in our explanation of commercial auto insurance. Still, it's important to realize that there tends to be far less standardization in commercial insurance than in personal lines. A policy issued by one carrier won't necessarily match one issued by a competitor in every important way. There may also be cases in which a standard BAP might be inappropriate or unobtainable for a particular entity. For instance, if a business commonly carries other people's goods on its vehicles or transports people for a fee, additional insurance options are worth exploring.

Wherever possible and appropriate, we'll also draw your attention to the similarities and differences between auto insurance for individuals and auto insurance for businesses. Indeed, there's some overlap that allows certain parties to remain insured when business vehicles are driven for personal use or vice versa. But whether your customers are mainly businesses that have their own cars or individuals who occasionally use their family's minivan for work, it's important to know where the overlap begins and ends.

Covered Vehicles

Commercial auto insurance is technically capable of covering any vehicle designed for use on public roads. However, the specific vehicles insured under a BAP will be indicated by numbers checked on the policy's declarations page. There are nine different numbers for nine different groups of vehicles. The significance of each number is summarized in the list below:

- **Symbol 1:** When this symbol is chosen, coverage applies to any vehicle designed for use on public roads, regardless of who owns it. For example, if it's used with regard to liability coverage, the business will be insured if it's sued in connection with practically any auto accident. The only things that would prevent the business from being covered would be either a specific exclusion written into a policy or a previous claim that exhausted the policy's dollar limits. It represents the broadest form of coverage.
- **Symbol 2:** When this symbol is chosen, coverage only applies to autos owned by the "named insured." (In most cases, the named insured is the business.) Unless special arrangements are made, it won't provide coverage for vehicles owned by someone else, such as an employee. It also won't make coverage applicable to vehicles that the business leases or borrows.
- **Symbol 3:** When this symbol is chosen, coverage only applies to private passenger vehicles owned by the named insured. It won't provide coverage for other people's private passenger vehicles, and it won't cover large trucks. It might only provide coverage for trailers under certain circumstances.
- **Symbol 4:** When this symbol is chosen, coverage only applies to vehicles that are owned by the named insured and aren't private passenger vehicles. In other words, it can make insurance applicable to a business's large trucks but not its cars.
- **Symbol 5:** When this symbol is chosen, coverage only applies to vehicles that are registered or stored in states where no-fault auto insurance is mandatory.
- **Symbol 6:** When this symbol is chosen, coverage only applies to vehicles that are registered or stored in states where uninsured motorist coverage is mandatory. You'll read more about uninsured motorist coverage in a later portion of this chapter.

- **Symbol 7:** When this symbol is chosen, coverage only applies to the specific, individual vehicles listed on the policy's declarations page. It's ideal for businesses that own or have access to multiple vehicles but only want to insure certain ones.
- **Symbol 8:** When this symbol is chosen, coverage only applies to vehicles that are leased, borrowed, rented or hired by the named insured. It doesn't provide coverage for vehicles owned by employees or by owners of the business or their families.
- **Symbol 9:** When this symbol is chosen, coverage only applies to vehicles that aren't owned, leased, borrowed, rented or hired by the named insured. For example, it might protect the employer if a worker causes an accident in her own car, but it won't cover the employer if that same worker causes an accident in a company car.

A business can request different symbols for each main kind of coverage. For instance, it may want Symbol 1 in regard to liability coverage but only Symbol 7 for property damage to its own vehicles. It's also possible to use multiple symbols at once. So if a business knows it will be using its own vehicles and an employee's vehicle but will never rent, lease, borrow or hire any others, it might want liability protection with symbols 2 and 9 selected.

Not every insurer will let businesses choose from all nine symbols under every circumstance. A carrier that's willing to offer Symbol 1 coverage for liability might not make Symbol 1 an option for covering damage to a business's own vehicles. It's also important to read coverage forms carefully instead of immediately assuming that the symbols correspond with the descriptions listed here. Particularly when not all nine symbols are available, an insurer might renumber the symbols on its forms. For example, if an insurer is not interested in offering coverage for all autos to anyone, it might designate Symbol 1 to mean something else, such as coverage only for owned vehicles.

Obviously, symbols should be chosen and indicated with care. If the wrong symbol is marked—or if no symbol is indicated at all—the business could have a significant coverage gap.

Who's an Insured?

In the previous section, we mentioned the term "named insured." The named insured is the main party who is protected by the commercial auto insurance policy. Unless the policy contains an exception, no one else will be covered for liability if an auto accident causes property damage or bodily injury. And unless the appropriate symbol is chosen (such as symbols 1, 8 or 9), no one else's vehicles will be covered for repairs.

In the vast majority of cases, the named insured in a BAP is the business. Most BAPs will also cover people besides the named insured, but only when certain conditions have been met.

Coverage under a BAP will usually extend to anyone driving a covered auto with the named insured's permission. In a hypothetical example, let's assume Jane is given access to a car that's owned and insured by Real Good Paper Company. Jane causes an accident while driving Real Good Paper Company's car. Since Jane had permission to drive the car, she will likely be covered for liability along with Real Good Paper Company if an accident victim ever sues. This would likely be true even if Jane doesn't have personal auto insurance of her own.

But as was mentioned in the previous section, the vehicle needs to have been properly listed on the policy's declaration page, either by name or by symbol. In other words, if Real Good Paper Company chose a symbol that doesn't include rental cars, Jane won't be insured under Real Good Paper Company's policy if she rents a car for business.

Who's Not an Insured?

Even when a business allows someone to use one of its vehicles, a few additional exceptions can stop coverage from extending to that individual. Perhaps most significantly, insurance won't apply to employees or business owners when they drive their personally owned vehicles. Suppose Gary is sent by Real Good Paper Company on business trips and uses his own vehicle. If Gary causes an accident on one of these trips and is held personally liable, the BAP usually won't cover him. He will probably have to seek protection under his personal auto policy.

There's also no protection for the owner of a vehicle that's borrowed, rented or hired by the named insured. In other words, if Real Good Paper Company decides to rent a van to take several employees to a seminar, the owner of the van might not be able to share coverage with Real Good Paper Company after an accident.

Finally, even when permission is granted, no one operating a covered vehicle will be covered if they're in the business of parking or servicing it. If Real Good Paper Company takes one of its vehicles to a mechanic who hits a pedestrian during a test drive, the mechanic cannot rely on Real Good Paper Company's insurance for protection.

Realize, though, that the exclusions we've just mentioned don't stop the named insured from being covered by its own policy. A business that's sued after an employee has an accident in his own car can still be covered for liability even when its employee can't. And a business that is sued after an accident in a rented vehicle can still be covered even when its owner can't. (This assumes, of course, that the appropriate symbol was used on the declarations page.)

To better understand these points, think about some of the examples you've just read about. In the example in which Gary caused an accident in his own vehicle, Real Good Paper Company would still have coverage for itself (but not for Gary) if Symbol 1 or Symbol 9 was selected. In the example in which Real Good Paper Company rented a van to take employees to a seminar, Real Good Paper Company would still have coverage for itself (but not the owner of the van) if Symbol 1 or Symbol 8 was selected.

If the business believes the requirements for being an insured party under the BAP are too narrow, changes can usually be approved. An employer may decide, for example, that it wants to insure a worker while he's driving his own car for business. Similarly, companies leasing vehicles to other businesses might demand that they be given additional protection under their customers' insurance. Of course, these changes and additions should be addressed as soon as possible and before an accident occurs.

Liability Coverage

While BAPs and personal auto policies aren't intended for the same audience or the same vehicles, the liability protection they provide to drivers is very similar. Both kinds of insurance can be used to manage liability for bodily injury or damage to someone else's property. They also help potentially liable parties pay to defend themselves.

Bodily Injury and Property Damage Liability

Bodily injury pertains to practically any kind of physical harm inflicted on another person as a result of an auto accident. It can mean an illness, temporary or permanent damage to a particular part of the body or even death. Because the severity and cost of bodily injury can be very high, having enough insurance for this risk should be one of a business's top priorities.

Property damage losses have a reputation for being less severe than losses for bodily injury, but it's easy to picture them happening at a higher rate. Even if an accident leaves a victim physically unscathed, the at-fault driver will usually still be legally responsible for compensating the other person for repairs. Property damage can also result when a driver hits something other than a vehicle, such as a building, an animal or a tree.

Many businesses opt not to purchase insurance for harm to their own vehicles, but forgoing liability insurance for bodily injury and property damage isn't an option. Vehicles must be covered by at least the minimum amount of liability insurance set by state law. States might have one minimum requirement for bodily injury and another minimum limit for property damage. There may also be mandatory minimum amounts of insurance per accident or per victim.

Because mandatory minimums differ among states, coverage automatically adjusts when a vehicle that's registered or normally garaged in one state is being operated in another state. Despite the minimums, businesses are often wise to purchase additional liability coverage. Questions worth asking when choosing a dollar limit for liability include:

- How much will extra coverage cost?
- Are we financially strong enough to withstand a major accident?
- Do we have an ethical responsibility to ensure that accident victims receive appropriate compensation?

Defense Costs

If legal action is taken or threatened against an insured party, the liability portion of the BAP will cover defense costs. The insurer's duty to defend is generally greater than its duty to pay for damages. Even if there's only a small possibility that an accident is covered by the policy, the insurance company might still need to provide a defense.

The cost of defending the insured party won't impact the amount of money available for bodily injury or property damage. However, the carrier is allowed to stop defending the insured once the policy's dollar limits have been met through any judgments or settlements. For example, imagine a policy covers a company for $200,000 per accident in the event of bodily injury. One of the company's covered employees caused an accident, and the victim claimed to suffer damage to her back and leg. The company's insurer settled with the victim in regard to her back injury for $200,000, but the parties couldn't agree on an amount for the foot problem. Since the insurer already paid out the full $200,000 limit for bodily injury, it won't be obligated to defend the business anymore if the victim sues.

Liability Exclusions

No matter the people or vehicles involved, some injuries and damages won't be covered by the BAP. Many of the exclusions mirror those found in personal auto policies for individuals. Some of the most important exclusions are listed here, and a few will be given more attention in later sections:

- There's no coverage for punitive damages. (Punitive damages are extra court penalties that are designed to punish people for especially egregious behavior. Covering these damages is usually prohibited by law.)
- There's no coverage for intentionally injuring someone or damaging their property on purpose.
- There's no coverage for property damage or bodily injury caused by pollution. (A possible exception exists when an auto accident releases a pollutant that wasn't on the business's premises and wasn't in a vehicle.)
- There's generally no coverage for damage to property in an insured party's care, custody or control. (If a business transports other people's property in its vehicles, it may want to purchase inland marine insurance.)
- There's no coverage if a vehicle is being used as part of an organized racing event or stunt.

Property Damage

If damage to a covered vehicle can't be blamed on someone else, repairs might be covered under the BAP's property damage section. Unlike liability coverage, property damage coverage is usually not required by law. Businesses might only need to purchase it if they rent or lease a vehicle or purchase one with borrowed money. Otherwise, they can opt to pay for damage out of their own pocket.

Another difference between coverage for liability and coverage for property damage is that the latter usually has a "deductible." The deductible is the amount of each loss the insured must pay before the insurance company will start paying. Depending on the policy, there might be one deductible per accident, per vehicle or per policy period.

By default, property damage coverage for covered autos is based on a vehicle's "actual cash value." A vehicle's actual cash value is its value immediately prior to an accident, including depreciation. Vehicles tend to depreciate almost immediately after they're purchased, so even a driver whose car is totaled in an accident is unlikely to receive enough insurance money for a brand-new, identical car. Businesses that want to insure their vehicles for more than actual cash value will need to make a special request and pay a higher premium.

Collision, Comprehensive and Other Coverages

Businesses that want to insure vehicles for property damage will usually choose "collision coverage," "comprehensive coverage" or both. These two kinds of coverage are also the main options in the market for personal auto insurance.

Collision coverage pays to repair or replace a driver's vehicle if he or she hits another object. That object is usually another vehicle, but it might be a tree, a road sign, a building or something else. Collision coverage is also for situations in which a vehicle is turned on its side.

Comprehensive coverage pays to repair or replace a vehicle when damage is caused by something other than a collision. It can also compensate the owner if a vehicle is stolen. By purchasing both collision and comprehensive coverage, an insured can be covered for practically any kind of physical damage that isn't specifically excluded in the policy.

A very basic third option might also be available to some applicants. This coverage, which goes by different names, only insures businesses against the perils specifically listed in the

policy. Under this option, an insured can be covered for the following perils:

- Fire.
- Lightning.
- Explosion.
- Theft.
- Windstorm.
- Hail.
- Earthquake.
- Flood.
- Mischief or vandalism.
- Sinking, burning collision or derailment of any object transporting the vehicle.

Property Damage Exclusions

Regardless of which option the business ultimately chooses, some kinds of damage typically won't be covered by a BAP. Like the liability exclusions, many of these will be familiar to people who sell personal auto insurance. Some common exclusions are as follows:

- There's no coverage for losses caused by war or terrorist attacks.
- There's no coverage for damage from wear and tear.
- There's no coverage for damage from nuclear accidents.
- There's no coverage for lost or damaged media used in the vehicle for enjoyment (such as cassettes or compact discs).

Uninsured Motorists Coverage

Whether we like it or not, there will always be people who believe the law doesn't apply to them and who will drive without liability insurance. So what can people do if an uninsured driver hits one of their vehicles? 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, an accident victim might discover that the at-fault driver lacks enough assets to pay for damages.

A policy feature 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:

- A covered auto is hit by someone who has no insurance.
- A covered auto is hit by someone who has less insurance than the law requires.
- A covered auto is hit by a hit-and-run driver.
- A covered auto is hit by someone whose insurer becomes insolvent.
- A covered auto is hit by someone whose insurer refuses to pay a claim.

Uninsured motorists coverage is mandatory in some parts 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 isn't entirely uncommon.

Uninsured motorists coverage is often beneficial to drivers of personal autos, but questions have arisen regarding its role in commercial lines. For instance, since the coverage is mainly designed to compensate people for bodily injury, logic suggests that it insures real, live people. Yet ambiguous language in some policies (and inconsistent rulings among some courts) have sometimes suggested that uninsured motorist coverage only insures the business and not an actual person.

Even if a carrier or a court makes it clear that the coverage can be used to insure real people (such as employees), many companies decide not to purchase it. These businesses often make the assumption that anyone who is injured in a covered auto will be an employee, who will have his or her medical expenses covered by workers compensation. This line of reasoning, while generally sound, might still create an insurance gap for the occasional passenger who doesn't work for the business. For instance, a covered auto might be involved in an accident while an independent contractor is driving it or while a customer is in the passenger seat.

Renting Vehicles

Coverage for rented vehicles can be obtained by choosing Symbol 1 or Symbol 8. In most cases, the coverage extends to the business and to the driver. However, if a vehicle is rented by an employee and not by the business, the employee might not be protected by the BAP.

Employees who rent their own vehicles (for business or pleasure) should already have coverage under their personal auto policy. If they don't have their own car and consequently don't have a personal auto policy, vehicles they rent can be covered by attaching a "drive other car" endorsement to the BAP. You'll read more about this endorsement later.

If a vehicle that's covered for liability is stolen, broken down or undergoing repairs, liability coverage is automatically extended to a borrowed temporary replacement. This protection applies regardless of which symbol appears on the declarations page.

Personal Use

Even if a vehicle is driven primarily for business, people with access to company vehicles are likely to also drive them for personal use. Assuming the appropriate symbol is marked on the declarations page, a business will remain covered for liability even if one of its owned or rented vehicles is being used for non-business purposes. But liability protection for the person driving the vehicle doesn't always exist.

In order for a driver to drive a company vehicle for personal use and still be covered for liability under the BAP, permission must have been granted by the business. In other words, if a company makes it clear that one of its cars is only to be used for conducting business, drivers won't be covered while driving to and from personal errands. Similarly, even if a business allows vehicles to be driven for personal use by an employee, permission might not extend to the employee's spouse, other family members or friends. If anyone besides the permitted driver uses a business's vehicle, the insurance company might not have to cover anyone for liability except the business.

Permission to drive a company-owned or company-borrowed car for personal use won't give drivers any protection when they use other vehicles. For example, even a vehicle rented on a personal credit card for use on a business trip can be a problem. In this scenario, the driver's personal auto policy would be relied on for coverage.

If a business wants to be generous, it can protect employees using non-business vehicles by specifically having them as named insureds in the policy. A more likely solution for workers who don't have their own auto insurance is "drive other car" (DOC) coverage. You'll read more about this endorsement to the BAP shortly.

Employees' Own Vehicles

Based on what you've already read, you should understand that businesses can be covered under the BAP for their own liability when an employee causes an accident in his or her own car. You should also understand that the employee is usually covered for liability when he or she causes an accident in a company car. But what about liability and property damage coverage for employees when they're driving their own vehicles?

Many workers are asked to perform short errands for their employer in their own car. Those workers might assume that if an accident occurs, their employer will step in and pay for any damage. In most cases, this assumption is incorrect.

Although the BAP covers employees for liability while they drive company cars, workers are excluded while operating their own vehicles. Liability protection after an auto accident will usually need to come from their personal auto policy.

Property damage to an employee's vehicle will also usually only be covered by personal auto insurance. Many insurers that let businesses insure all vehicles for liability (by selecting Symbol 1) don't let them do the same in regard to property damage.

In cases where there's some overlap in coverage between an employee's personal policy and an employer's BAP, claims will be made first against the vehicle owner's insurance. (This includes any liability claims against the business.) If the limits of the owner's policy have been exhausted, the employer's BAP will be next in line. Again, the BAP often provides excess liability protection for the employer but rarely any excess coverage for the employee.

A handful of businesses choose to add an endorsement to their policy that specifically names employees as insureds. This strategy eliminates liability and property exclusions for named employees who have accidents in their own vehicles, but it often inadvertently gives employees more coverage (and more control over the insurance) than the employer intended. Due to the costs and complications associated with that option, many employers prefer alternative strategies. One option is to provide money to employed drivers so they can purchase better personal auto insurance.

Drive Other Car Coverage

Some business owners and employees rely on company cars and don't actually own a vehicle. Not owning a vehicle usually means they don't have a personal auto insurance policy either. This lack of insurance can create problems if they're ever involved in an accident with a car they rent or borrow for personal use.

Although the owners of rented or borrowed vehicles are likely to have some auto coverage that the otherwise uninsured driver can rely on, there are no guarantees. The owner of the rented or borrowed vehicle might only have a minimum amount of liability insurance or perhaps no insurance at all. In either of those cases, the driver using the vehicle could have a major liability exposure.

Businesses that already furnish company cars to people can help alleviate this problem by purchasing "drive other car" coverage. Drive other car coverage is added to the BAP for an additional cost and is designed for drivers who don't normally use any other vehicles and don't have personal auto insurance. It covers workers who are held liable for an accident involving practically any vehicle (other than one they own), regardless of whether they're driving for business reasons or personal ones.

A drive other car endorsement covers the individual specifically named in the policy and also extends to the person's cohabitating spouse. Unless requested, it won't cover non-spouses who live with the named driver, and it won't cover a spouse who lives at another location. The endorsement is usually purchased solely for the purpose of covering the driver for liability, but uninsured motorist, physical damage and other coverages may also be available.

Employee Injuries

A BAP usually won't help pay for bodily injuries to workers who are hurt while doing their jobs. If an injured worker is considered an employee, benefits should be available through the business's workers compensation insurance. If the injured worker is considered an independent contractor, coverage might exist under employers liability insurance. The BAP might make an exception if the injured worker is a domestic employee (such as a housekeeper) who is not required to be covered by workers compensation. The rules for covering employees for workers compensation differ from state to state.

Moving Property to and From Vehicles

Businesses that transport goods need to be aware of where coverage under a BAP starts and stops. Essentially, the BAP provides no coverage when property being transported or delivered is damaged. These businesses should also be aware that it only provides a limited amount of liability coverage if other property or a person is injured while a delivery is underway.

Liability coverage exists under the BAP while property is being moved to a covered auto and while it is being moved from the auto to the point of delivery. There is no liability coverage for accidents that occur after property has been delivered.

For the sake of an example, think of a furniture store that's delivering a sofa to a customer. If the store's employees accidentally knock down an antique vase while carrying the sofa into the living room, the BAP should respond with coverage. But if one of the employees knocks the vase down with her elbow after placing the couch in its intended resting place, the BAP is the wrong place to look for protection.

Liability for accidents that occur after property has been delivered is supposed to be covered by commercial general liability (CGL) insurance, not commercial auto insurance. In fact, many experts advise businesses to buy their BAP and CGL policies from the same carrier. Following this advice might eliminate some confusion when accidents involving pickups or deliveries take place.

Although the BAP will cover businesses when they damage other property while transporting goods, damage to the transported goods will be excluded. For an example, think of furniture delivery again. If a delivery person brings in an end table and accidentally knocks one side against a wall, damage to the table won't be covered. In this scenario, the table was still in the delivery person's care, custody or control. Property in the business's care, custody or control should be covered by some form of inland marine insurance or other commercial property insurance.

Business Use and the Personal Auto Policy

As a general rule, vehicles owned by individuals are meant to be insured through personal auto insurance. Vehicles owned by business entities are meant to be insured through commercial auto insurance.

For the sake of convenience and costs, small-business owners occasionally prefer to use their personal auto policy to cover company-owned vehicles. This strategy might be allowed under limited circumstances by some carriers and might result in lower premiums. However, it can create many complications at claim time and can expose employers and employees to major coverage gaps. Some of the drawbacks of insuring a company-owned vehicle thorough a personal auto policy (if allowed by the insurer) are listed next:

- Liability limits for personal auto policies tend to be much lower than limits under a BAP. This can create a problem if an accident victim sues the business and the at-fault driver.
- Personal auto insurance typically excludes accidents involving vehicles that are regularly available to the insured but aren't specifically listed on the declarations page. This can create problems if a company vehicle is insured by a boss's personal policy but is used regularly by employees.
- Personal auto policies often won't respond to claims involving vehicles that carry people for a fee. This can create problems for cab companies and limousine services.
- Personal auto policies sometimes don't cover people or businesses at all when a large truck is used for commercial purposes. This can create problems for movers, trucking companies and other businesses that transport large items via public roads.
- Although personally owned cars and vans can be insured through a personal auto policy and used for business purposes, the insured might need to disclose the business use to the insurance company. If drivers regularly use a personally owned vehicle for business and don't alert their insurer, they might have problems getting their claims paid.

Conclusion

Businesses have enough to worry about without having to fret over auto accidents. Commercial auto insurance can help protect them so that they can keep their attention on ways to offer new products and good service. Still, commercial auto insurance tends to be a more complicated subject than personal auto insurance. To sell the appropriate policy, you need to have a strong understanding of coverage forms and the risks they address.

Below is the Final Examination for this course. Turn to page 118 to enroll and submit your exam(s). You may also enroll and complete this course online:

InstituteOnline.com

Your certificate will be issued upon successful completion of the course.

FINAL EXAM

1. Claimants who don't receive the kind of compensation they expect from their insurer are likely to _____.
   A. engage in greater risk prevention
   B. delay payment of future premiums
   C. take their business elsewhere
   D. join the insurer in a class action suit

2. Individuals known as "public adjusters" represent _____.
   A. insurance companies
   B. claimants
   C. insurance regulators
   D. property appraisers

3. When consumers believe a claims decision is unfair or inappropriate, they often have the ability to _____.
   A. receive a partial return of paid premiums
   B. withhold commissions from their agent or broker
   C. upgrade their coverage on a retroactive basis
   D. appeal the decision through some kind of internal review board

4. One of the simplest yet most effective actions an insurer can take after a catastrophe is to _____.
   A. enforce new peril-specific deductibles
   B. significantly revise its actuarial tables
   C. reduce compensation to captive agents
   D. be noticeably present in the affected area

5. Casualty insurance often calls on the insurer to cover _____.
   A. intentional acts
   B. acts of war
   C. the cost of rebuilding the insured's property
   D. the cost of defending the insured

6. Claims-related penalties are more likely to be above and beyond the amount actually being disputed if the insurer is accused of _____.
   A. experience rating
   B. an unfair claims settlement practice
   C. demanding access to damaged property
   D. not insuring high-risk applicants

7. Most forms of commercial property insurance have _____.
   A. elimination periods
   B. coinsurance requirements
   C. extended reporting periods
   D. fire exclusions

8. Product liability is a concern for businesses that _____.
   A. provide services to the public
   B. give financial advice to investors
   C. manufacture or sell goods
   D. serve in fiduciary capacities

EXAM CONTINUES ON NEXT PAGE

9. Contractual liability is liability that's accepted _____.
   A. by businesses organized as sole proprietorships
   B. as part of a court's ruling against a business
   C. as part of an oral or written agreement
   D. in accordance with state or federal statutes

10. _____ liability exists when one party is held indirectly responsible for damage caused by someone else.
   A. Product
   B. Vicarious
   C. Contractual
   D. Statutory

11. Some states prohibit insurers from covering _____.
   A. punitive damages
   B. actual damages
   C. fire losses
   D. additional living expenses

12. In regard to a commercial general liability insurance policy, advertising injury occurs when a business _____.
   A. fails to abide by the rules in a contract
   B. knowingly makes false statements when talking to customers
   C. loses business because of unfavorable media coverage
   D. commits an offense against someone in its promotional materials

13. Commercial general liability insurance can be issued through the use of either an occurrence form or a(n) _____.
   A. claims-made form
   B. retroactive form
   C. unendorsed form
   D. elimination period form

14. A person may be eligible for workers compensation after _____.
   A. agreeing to work as an independent contractor
   B. suffering a workplace injury
   C. becoming ill during a paid vacation
   D. falling at home while preparing for work

15. Workers compensation insurance is almost always paired with _____.
   A. commercial auto insurance
   B. business interruption insurance
   C. employers liability insurance
   D. key-person disability insurance

16. A workers compensation insurance policy serves as a contract between the insurance company and the _____.
   A. employer
   B. employee
   C. independent contractor
   D. state insurance department

17. _____ made sweeping changes to health insurance underwriting beginning in 2010.
   A. The Family and Medical Leave Act
   B. The Patient Protection and Affordable Care Act
   C. The Consolidated Omnibus Reconciliation Act
   D. The Health Insurance Portability and Accountability Act

EXAM CONTINUES ON NEXT PAGE

18. Like coinsurance fees, copayments are meant to make patients more responsible for the cost of care and to discourage _____.
    A. unhealthy lifestyles
    B. preventive care
    C. unnecessary medical visits
    D. input from primary care doctors

19. In accordance with the Health Insurance Portability and Accountability Act, health insurance policies sold in the individual market are _____.
    A. guaranteed renewable
    B. conditionally renewable
    C. non-cancelable
    D. unregulated

20. A medical problem experienced prior to an insurance policy's effective date is known as a _____
    A. chronic condition
    B. pre-existing condition
    C. standard risk
    D. sub-standard risk

21. _____ tend to give policyholders the greatest level of choice regarding which medical providers they can see.
    A. Reimbursement policies
    B. Health Maintenance Organizations
    C. Managed-care plans
    D. Medicare Advantage plans

22. Medical providers who have contracted with insurers to treat subscribers are part of a plan's _____.
    A. formulary
    B. medical loss ratio
    C. network
    D. fee schedule

23. Historically, one of the distinguishing characteristics of Blue Cross/Blue Shield entities has been their _____.
    A. coverage of non-traditional medicine
    B. high deductibles
    C. non-profit status
    D. small networks

24. A patient in an HMO will have all of his or her care coordinated by a _____.
    A. primary care physician
    B. lab specialist
    C. internal review board
    D. licensed patient advocate

25. One of the attractive features of an HMO is its emphasis on _____.
    A. mental health care
    B. maternity care
    C. preventive care
    D. custodial care

26. A health savings account must be paired with a(n) _____.
    A. HMO plan
    B. PPO plan
    C. Blue Cross/Blue Shield plan
    D. high-deductible health insurance plan

EXAM CONTINUES ON NEXT PAGE

27. Group health insurance covers several people through _____.
    A. a single insurance policy
    B. several separate insurance policies
    C. individually underwritten policies
    D. state-supported pooling mechanisms

28. If a self-insured plan wants to manage the risk of unexpectedly large claims, it can purchase _____.
    A. stop-loss coverage
    B. employment practices coverage
    C. fiduciary liability insurance
    D. personal injury protection

29. If someone has health insurance from multiple sources, it's important to examine a plan's _____.
    A. coordination of benefits provision
    B. incontestability clause
    C. settlement option provision
    D. beneficiary designation page

30. _____ insurance pays business owners the amount of money they would have earned if a covered peril had not forced them to suspend normal operations.
    A. Business income
    B. Extra expense
    C. Ocean marine
    D. Commercial liability

31. Unlike business income insurance, which usually features a three-day waiting period before coverage can begin, coverage of extra expenses starts _____.
    A. 24 hours after an interruption
    B. One week after an interruption
    C. 30 days after an interruption
    D. at the very beginning of an interruption

32. Coverage of business income and extra expenses lasts until insured losses exceed the policy's dollar limit or until the end of the _____.
    A. period of restoration
    B. rescission period
    C. free-look period
    D. look-back period

33. The perils covered by business interruption insurance should usually be identical to the perils in the business's _____ policy.
    A. corporate split-dollar
    B. product liability
    C. property insurance
    D. workers compensation

34. Perils commonly excluded from business interruption coverage include earthquakes, floods, radiation and _____.
    A. fire
    B. wind
    C. acts of war
    D. riot or civil commotion

35. The most traditional form of group life insurance covers enrollees for _____.
    A. guaranteed-renewable, one-year terms
    B. guaranteed-renewable, three-year terms
    C. conditionally renewable five-year terms
    D. conditionally renewable 10-year terms

EXAM CONTINUES ON NEXT PAGE

36. In a voluntary group plan, eligible employees will have a chance to enroll when they're hired or during a(n) _____.
    A. annual open enrollment period
    B. annual free-look period
    C. extended enrollment period
    D. open elimination period

37. The limit on enrollment periods exists to prevent a problem known as _____.
    A. underinsurance
    B. pooling of risks
    C. adverse selection
    D. post-claims underwriting

38. The cost differential between group life insurance and life insurance for one person will depend greatly on _____.
    A. the insurer's medical loss ratio
    B. the business's liability premiums
    C. the individual's health
    D. the desired settlement option

39. Unlike term life insurance, permanent life insurance is designed to keep somebody insured _____.
    A. until retirement
    B. until age 65
    C. for only a few years
    D. for the rest of their lifetime

40. Life insurance will be considered part of the deceased's estate for tax purposes if _____.
    A. the policy was canceled more than five years before death
    B. the estate was listed as a beneficiary
    C. the deceased had no ownership interests in the policy
    D. the insurance was purchased and owned by a spouse

41. In general, businesses that don't list themselves as beneficiaries can receive tax deductions for _____.
    A. paying group life insurance premiums
    B. eliminating a disability insurance plan
    C. transitioning to a non-grandfathered health plan
    D. working without an insurance broker

42. If death benefits in a group term life insurance plan exceed $50,000, some imputed income might be produced and be _____.
    A. taxable to the employee
    B. deductible by the employee
    C. paid to the insurance company
    D. held in premium fund trust accounts

43. In the vast majority of cases, the named insured in a BAP is the _____.
    A. business
    B. employee
    C. accident victim
    D. vehicle manufacturer

44. If legal action is taken or threatened against an insured party, the liability portion of the BAP will cover _____.
    A. the insured's family members
    B. defense costs
    C. damage to the insured's vehicle
    D. medical payments to employees

EXAM CONTINUES ON NEXT PAGE

45. By default, property damage coverage for covered autos is based on a vehicle's _____.
    A. replacement cost
    B. actual cash value
    C. maximum market value
    D. financed amount

46. _____ coverage pays to repair or replace a driver's vehicle when he or she hits another object.
    A. Collision
    B. Other-than-collision
    C. Uninsured motorist
    D. Underinsured motorist

47. In order for a driver to drive a company vehicle for personal use and still be covered for liability under the BAP, _____.
    A. the driver must be a relative of the business owner
    B. permission must have been granted by the business
    C. the personal use must immediately follow a company function
    D. personal auto coverage must have been issued by the same carrier

48. Although the BAP covers employees for liability while they drive company cars, workers are excluded while _____.
    A. driving in other states
    B. driving on private property
    C. operating their own vehicles
    D. transporting a client for free

49. In cases where there's some overlap in coverage between an employee's personal policy and an employer's BAP, claims will be made against _____.
    A. the employer's auto insurance
    B. the employer's general liability insurance
    C. the vehicle owner's policy
    D. the most recently purchased auto policy

50. A BAP usually won't help pay for bodily injuries to _____.
    A. pedestrians who are struck by business employees
    B. workers who are hurt while doing their jobs
    C. accident victims who aren't employed by the business
    D. a business's customers who are hit in a parking lot

END OF EXAM

Turn to page 118 to enroll and submit your exam(s)

PRINCIPLES FOR INSURANCE PROFESSIONALS:

Second Edition

Continuing Education
for Illinois Insurance Professionals

PRINCIPLES FOR INSURANCE PROFESSIONALS:
SECOND EDITION

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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: Second Edition" is intended to help 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 is about auto insurance, including optional coverage and the kinds mandated by law.
- Chapter 2 looks at disability insurance, including policies for short-term needs and plans for long-term needs.
- Chapter 3 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 4 summarizes the importance and versatility of life insurance, including term life and permanent life.
- Chapter 5 explores the options for people interested in annuities, including fixed annuities, variable annuities and indexed annuities.
- Chapter 6 briefs readers on the common elements in a long-term care policy, including elimination periods, benefit periods and benefit triggers.
- Chapter 7 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 give you enough background information so that you can discern 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: 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.

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 (ISO) in the 1970s and has been revised on several occasions. Each insurance company can choose to use language from the ISO's Personal Auto Policy in full, in part or not at all, but it remains the standard among most of the industry.

The Personal Auto 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 motorist coverage.
- Property 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 more coverage than what's minimally required by the government.

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 drivers 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 or register 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. If a vehicle's owner and its driver aren't the same person and both have insurance, the owner's policy will usually pay first, and the driver's policy will pay for liability that exceeds the owner's insurance limits.

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 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 anyone who will have regular access to their car (as opposed to infrequent, temporary use). 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. Despite the likely increase in insurance costs, making these important disclosures to the insurance can help prevent serious coverage gaps.

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.

In essence, medical payments coverage in an auto policy is like health insurance that only pays if the insured person is hurt in an auto accident. It 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).

In auto insurance, personal injury protection (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.

Medical payments 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 Motorist 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.

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 motorist 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.

In general, uninsured motorist coverage is intended to compensate a policyholder when they suffer bodily injury due to an insured driver. Property damage due to an uninsured driver might only be covered by this portion of the policy in limited circumstances and/or in certain states.

Auto insurers provide uninsured motorist 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.
- The policyholder is hit by someone whose insurance company refuses to pay for losses.

In order to receive benefits from the uninsured motorist portion of an auto policy, the victim will need to alert both the police and the insurance company.

Uninsured motorist 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 motorist 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 motorist 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 motorist 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 Motorist Coverage

A somewhat similar policy feature known as "underinsured motorist 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. Like uninsured motorist coverage, underinsured motorist coverage typically responds to cases of bodily injury and not necessarily property damage.

As an example, let's assume George has $100,000 of underinsured motorist 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 motorist coverage would handle the additional $40,000.

Although our example might make underinsured motorist coverage seem very simple, some important conditions must be met for the insurance to work. Most significantly, the victim's limit for underinsured motorist coverage usually must be greater than the at-fault driver's liability limit. If the victim has $100,000 in underinsured motorist coverage and the at-fault driver has $100,000 in liability coverage, this part of the victim's policy is likely to be irrelevant. To determine how much underinsured motorist coverage might be available after a particular accident, start with the victim's policy limit for underinsured motorist coverage and then subtract the at-fault driver's insurance limit for bodily injury.

In most states, underinsured motorist 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.

Property Coverage for Your Own Car

In addition to providing important liability protection, auto insurance policies can cover property 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.

An accident victim's insurance company can get its money back by suing the at-fault driver or negotiating with the at-fault driver's insurer thanks to a process called "subrogation."

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, freezing and wear and tear.

Unlike other portions of the typical auto policy, property 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.

Property coverage on a driver's own vehicle will likely be mandatory if the owner has a car loan. In that case, full property coverage will usually need to be maintained at least until the loan is paid off.

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. There would also be no coverage for theft, fires and other perils that aren't auto accidents.

Collision Coverage

"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 as part of their property coverage 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 but 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.

After most accidents, drivers with property coverage on their vehicle will be compensated in an amount equal to the cost of repairing the vehicle. However, due to the rapid rate of depreciation, the cost of repairing a vehicle might eventually 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.

In the event that someone with an auto loan has a totaled vehicle, "gap insurance" can help pay the difference between the remaining loan balance and the vehicle's actual cash value.

Driving Other People's Cars

Drivers generally remain insured by their own insurance while driving other people's cars with the owner's 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 usually borrow each other's cars and remain 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 damage 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.

With respect to auto insurance, driving to and from work is generally still considered to be personal use, 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 occasional 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.)
- Unless special arrangements are made, drivers who use their personal vehicles as part of a ride-sharing service will usually have little or no personal auto insurance at the point when they make themselves available to potential riders (regardless of when they actually have a passenger in their vehicle).

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 2: 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. Although federal laws have reduced insurance companies' abilities to deny or exclude coverage based on pre-existing conditions, those federal protections might not apply to disability insurance.

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 might be suitable mainly 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 abilities. 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 chapter.

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 most 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.

By only paying benefits when a disabled person actually loses income, disability insurance, to a certain extent, follows the "principle of indemnity." In short, the principle of indemnity ensures that people aren't made better off after a loss than before it.

Own Occupation vs. Any Occupation

The most comprehensive (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 disability 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, "any-occupation" disability insurance pays benefits when people cannot perform the duties required by 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 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.

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.

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 disability 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

In disability insurance, the benefit amount will be based mainly on a worker's salary or wages. The income used to calculate the benefit amount will be the insured's 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 either 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 (such as 75 percent) 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 vs. 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 disability plans are generally 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 disability insurance policies are portable when the insured changes jobs.
- Unlike group coverage, benefits from individual disability insurance 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 3: 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 at least equal in value to their mortgage loan, if not more. 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 likely 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 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. Also, roommates who are unrelated to one another might not be able to rely on the same policy and might need to buy their own separate coverage.

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

In homeowners insurance, 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 (In general, the declarations page is the policy's first-page summary of the purchased insurance.)

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

In homeowners insurance, Coverage B is property insurance for 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

By default, standard forms of 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 (10 percent of the person's Coverage C limit).

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 30 or 50 percent of their contents coverage.

Before moving on to other portions of the standard policy, let's examine additional living expenses 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.

Benefits for additional living expenses 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.

Benefits for additional living expenses 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 mansion.

Beyond housing, benefits for additional living expenses 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.

Coverage E

In homeowners insurance, Coverage E 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.

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 in large amounts 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.

For a scenario to be covered by the personal liability portion of a homeowners insurance policy, the insured's alleged negligence needs to have resulted in loss or damage to property or 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.

Conversely, geography sometimes 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 for damage 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 might 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 was actually responsible for the loss.

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, 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.

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.

In liability insurance, 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 expenses:

- 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 often 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 chapter 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 of 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 30 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 50 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.

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 similar 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.

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 insurance 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 minus any deductible.

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 minus any deductible.

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 minus any deductible. The remaining $10,000 would be considered an uninsured loss.

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

- Pro-rated settlement = (Insurance carried ÷ insurance required) × actual loss – deductible.
- Pro-rated settlement = [Coverage A limit ÷ (80 percent × replacement cost at claim time)] × actual loss – deductible.

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—at least in homeowners insurance—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 4: LIFE INSURANCE

Introduction

Life insurance is not only one of the most popular kinds of insurance in society but also one of the oldest. The practice of providing financial assistance to dependents after someone's death dates at least as far back as ancient Mesopotamia, where the Code of Hammurabi required the state to provide compensation to families when a robbery resulted in a victim's death. Over time, life insurance concepts also found their way into guilds and religious societies. When a fellow tradesman or worshiper passed away, members of these organizations would pool their money together and help pay for funerals and other final expenses.

Early life insurance arrangements were relatively informal and would often only involve short-term contracts between two people. An individual who was scheduled to undergo a dangerous task or a risky journey would sometimes pay a single sum to a wealthy person in exchange for an agreement to provide death benefits to surviving family members. But if the person paying the sum to the wealthier person survived the particular ordeal, the wealthier person (known as the "underwriter") could keep the money and wouldn't need to pay anything to the family.

The creation of life insurance companies was the byproduct of consumer demand and actuarial principles. The world was becoming more industrialized, and fewer heads of households could adequately prepare for death by leaving valuable farmland to their heirs. Meanwhile, underwriters realized that they could reduce their financial risks by insuring several lives instead of just one. The need for life insurance became more broadly recognizable regardless of social class, and the businesses that were interested in offering this important product became bigger and bigger.

Today's life insurance companies have collectively underwritten trillions of dollars in coverage on millions of lives. And even among the relatively few adults with absolutely no life insurance, the idea of protecting their loved ones in the event of an untimely death has almost certainly crossed their mind. Many of them are just waiting for someone to explain how this insurance actually works.

Purposes of Life Insurance

Most life insurance purchases are made to help survivors deal with the financial consequences of a loved one's death. Long-term consequences typically include the loss of the deceased's income, which would have otherwise been used to maintain a family's standard of living and help achieve such future goals as repayment of a mortgage loan or funding of a child's college education. Short-term consequences might include the unexpected costs pertaining to funerals, burials and unpaid medical bills.

Unlike other major assets that might be passed down from the deceased to heirs, life insurance proceeds are typically exempt from the sometimes drawn-out probate process. As a result, beneficiaries usually don't need to wait too long after a death before receiving the money they might desperately need.

Over the past 50 years or so, life insurance has successfully served other purposes, too. These additional uses of life insurance might not be applicable or suitable for the average purchaser, but they can certainly help a buyer under the right circumstances. For example, a life insurance policy might play an important role in the financial plans of the following hypothetical consumers:

- Bill is a wealthy retiree who wants to leave as much of his estate as possible to family, friends and charities instead of losing a significant chunk of it to federal estate taxes after his death. With the right kind of life insurance policy, he might be able to help his family pay off the sizable estate tax bill or even avoid it altogether.
- Jan has just made the last mortgage payment on her home and is in the last few years of her career. She has two adult and financially independent children and is reasonably confident that her savings and Social Security will be enough to fund a modest retirement. However, she would like a third layer of income in case her projections end up being slightly inaccurate. With the right kind of life insurance policy, she might be able to earn some extra interest on her money or even exchange part of the policy's death benefit for emergency cash withdrawals.
- Mike has a high-risk, high-reward philosophy when it comes to investing, and it's served him and his family well. However, he knows he should park at least some of his money in a low-risk investment in case the market experiences a major depression. With the right kind of life insurance policy, he might be able to create some balance in his portfolio.
- Melinda and Brian are successful business partners who aren't sure what would happen if one of them were to die in an accident. They both have spouses, but it's not clear whether either spouse would ever want to take over part of the business. With the right kind of life insurance, Melinda and Brian can ensure that the surviving partner can purchase the deceased partner's portion of the business and that any surviving spouse is fairly compensated.

Over the next several pages, we will explore these big, small and medium-sized needs in greater detail and explain how life insurance might cater to them. To a lesser (but still important)

degree, we will also be sure to acknowledge that as flexible as life insurance can often be, it isn't the best solution to every problem.

Determining Life Insurance Needs

Despite the versatility and popularity of life insurance, the amount of coverage that is appropriate for a purchaser will be different from person to person. In fact, what's considered an appropriate amount at the time of purchase is likely to be different from the amount that is truly needed by the same person several years later.

Even when applicants recognize the importance of life insurance, they often misjudge the size of death benefits that they really need in order to accomplish their goals. To guide people to the right amount, life insurance producers must become familiar with each prospect's financial situation and continue to encourage an open dialogue in the years following a sale.

For several decades, the life insurance industry attempted to determine an applicant's needed amount of coverage by calculating the individual's "human life value." This calculation relied heavily on the insured person's income and unfortunately led to such broad recommendations as, "Everyone should purchase life insurance equal to at least five times their annual salary."

The focus on income was both understandable and a good start, but it didn't allow for variables in family structures (such as single-income families vs. two-income families) or for long-term goals that weren't necessarily tied to salary (such as a desire, regardless of current income, to fund a surviving child's education).

Rather than rely on basic calculations of human-life value, most of today's life insurance professionals estimate the suitable amount of coverage by conducting some kind of "needs analysis." Income is generally an important factor in a needs analysis, but it is far from the only variable that is considered. A common, thorough needs analysis explores the specifics of a person's financial goals and is likely to involve getting answers to the following questions, among others:

- Which expenses, if any, might actually be eliminated by an insured person's death?
- 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 money from a policy's death benefit?
- 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 money 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 directly related to the insured person's death?
- How much money should be reserved for a favorite charity or some other non-traditional beneficiary?
- What other sources of income (such as savings, Social Security benefits, other insurance and survivors' employment income) are likely to be in place in order to accomplish the buyer's goals?

One potential drawback to a needs analysis is that it is subject to change in the years after a policy is issued. Mortgage loans are paid off. New children are born, and older ones (we hope) become financially independent. Marriages begin and sometimes end. These occurrences are practically a part of life and are likely to have an impact on how much life insurance is really necessary for a given individual.

Producers should, therefore, feel obligated to make contact with their existing customers at least every few years and suggest conducting a revised needs analysis. If the revised analysis points toward a smaller need, the insured is likely to save a bit of money. And if the revised analysis shows a larger need, obtaining a bigger death benefit can help keep the owner's goals on track.

Is Life Insurance for Everyone?

If insurance professionals are going to trust the results of a needs analysis, they must be willing to acknowledge those relatively rare cases in which the need for coverage is very small or even nonexistent. If an individual has no dependents, life insurance might not truly be necessary. If someone's sole concern is having enough money for burial, funeral and other end-of-life expenses and the person is already covered under a modest group life insurance plan, the purchase of a separate policy might not be a legitimate priority.

Although it may be acceptable to emphasize some of the other positive features of life insurance (such as tax issues and the potential to receive dividends or low-interest loans from the insurance company), producers should never forget that the most important promise contained in a life insurance policy is the insurer's promise to pay a death benefit. If the size of the death benefit is not one of the buyer's major concerns, life insurance might not be the best solution to the person's problem. Or at the very least, the purchase of life insurance for this type of person should probably be considered within the context of the buyer's overall financial plan. Such cases might require knowledge beyond the typical insurance producer's realm of expertise and might need to include consultation with the person's attorney, accountant or other trusted adviser.

Understanding Life Insurance Companies

Most life insurance in the United States is issued by large insurance companies. Policies might also be obtainable through fraternal organizations, banks and (to a considerably lesser degree) credit card companies. The same companies that sell life insurance are also likely to sell annuities and some forms of accident and health insurance.

Insurance companies can generally be categorized as either "stock companies" or "mutual companies." A stock company is owned by investors who might or might not have purchased insurance from that particular company. A mutual company, on the other hand, is owned by the same individuals who have purchased insurance from it. In other words, the company's stockholders and its policyholders are the same people. As

stockholders, people who purchase life insurance from a mutual company might receive sums of money called “dividends,” which can be given as cash or used to reduce future insurance premiums. Dividends from a mutual company are usually treated as a return of the person’s premium and generally aren’t taxed as income.

Life insurance policies that have the potential for payments of dividends are called “participating policies.” Life insurance policies that do not include the potential payment of dividends to policyholders are called “non-participating policies” and are primarily sold by stock companies. Some mutual companies might also offer non-participating policies to the public. In exchange for the lack of possible dividends, non-participating policies tend to have lower initial premiums.

Mortality Tables

Regardless of whether they’re organized as stock companies or mutual companies, life insurers rely on actuarial data called “mortality tables” to help them price their products and to decide how many lives to insure. Mortality tables are statistically–based representations of each age group’s susceptibility to death each year. These tables usually break mortality rates down for insurers by giving them the annual, estimated deaths per 1,000 people in each age group. Although they can’t necessarily predict how long a particular person will live, they help insurers make relatively accurate predictions about how many of an insurer’s policyholders will die over a given time period and, as a result, how much money will need to be paid to beneficiaries.

Insurer Solvency

Regulators require that life insurance companies keep a significant amount of money in reserve in order to pay death benefits and to provide refunds to consumers who are entitled to them. However, an unstable company still might struggle to honor its contractual obligations during a bad economy or at any point when a significant number of policyholders suddenly decide to cancel their coverage. States generally have guaranty funds that can compensate beneficiaries if a life insurance company is unable to make good on a legitimate claim, but there are limits to the amounts that these funds will pay, and the wait can be long and inconvenient.

For these reasons and more, consumers and producers should focus not only on the price of life insurance but also on the financial stability of the company that is behind the given policy. Ratings organizations such as A.M. Best and Weiss Ratings can provide an evaluation of an insurer’s financial health and can help producers determine which companies are more likely than others to become insolvent or are at least more likely to raise prices.

Life Insurance Agents

A person who wants to sell life insurance to others must be licensed. The type of required license will depend on the type of life insurance being sold.

The basic life insurance license issued by a state’s insurance department can be used to sell most kinds of life insurance. However, some kinds of life insurance are actually a combination of insurance and a securities product. These types of insurance are collectively known as “variable life insurance” and have a cash value that can increase or decrease in conjunction with the stock market or other economic factors.

In order to sell variable life insurance, the seller must have a life insurance license issued by his or her state and must pass the appropriate national exam pertaining to securities. (These exams are typically known by a series number, such as “Series 6” or “Series 7.”)

In addition to being regulated by the state insurance department, an insurance agent who sells variable life insurance is also regulated by a national regulatory body called the “Financial Industry Regulatory Authority” (FINRA). Both FINRA and a state’s insurance department require that life insurance professionals complete continuing education courses in order to renew their license.

Duties of Life Insurance Agents

Along with explaining products and evaluating consumers’ needs, life insurance agents often act as “field underwriters” for the insurance company. As a field underwriter, the life insurance agent is expected to consider a potential buyer’s risk profile and determine whether the person is likely to be a good customer for the insurer.

Although insurance companies employ other underwriters who do not also work in sales, good field underwriting can reduce an insurer’s administrative costs and help an applicant maintain reasonable expectations about whether affordable coverage will ultimately be obtainable. As a result, producers should develop strong knowledge regarding an insurance company’s underwriting guidelines and understand which types of applicants are probably too risky to insure.

When members of the public purchase life insurance, they typically refer to the person who sold it to them as “their agent.” Technically, however, someone who is a life insurance agent represents the insurance company in the sales transaction. This is yet another reason why life insurance agents must be careful not to overburden an insurer with knowingly risky applicants.

If an applicant has a medical condition, hobby or lifestyle that he or she does not want to disclose to the insurer, the agent must disclose the information anyway. Despite being strongly associated with sales, an observant agent is also the life insurance company’s first line of defense against insurance fraud. Agents have an obligation to only bring applicants and insurers together in good faith.

Upon receiving all necessary information (often including medical reports) from life insurance applicants, agents will collect an initial insurance premium and be responsible for sending these funds to the insurance company. When the applicant pays the first premium, the agent will also typically issue some kind of a receipt, which may be conditional or fully binding.

If the agent issues a fully binding receipt, the applicant will have immediate coverage under the life insurance policy and can’t have the coverage rescinded by the insurer unless fraud is detected.

In most cases, the receipt issued by the agent is conditional upon all of the application information being reviewed and approved by the insurance company’s underwriting department. If an applicant with a conditional receipt would have been approved by the underwriting department but dies before the approval takes place, the policy will be in force, and death benefits will be awarded to the deceased’s beneficiaries. If an applicant with a conditional receipt wouldn’t have been approved and dies before the underwriting department has completed its review of the application, the policy will not be in force, and no death benefits will be paid.

Before engaging in a life insurance transaction on behalf of an insurance company, agents should have a clear understanding of the types of receipts they may issue. They should also provide as much clarity to applicants as possible and not allow consumers to believe coverage is in place when it is still subject to an underwriter's approval.

The Life Insurance Application

Life insurance applications are intended to give underwriters the facts they need to either accept or reject a potential policyholder. In practically every case, the application is considered part of the contract (along with the insurance policy) between the insurer and the buyer. If the insurer later discovers that an application wasn't completed honestly, the policy might be terminated (in a process known as "rescission"), or the owner might be forced to pay higher premiums.

While each insurer is likely to include different items on its applications, a modern life insurance application is still likely to ask the applicant to provide information about the following topics:

- Name.
- Age.
- Health.
- Amount of requested coverage.
- Gender.
- Address.
- Occupation.
- Hobbies.
- The applicant's relationship to the insured individual.
- The applicant's relationship to the policy's beneficiary.
- Other life insurance products that the person already owns.
- Other life insurance products that the person applied for but did not receive.

The applicant must sign the application and attest that the information on it is accurate to the best of his or her knowledge. A separate portion of the application also requires the agent's signature and provides space for the agent to leave any additional comments that might be helpful to the insurance company's underwriting department. Upon receipt, the underwriting department will review the application, evaluate the applicant's risk profile and request additional information as necessary.

Evaluating the Application and Pricing the Policy

Prices for life insurance—and the factors that influence them—will differ from company to company. Though practically all life insurance carriers will care about risk-related issues such as age, health and tobacco use, the line between an insurable person and an uninsurable person isn't identical across the industry. Similarly, depending on the specific policy and the insurer's underwriting criteria, the same person might be eligible for relatively cheap coverage from one company but only qualify for relatively expensive coverage from another.

Still, we can make some basic generalizations about how life insurers categorize applicants and how they view certain types of applicant-related information. For the purposes of this course material, we will say that life insurance companies categorize insurance applicants into four broad groups:

- Preferred risks: These are applicants with an above-average life expectancy for their age. They will generally pay the smallest amount for life insurance.
- Standard risks: These are applicants with an average life expectancy for their age. They will generally pay a moderate amount for life insurance.
- Substandard risks: These are applicants with a below-average life expectancy for their age. They will pay the largest amount for life insurance.
- Denied risks: These are applicants who won't be issued life insurance at all.

In practice, the various categories of applicants tend to be greater in number and more complex than the three mentioned here. For example, some companies have a category for "super-preferred" risks, which is essentially for applicants whose life expectancy is extremely high for their age rather than just above average. Several sub-categories might also exist based on whether an applicant is a smoker or a non-smoker.

Life Insurance and Medical Information

Information about an applicant's health is central to life insurance underwriting. The more information an underwriter has at his or her disposal, the quicker and fairer the underwriting process can be.

As we will see in the pages that follow, life insurance producers and their clients must have an open dialogue about family histories, medical diagnoses and drug treatments, even as each party does its best to remain respectful toward the subject matter and preserve as much privacy as possible.

In order to evaluate an applicant's risk profile, life insurance agents must do more than simply ask if the person is in "good health." Many insurance veterans will tell you that most of their prospects claim to be healthy, even if their cholesterol and blood pressure levels are dangerously high and their medical files are abnormally thick. Unless they are suffering from a diagnosed and terminal medical problem, many potential buyers might assume that most of their health issues are minor and, therefore, don't really need to be disclosed.

For clarity's sake, a life insurance producer should ask the applicant to disclose any ailment or injury that required either hospitalization or prescription medication. The insurance company will ultimately want to know the reasons behind any past or imminent surgeries, learn why applicants visited any medical specialists and find out the identities of people's current physicians.

In addition to inquiring about one's personal medical status, a life insurance company will probably ask about family history. For risk management purposes, the insurer will ask if an applicant's blood relatives—usually limited to parents and siblings—died young or were diagnosed with cancer, heart disease or other serious ailments. Note, however, that some states prohibit discrimination on the basis of genetics as long as the applicant has not been officially diagnosed with a genetic condition.

Life insurers use industry databases and attending physicians' statements to verify applicants' medical histories. But files obtained through the Medical Information Bureau, which we will

study later, are not substantial enough to give an underwriter a guaranteed understanding of an individual's health situation, and the files sometimes contain errors or misleading facts. Meanwhile, attending physicians' statements might be too vague in some respects and overly detailed in other areas.

For these reasons and more, life insurance applicants are typically given space on an application to elaborate on their conditions as needed. They can explain, for example, that their cancer was diagnosed 10 years ago and has not been detected in recent checkups, or that a drug usually given to patients with liver problems was, in fact, prescribed for a completely different and less serious condition.

The Medical Information Bureau

One controversial—and some would say misunderstood—source of applicants' medical information is the Medical Information Bureau (MIB). Founded in 1902, the Massachusetts-based organization claims to have saved the buying public millions of dollars by detecting consumer fraud in the life and health insurance markets. This nonprofit entity is funded by over 600 life and health insurers that pay dues to the MIB based on the number of times they access the organization's database and the number of policies they have on file with the bureau.

When a person applies for an individual life, health or disability policy, an insurance company that maintains membership with the MIB may choose to report medical information to the bureau. The bureau does not accept any information directly from hospitals or doctors. All information must come from member insurers, and the insurers' information must have come either from the applicant as part of the application process or from a physician who received the applicant's consent to disclose it. The applicant's consent usually comes from an item on the insurance application called an "MIB Pre-Notice," which explains the kinds of information an MIB member might report and the reasons why insurers access MIB files.

MIB records consist of codes, with each code representing one of 230 specific risk factors. The MIB does not intend for its codes to disqualify someone automatically for life or health insurance. Instead, it expects its members to view these codes as red flags and encourages insurance companies to investigate an applicant's specific health status independently. The meaning behind each code is not disclosed to the public or to unauthorized employees.

The MIB maintains files for seven years and also keeps an "Insurance Activity Index," which keeps track of the MIB members who access a consumer's file within two years. Access to the files is granted only to MIB members who either have a pending application or a pending insurance claim.

The MIB's low profile might explain why there has been confusion over the years regarding consumer's access to their MIB records. In fact, the bureau operates in a fashion similar to the major credit bureaus in the United States. Consumers are entitled to view their MIB file once each year by calling the organization and providing it with their name, address, birthday and other identifying information. Consumers can also receive a free view within 30 days of a negative action taken against them by an insurance company. Additional copies of one's MIB file require a processing fee and a 30-day waiting period.

When people make a valid request for their information, the MIB will tell them what appears in their file, who reported all the information and the names of members who accessed their file. If consumers believe there is an error in their file, the MIB requires the insurer that reported the disputed data to reinvestigate the matter. When people are not satisfied with the results of a reinvestigation, they have an opportunity to add a note to their file that explains the dispute from their point of view.

Paramedical Exams

Sometimes a life insurance applicant can be issued or denied a policy based on the information found in an application and an attending physician's statement. However, many companies require each applicant or certain applicants to go through a paramedical examination before a policy may be issued.

Examined applicants can expect to have their blood pressure taken, their height and weight measured and, perhaps, some of their blood analyzed. If an applicant is not required to submit to a paramedical examination, he or she has probably bought a somewhat pricy policy or opted for a relatively small death benefit.

Life Insurance and Gender

Initially, societal views about gender and the idea of men being the financial providers for families meant that very few women purchased life insurance. As females took a greater liking to the product, they found that child-bearing risks created an unfavorable situation for them. According to a historical overview printed by Best's Review, if a woman was of child-bearing age, she was often denied life insurance or only offered it at a high price. Costs were even steeper if she applied during the first three months of pregnancy, and a one-year waiting period was common if she was any closer to giving birth.

As childbirth became safer, women began living longer on average than men. For instance, according to the Centers for Disease Control and Prevention, a woman's life expectancy in 2019 was 81.4 years, and a man's life expectancy was 76.3 years.

The difference in life expectancy between the sexes explains why gender-based prices continue to be allowed for life insurance. In general, if a man and a woman of the same age both apply for the same policy with the same death benefit, the man will be required to pay a bit more.

The opposite is true when a life insurance company issues an annuity. In that case, if a man and a woman of the same age both request to receive regular payments from the insurance company through an annuity, the woman will receive smaller regular payments than the man.

The different treatment of men and women in insurance has become increasingly unique to the life insurance side of the industry. Federal and state governments have moved to ban gender discrimination in health, property and casualty insurance in various ways.

Underwriting and Smoking

America's relationship with smoking has changed quite a bit since the days when doctors puffed away in front of their patients and when celebrities hawked cigarettes on television. According to the CDC, in 2019, only about 15 percent of adult men smoked, compared to 13 percent of women. Life insurance companies have changed with the times and have given discounts to non-smokers at least as far back as the 1960s.

For a long time, most life insurance companies granted coverage at a discount if the applicant had avoided cigarettes for at least a year. Over time, some companies have flirted with different rating classes for smokers and charged people a little less if they smoked cigars or pipes rather than cigarettes. People have also

been grouped based on the number of cigarettes they smoke in a day.

Tests for nicotine are a common part of the application and underwriting process. If the insurer discovers that an alleged non-smoker actually uses tobacco products, the person can usually still obtain life insurance by paying a higher premium.

Underwriting and Hobbies

What people do during their free time can say a lot about their chances of living a long life. In an era when extreme sports have their own televised events, life insurers have become increasingly careful when confronted with applicants who race cars, climb mountains, fly small planes or have other dangerous hobbies.

An extreme hobbyist's insurability will depend on the details of the activity. If a man climbs mountains, does he intend to find his way to one of the world's tallest structures? If a woman enjoys scuba diving, how deep does she plan on swimming? If the applicant is a pilot or race car driver, is his or her vehicle in excellent condition? Will the applicant be engaging in the hobby alone or in a group setting where help is more likely to arrive in an emergency?

Experience can also be a key underwriting factor in these cases. If someone has gone through some kind of licensing or certification process, the underwriter might view the applicant as someone who learned proper procedures and who is expected to adhere to a safety-first code of conduct.

When a dangerous hobby is likely to have a significant impact on an applicant's eligibility for life insurance, it might be possible to obtain affordable coverage by excluding the hobby as a covered cause of death or by paying a higher premium.

How Life Insurance Policies Work

At this point, we will review the common parts of a life insurance policy and their importance to consumers. The policy is considered part of a contract between the person buying the insurance and the company issuing it. Therefore, it is very important that applicants, policyholders, agents and insurers all have a firm understanding of what a policy actually says.

Unlike many kinds of property and casualty insurance carriers, the life insurance industry does not use the same standard policy forms across all states and all companies. In other words, a policy from Company A in one state isn't guaranteed to be written the same way or contain exactly the same features as a policy from Company B in another state. However, regulatory trade organizations such as the National Association of Insurance Commissioners (NAIC) have drafted life insurance rules and laws that many states have implemented with minimal or no changes.

Even where guidelines from groups like the NAIC have not been followed, state rules often dictate the wording of certain policy sections as well as their placement and font size. Such rules aim to create at least some level of uniformity and consumer protection regardless of which company is actually selling a life insurance product.

Ownership Rights

Besides the insurance company, there are at least three parties who are connected by a life insurance policy:

- The owner.
- The insured.
- The beneficiary.

The "owner" is the person who has "ownership rights" over the policy and is the only party, besides the insurance company, who decides how the policy is set up. In most cases, the owner is the same person who is responsible for paying the life insurance premiums. This person will sometimes be referred to as the "policyholder."

The "insured" is the individual whose life expectancy is analyzed during the application/underwriting process and is the person whose death will result in payments to the policy's beneficiary. The insured and the owner are usually the same person, but it is also possible for one person to be the owner of a life insurance policy on another person's life. For instance, a husband and wife might have a life insurance policy that lists the husband as the owner and the wife as the insured or vice versa. You'll read more about possible arrangements between the owner and the insured in the section called "Insurable Interest."

The "beneficiary" is the person or entity who will receive death benefits when the insured passes away. Although there is tremendous flexibility regarding who can be a life insurance beneficiary, the owner is typically the only person who can make that choice. In fact, an owner even has the ability to change his or her mind and replace one beneficiary with another after the policy has been issued. You'll read more about how this works in the section called "Beneficiaries."

Other rights that belong to the owner (and not to the insured or the beneficiary) are listed below:

- The right to use the life insurance policy as collateral for a loan from the insurer or another lender.
- The right to withdraw money from the policy's cash value (if the policy has cash value).
- The right to terminate the life insurance policy or make changes to it (pending the insurance company's approval).
- The right to receive dividends from the insurance company (if the policy is a participating policy).
- The right to decide whether the beneficiary will receive death benefits in a lump sum or in multiple installments.
- The ability to transfer all or a portion of the ownership rights to someone else.

Assignment

The ability to transfer a life insurance policy's ownership rights to someone else is known as "assignment." There are multiple types of assignment. In an "absolute assignment," the policy's original owner transfers all ownership rights. More commonly, though, an owner will only assign certain rights to other people and maintain control over other aspects of the coverage.

One of the most common types of assignment is a "collateral assignment." In this arrangement, the owner gives a creditor the right to name itself as the policy's beneficiary in exchange for a loan. If the owner pays the creditor back before the insured dies, the creditor's limited ownership rights end and are returned to the previous owner. If the owner's debt has not been paid off at the time of the insured's death, the creditor will be repaid from the death benefit, and any remaining death benefits will be paid to the owner's chosen beneficiary.

Regardless of the type of assignment or the reason behind it, the insurance company must be notified and approve of the assignment before it can go into effect. If the owner fails to alert the insurer to an assignment and a death occurs, the insurance company might not need to honor the transfer of ownership and might only need to abide by the version of the policy that it has on file.

Insurable Interest

Before someone can purchase insurance, the insurance company must believe that the policy's owner will want the insured item or insured individual to remain unharmed. This desire to keep insured items or insured people out of danger is called "insurable interest."

Since most people would prefer to stay alive for a reasonably long time, they are considered to have an insurable interest in their own lives and are therefore allowed to purchase life insurance on themselves. The rare exception to this rule about insuring yourself might arise if you attempt to purchase a policy with an unreasonably high death benefit.

Insurable interest can also exist between two or more people. For example, it is generally assumed that family members and business partners have an insurable interest in one another. However, in the event that someone is purchasing life insurance on another person, both the intended owner and the intended insured will usually need to sign the application. One exception to this rule might involve a parent purchasing life insurance on a newborn, which would obviously not require signature from both parties.

For the purpose of life insurance, insurable interest only needs to exist at the point when the insurer receives the application. If circumstances change between then and the time of the insured's death, the owner has the option (but is not obligated) to assign the policy to a more appropriate party. As an example, consider a scenario in which a married couple purchased insurance on each other's lives but ultimately got divorced. Even if neither person is dependent on the other for palimony, alimony or child support, the divorce (and the possible loss of insurable interest) typically won't invalidate the old coverage.

It is important to note that insurable interest is only needed between the owner and the insured. A life insurance policy's beneficiary is likely to have an insurable interest in the insured person's life but is not technically required to have one. The owner can typically name any person or any organization as a beneficiary.

Paying Premiums

Another decision left up to the owner is the schedule for paying the premiums. Policyholders can usually opt among making monthly, quarterly or annual payments. Paying annual premiums is a common recommendation because it reduces the insurer's administrative costs and can actually make coverage a little cheaper. Single-premium policies are also available but are rarely sold because few people have the disposable income to make such a large purchase in just one installment. Regardless of the payment schedule, premiums can typically be paid via check, a pre-authorized debit or bank account or (in the case of group life insurance) a payroll deduction.

Life insurance premiums are usually "level," meaning they remain the same for either the entire duration of the policy or for at least an extended period of time. If the policyholder has insurance that is intended to remain in force for the rest of someone's lifetime, level premiums tend to be the default option. If the insurance is only temporary but has the potential to be renewed for another period of time, the policyholder will typically pay level premiums equal to one amount until the renewal option is exercised. Then, level premiums equal to a different amount will be paid until the policy is either cancelled or renewed again. This temporary coverage (usually with renewal options) is called "term life insurance" and will be explained in greater detail later in this chapter.

Paid-Up/Limited-Pay Policies

Believe it or not, some life insurance products are designed to let the owner stop paying premiums at a certain point and still keep the coverage intact. These "limited-pay" or "paid-up" policies tend to cost more than other forms of life insurance during the first several years after they're purchased, but they can be beneficial for consumers who want permanent life insurance protection without having to worry about premiums during retirement.

When an insurer sells a limited-pay life insurance policy, it is making assumptions about the policy's future "cash value." The cash value is essentially a combination of the premiums that have already been paid, plus interest earned on those premiums, plus (in the case of a participating policy) dividends from the insurance company. We will explore this concept in more detail later in this course.

With a limited-pay policy, premiums will stop being paid once the cash value reaches a certain amount determined by the insurance company. At that point, the insurer will expect the policy's cash value to be large enough to offset the need for the premiums.

A true limited-pay or paid-up life insurance policy will contain a contractual guarantee that the owner will, indeed, never need to pay premiums after a certain point. With this type of policy, it makes no difference whether economic factors end up being less favorable than the insurance company's projections.

Unfortunately, some consumers have been confused by insurance company projections and have purchased similar kinds of policies that didn't contain these guarantees. Instead, they relied on an agent's verbal assurances or based their buying decisions on confusing charts from the insurance company. Assuming that their premiums would permanently "vanish," many of these confused or misled buyers eventually learned that they needed to pay premiums again in order to keep their coverage in force. For this reason and others, it is imperative that insurance agents communicate clearly regarding what a life insurance actually guarantees and what pieces of data are merely based on assumptions.

Grace Periods

In the event that a consumer either forgets or chooses not to pay premiums on time, the life insurance policy usually will remain in effect for at least one month after the due date. (Some states allow even more time if the owner is a senior citizen.) This is the policy's "grace period." If the insured dies during the grace period, the insurance company will pay death benefits to the beneficiary minus the amount of unpaid premiums.

Automatic Premium Loans

Life insurance policies that are designed to insure someone for the rest of his or her life (as opposed to insuring the person for only a pre-determined number of years) have a cash value that can be utilized in case premiums still haven't been paid by the end of a grace period. Usually at no cost, insurance companies

will include an amendment or "rider" to these policies that allows for an "automatic premium loan." When this type of feature is included in a policy, the insurance company will use part of the policy's cash value in order to compensate itself for unpaid premiums after a grace period. As long as the cash value is sufficient to pay the premiums and a bit of interest on the loan, the policy will remain in force, and the insured will remain covered.

Note, however, that many insurance policies sold today are "term insurance" policies and do not have any cash value. The automatic premium loan option is one of several differences between term coverage and permanent coverage. We will explore the other important distinctions between these two broad types of life insurance later in these materials.

Waiver of Premium

Many life insurance policies include a "wavier of premium" provision, which excuses the owner from paying premiums while he or she is significantly disabled. The ability to exercise this provision might be limited to owners of a certain age, such as those younger than 65. When it is exercised, it continues to waive the owner's premium as long as the disability can be verified.

Waivers of premium can seem like a neat addition to a life insurance policy, but they might not make the most financial sense if the owner needs to pay something extra in order to get it. Presumably, the same people who would struggle to pay life insurance premiums while disabled would also struggle to pay rent, mortgage debts, utility bills and other essentials, none of which would be helped by life insurance. For this reason, someone who is interested in a waiver of premium should probably take a step back and consider all the ways disabilities might impact one's financial health. Assuming the cost isn't overly prohibitive, this type of person should probably consider speaking with an agent about a separate disability insurance policy. Remember, for most people, life insurance should be about the death benefit.

Reinstatement Clauses

"Reinstatement clauses" give people who canceled their life insurance a chance to regain it under special conditions. The chance to reinstate a cancelled or "lapsed" policy generally lasts three to five years, depending on the insurer.

The good news about opting for reinstatement is that the policyholder might be able to regain the previously cancelled policy's cash value (assuming they didn't receive it as part of a lump sum after cancellation). Plus, when the policy is reinstated, the owner will often be charged the same premiums that were in place at the time of cancellation instead of a higher premium based on the person's age.

The bad news for people who want to reinstate a cancelled policy is that the owner will need to pay all premiums that would've been due between the point of cancellation and the point of reinstatement. Also, the insured might need to medically qualify for coverage again and might run into problems if he or she has experienced serious medical issues in the interim. As a result, many people only pursue reinstatement if they are likely to earn back a significant amount of a policy's cash value. Insurable people who cancel one policy and later want life insurance again might simply consider applying for a brand-new policy instead.

Death Benefits

The size of a life insurance death benefit is generally decided at the time of application by the policy's intended owner. Of course, there are some minor exceptions to this rule. For example, an insurer might be hesitant to issue a multi-million-dollar policy on a middle-income stay-at-home parent because the death benefit would seem significantly out of line with the person's needs and might be a red flag of insurance fraud. Similarly, applicants who only want a tiny bit of coverage might be required to purchase a bit more in order to cover the insurer's administrative costs.

The size of the death benefit that will be payable to beneficiaries is sometimes known as the policy's "face amount" or "face value." So a term life insurance policy with a $100,000 death benefit might be said to have a "$100,000 face." In order to properly calculate the appropriate death benefit for an insurance applicant, please review the section "Determining Life Insurance Needs" found earlier in these materials.

Settlement Options

The ways in which death benefits can be paid to beneficiaries after the insured's death are called "settlement options." A settlement option can be chosen by the owner in advance of the insured's death or, if the owner decides not to pick one, left up to the beneficiary.

Most beneficiaries would probably prefer to choose the settlement option on their own after the insured has died, but there are cases in which having the owner pre-select the manner of payment is advisable. If the policy's beneficiary is a child or even an adult who is not particularly responsible with money, the owner can choose a settlement option that restricts access to death benefits but still provides necessary money to the underage or financially unstable individual.

The most common settlement option gives the death benefit to the beneficiary in a single lump sum. In fact, if neither the owner nor the beneficiary voices a preference for a particular settlement option, this will likely be the insurance company's default way of paying policy proceeds. Other common settlement options are listed below:

- Leave the death benefit with the insurer and allow it to earn interest until a particular time or event.
- Leave the death benefit with the insurer but allow the beneficiary to receive periodic payments of dividends and/or interest.
- Break the death benefit into chunks of money that are given to the beneficiary at regular intervals until a certain date has passed.
- Break the death benefit into chunks of money that are given to the beneficiary at regular intervals until the money runs out.
- Convert the death benefit into an annuity that pays the beneficiary a set amount for the rest of his or her life.

No matter the chosen option, the insurance company will usually need to receive a valid death certificate before it will give death benefits to the beneficiary. Copies are usually available from funeral homes, cremation service providers and local government offices.

Beneficiaries

The beneficiary on a life insurance policy can be a person, business, charity, trust or estate. It is usually chosen by the owner, who even has the right to name himself or herself as the beneficiary.

While it is sometimes possible for the owner and the beneficiary to be the same person, the beneficiary cannot also be the insured. This makes sense when we consider that the beneficiary receives money after the insured dies. In the event that the insured is listed as the beneficiary, the death benefits will technically be passed along to the deceased's estate, which can create probate and tax issues that will be explained later.

Most beneficiaries are "revocable beneficiaries" and can lose their right to death benefits if the owner completes the appropriate paperwork with the insurance company. Other beneficiaries are "irrevocable beneficiaries" and cannot lose their beneficiary status unless they first provide consent to the insurer. As much as the owner might want to replace this kind of beneficiary with someone else, the owner lacks the power to make this type of change. Common scenarios in which an irrevocable beneficiary might be used include those in which a lender is named as a beneficiary until a debt is repaid and those in which former spouses are required to keep their former husband or wife (or their children) as beneficiaries as part of a divorce settlement. Note that an irrevocable beneficiary might also have the ability to veto (but not initiate) certain changes to the policy, such as a change in the death benefit or the use of the policy as collateral for a loan.

Other distinctions can be made between "primary beneficiaries" and "contingent beneficiaries." A primary beneficiary is the first person in line to receive death benefits when the insured passes away. As long as the primary beneficiary is alive at that time, the contingent beneficiary receives no money from the insurance company. On the other hand, if the primary beneficiary passes away before the insured's death, the contingent beneficiary will receive the policy's face amount. Having a contingent beneficiary can be particularly helpful if the insured and the primary beneficiary die in the same accident.

Even if the person who is supposed to benefit from the life insurance policy is very obvious to the applicant, care must be taken to ensure that the designation of a beneficiary is absolutely clear. For example, generic phrases such as "my spouse" or "my children" should usually be replaced with the actual names of those intended beneficiaries. If the purchase of a policy is followed by divorce and remarriage to a different person, it may be unclear as to which spouse is entitled to the death benefits. Similarly, if the beneficiary simply contains phrases like "my children," there might eventually be a dispute as to whether each child should receive the same percentage of the death benefit or perhaps an argument over whether children from previous marriages should receive money, too.

Including a child as a beneficiary can cause problems if the insured dies before the child becomes an adult. Since this can cause the death benefits to be tied up for an unreasonable time in the court system, many life insurance professionals recommend that parents create a trust to receive and hold the money until the child turns 18 or 21. Similar recommendations are often made for adult sons or daughters who are intended to be beneficiaries but are significantly disabled. When these recommendations are followed, the death benefit for sons or daughters might be reduced in order to cover the cost of establishing and maintaining the trust.

Entire Contract Clause

The "entire contract clause" is a seemingly minor portion of a life insurance policy that actually provides some important mutual protection to insurers and their customers. It essentially states that the entire contract between the insurer and the applicant consists of the policy itself, the application and any medical report obtained during the underwriting process.

For the insurer, this means that any exclusions or restrictions relating to the policy must be disclosed in these documents and can't be added at a later date without the owner's consent. For the applicant, this means that even if the person attempts to hide certain medical issues by being vague on the application, the insurer can utilize information in the medical report to make a final decision about pricing and eligibility.

Incontestability Clause

Many years ago, insurance companies began inserting "incontestability clauses" into their policies in order to strengthen the level of trust between the public and the life insurance community. The purpose of the clause is to assure policyholders that the insurer won't take unreasonable measures in order to deny death benefits to beneficiaries.

Under the most common type of incontestability clause, the insurance company has only two years from the policy's effective date to investigate potentially false information on the original application and rescind the policy. If the insurance company detects potential fraud on the application after this two-year period has expired, the insurance company usually must still keep the policy in force and pay the death benefit when the insured dies.

Exceptions to the two-year limit—though relatively few in number—are still important to know. They include, but are not necessarily limited to, the following circumstances:

- The insurance company determines that the beneficiary is planning to murder or has murdered the insured.
- The insurance company determines that an impostor was involved in completing the insured's medical exam.

If the insurance company determines that an applicant did not honestly disclose his or her age or gender, a different portion of the policy (and not the incontestability clause) will determine what happens next. This type of situation is explained in the next section.

Misstatement of Age or Gender

Under a "misstatement of age or gender clause," the insurance company is allowed to adjust the policy's face amount (effectively, the death benefit) if the applicant's stated age or gender turns out to be incorrect. This clause is separate from the incontestability clause and doesn't allow the insurer to rescind an entire policy. It can also be exercised regardless of whether the error in age or gender is discovered later than two years after the policy's issue date.

Believe it or not, many cases of incorrect ages and genders are honest mistakes committed by applicants and insurance producers. For example, an applicant who is asked for his or her age might be confused by the fact that some insurers care about the person's exact age at the time of application while others actually round up to the next age if the applicant's birthday is within the next few months. Meanwhile, a producer who is helping to insure a child might learn the child's name from parents and incorrectly assume that the name is only used by one of the two sexes.

These problems can be minimized by asking very exact questions on the application and during any fact-finding interviews. Instead of asking for ages, some insurers are clearer

and ask for birthdates. Instead of asking for names of children and allowing themselves to make assumptions about gender, agents can simply ask the parents to identify the child's gender. It might seem like a silly request in some cases, but it can prevent inconveniences and surprises in later years.

For insured members of the transgender community, (at least at the time of this writing), be aware that life insurance companies will usually base pricing on a person's gender at birth regardless of a change in identity.

Suicide Clause

Similar to the incontestability clause, the "suicide clause" allows the insurance company to deny death benefits to beneficiaries if the insured commits suicide within two years of the policy's issue date. This clause is intended to prevent a problem called "adverse selection," in which insurance is primarily purchased by high-risk consumers who are certain that they will be using it.

By putting a two-year exclusion on suicides, insurers believe that they are protecting themselves adequately against buyers who intend on killing themselves soon after an insurance purchase. However, once the two-year period has ended, cases of suicide will generally result in death benefits going to the beneficiary.

If the suicide clause is to be exercised after the insured's death, the burden of proof regarding the suicide belongs to the insurer. In other words, the death is considered to not have been a suicide unless the insurer can prove otherwise. Instead of the death benefit, beneficiaries who are impacted by the suicide clause will often receive a return of all premiums paid by the policyholder to the insurer.

Exclusions

Although life insurance policies tend to have fewer specific exclusions than property and casualty insurance policies, a few causes of death that aren't covered deserve to be mentioned here.

Aviation

Earlier in these materials, you read about dangerous hobbies and how they can sometimes be excluded as a cause of death. Depending on the policy, aviation might be considered one of those dangerous hobbies or might have its own exclusion regardless of whether the applicant engages in it.

When aviation exclusions appear in a life insurance policy, they typically exclude deaths that occur while flying or riding in a non-commercial plane. Deaths of passengers on commercial flights are usually not exempt from coverage.

War

War exclusions tend to be part of life insurance policies when the United States is engaged in dangerous international conflicts. When they are present, the exclusions might be reserved for cases in which the insured is within the allowed age range for joining the military. Policies issued during peacetime might not have any war exclusions at all.

Dividends

Policyholders who have a "participating policy" (typically bought from a mutual company) are eligible for "dividends." Within the context of life insurance, dividends are a refund of premiums paid back by the insurer to the consumer. These refunds are possible when an insurer underestimates its mortality risks, has a better-than-anticipated return on its investments or figures out a way to reduce its administrative expenses.

The policyholder (not the beneficiary) is the person who receives life insurance dividends and gets to decide how to use them. Common uses for policy dividends are as follows:

- They can be paid directly to the policyholder.
- They can be kept with the insurer and used to reduce or eliminate future premiums.
- They can be kept with the insurer and used to increase the policy's death benefit.
- They can be kept with the insurer and used to increase the policy's cash value (if the policy has cash value in the first place).

Since dividends from life insurance are commonly used to offset future premiums and as a factor in long-term financial planning, it is very important to note that they are never guaranteed. Most mutual insurance companies do their best to provide dividends to policyholders each year, but the size of an annual dividend can rise one year and drop the next. It's even possible for participating policyholders to go a year or more without receiving any dividends.

Another important point to remember about life insurance dividends is that they are generally tax-free. This can be a confusing point because of the ways in which the term "dividends" is more commonly used by stockbrokers, financial planners and other investment professionals.

It can be simpler to understand the tax status of life insurance dividends if you remember that they are considered a refund of paid premiums. In most cases, people will pay for life insurance premiums with money that has already been subjected to income taxes. So if dividends are considered to be a return of those already-taxed dollars, the money won't be taxed again.

One relative exception to this rule about taxes involves cases in which dividends are allowed to accumulate with the insurance company and earn interest. When those dividends are paid out in the form of cash or as part of the death benefit, the dividends themselves will be free from income taxes, but the interest earned on them will usually be taxable.

Free-Look Periods

A policy provision called a "free-look period" gives new policyholders a short amount of time to possibly reconsider their purchase, cancel the policy and receive a refund of that first premium with no questions asked. In order to receive a full return of the first premium, the owner must return the policy to the home office or to the producer before the free-look period expires.

The free-look period begins on the day the policy's owner receives the newly issued life insurance policy from the insurer. The deadline for a complete return of premium and other related fees will depend on state laws and policy language. Some insurers limit the free-look period to 10 days. Others allow for a 20-day period. In some states, people over the age of 60 have received a 30-day free-look period for life insurance policies and annuity contracts.

Policy Riders

Now that we've gone through the basics of how life insurance policies work, let's focus on common add-ons to those policies. In the insurance community, these add-ons are referred to as "riders." Though they can technically be any amendment to an insurer's basic insurance policy (including an amendment that removes a consumer-friendly feature within the insurance

contract), we'll focus on those beneficial riders that can give the buyer better coverage or, at least, greater flexibility.

Some riders might be offered for free by the insurer, but most are likely to be added to a life insurance policy only when the owner is willing to pay extra premiums. The extra cost for each individual rider probably won't seem high, but costs can add up when viewed as an entire package. Just as they would with any aspect of an insurance product, consumers should weigh the cost of a rider's benefits against their needs. An experienced and honest life insurance producer can play an important advisory role during this process.

Guaranteed Purchase Option

A rider allowing for a "guaranteed purchase option" gives the owner the opportunity to purchase additional life insurance at various points without needing to medically qualify for it. This rider typically can be exercised at specific intervals (such as every five years or every 10 years) or upon certain major life events (such as marriage or the birth of a child). The ability to exercise a guaranteed purchase option is usually restricted by age and is likely to disappear once the insured turns 65. (The exact cutoff for using the option will depend on the product and the insurer.)

The guaranteed purchase option is probably best suited for individuals who predict they will need more life insurance but are concerned about developing a major health problem before they have a chance to buy it. If, however, the buyer is interested in this rider simply because of the risk of being older and having to pay higher premiums because of age, the guaranteed purchase option won't alleviate the concern. When the guaranteed purchase option is exercised, any additional insurance purchased at that point will be priced on the basis of the insured's current age (known as "attained age") and not on how old the person was when originally applying for the policy (known as "issue age.") In other words, this rider prevents the insurer from charging the person more for new coverage because of health, but it doesn't stop the insurer from charging the person more for new coverage based on age.

Accelerated Death Benefits

Life insurance that is designed to cover someone until they are very old typically has a cash value that can be used to borrow money against in case of an emergency. However, millions of life insurance customers have a product called "term insurance," which isn't meant for older people and doesn't have the flexibility of cash value. Furthermore, even among people with cash-value life insurance, there are scenarios in which the amount of money available to borrow or withdraw is insufficient to meet the owner's pressing financial needs.

The desire to access a significant amount of money from a life insurance policy became particularly intense during the era of the AIDS crisis in the 1980s and 1990s. Many AIDS patients struggled to maintain their standard of living while paying for necessary medical care and often didn't have assets besides life insurance to help with those major costs.

Transactions called "viatical settlements" allowed terminally ill individuals to sell their in-force life insurance policies to investors in exchange for several thousands of dollars. In return for paying the insured significant amounts of money and agreeing to pay any remaining premiums, the investors were entitled to the death benefits when the ill person eventually passed away. Over time, viatical settlements evolved into "life settlements," in which the person selling his or her life insurance to an investor is a senior citizen rather than a terminally ill individual.

Viatical and life settlements allowed term life insurance customers to receive necessary dollars in connection with their policies and allowed those with cash-value life insurance to get significantly more from investors than they could receive from their insurance company. Although the life insurance industry generally frowned on these transactions, it eventually decided to adapt by offering "accelerated death benefits."

Someone with an accelerated death benefit rider has the opportunity to receive a portion of the policy's death benefit (not just the policy's cash value) when the insured is diagnosed with a terminal illness. In general, a terminal illness is defined as any illness that is likely to result in the person having less than two years to live. Similar riders are also available for cases in which money from the death benefit might be needed to fund long-term care services.

The recipient of accelerated death benefits can use the money to pay for whatever goods or services he or she deems necessary and doesn't need to spend it on medical care. When the insured dies, any portion of the death benefit that was not already provided as an accelerated death benefit will be passed along to the policy's beneficiary.

Double Indemnity

A "double indemnity" rider is a popular add-on to life insurance policies that doubles the death benefit if the insured dies in an accident. The rider is often paired with "dismemberment" coverage, which pays a certain amount if the insured loses a limb or an eye but is still alive.

In order for the double indemnity rider to be exercised, the insured must die within a certain period (often 90 days) following the accident. Also, the death typically needs to occur before the insured reaches a certain age, such as 65.

The possibility of a doubled death benefit is very attractive to consumers, but that attraction tends to ignore statistics and the important concept of a needs analysis. Most deaths result from illnesses or natural causes, so the double indemnity rider usually doesn't pay off. Furthermore, consumers rarely consider the fact that the manner in which the insured dies is unlikely to have an impact on the beneficiary's needs. A family with one income, two children and a mortgaged house isn't likely to be in worse shape if the insured dies in a car accident instead of from a heart attack.

If a double indemnity clause is included in a life insurance policy at no cost, most insurance professionals won't object to it. But if it can only be added in exchange for a higher premium, the money used to purchase the rider might be better used by purchasing a higher overall death benefit. By spending the money in this fashion, the owner gains extra protection regardless of whether death is caused by an accident or by something completely different.

Cost of Living Adjustments

The appropriateness of a death benefit can change as a result of inflation, deflation and other effects on the money supply. Rather than completing a new needs analysis every few years, some life insurance buyers might choose to address their concerns about inflation by purchasing a "cost-of-living adjustment" (COLA) rider. This type of rider can increase the death benefit in connection with an economic index (such as the Consumer Price Index) or can be formulated to add a specific dollar amount of coverage on a regular schedule.

Return of Premium

A "return of premium" rider might be added to a term life insurance product if the owner believes the insured is likely to outlive the term of the policy. If the insured dies while the policy is in effect, the beneficiary receives the death benefit. If the insured is still alive when the policy expires, the beneficiary receives the sum of premiums paid by the owner to the insurance company.

This rider ensures that the owner doesn't lose much (if anything) if the policy never pays a death benefit, but it also can make term life insurance (generally considered the cheapest type of coverage) significantly more expensive.

Types of Life Insurance

We've explored the basic need for life insurance, the most common policy provisions and some of the most popular riders to life insurance products. But there are still many specific types of life insurance that deserve to be explained here, all of which function in their own way and serve different purposes.

The next several pages will be devoted to a review of these various types of insurance products, beginning with a discussion of the differences between term life insurance and the many types of permanent life insurance.

Term Life Insurance

"Term life insurance" is life insurance that is scheduled to remain in force for a set period of time and then expire. It is the least complicated form of life insurance and—if only kept for a relatively short period of time—the cheapest.

Term life insurance is a good fit for people whose need for coverage is temporary. It's also a potentially appropriate product for someone who may technically have a permanent need for coverage but is unwilling to pay higher premiums.

Common examples in which term life insurance might be a wise choice include:

- A spouse wants to provide death benefits for the other spouse in case death occurs prior to the survivor being eligible for Social Security.
- A parent wants to provide death benefits that will mainly be used to fund the cost of raising a child until the age of 18 or 21.
- An adult child wants to provide death benefits for aging parents in case the adult child dies before the parents.
- A homeowner wants to provide death benefits to a creditor in order to pay off the remaining balance of a mortgage loan or other debt.
- Business partners want to insure one another in case one of them dies but are unsure how long the partnership will last.

Term life insurance policies generally can cover people for anywhere from one, 20 or 30 years. During each specified term (number of years), both the death benefit and the premiums will usually remain unchanged. Then, at the end of a term, the policyholder usually has the ability to renew the policy for another term regardless of the insured's health. However, coverage under the new term will usually be based on the insured's age at the time of renewal.

The ability to renew for another term (in exchange for a higher age-based premium) will often continue to be an option for the policyholder until the insured turns 65 or some other age established by the insurer. If the policyholder intends on keeping life insurance in force longer than that, permanent life insurance (and not term life insurance) might be the better choice.

Unlike the various types of permanent life insurance, term life insurance has no cash value. In practical terms, this means the policyholder is paying purely for the death benefit and not for the ability to utilize the policy in other ways. Since it lacks cash value, term life insurance can't be used as collateral for a loan, can't be used to accumulate and withdraw interest, and can't be surrendered in exchange for a lump sum or series of payments from the insurance company. If the insured dies during the policy term, the beneficiary gets the face amount. If the insured dies after the policy term, or if the policy is cancelled, the beneficiary typically gets nothing.

Without cash value, term life insurance is generally less expensive and less complicated than permanent life insurance. This price differential is particularly likely when the policyholder does not intend to renew a term policy beyond middle age. Still, the consumer who saves money by purchasing term life insurance loses the flexibility that is provided by permanent life insurance. Producers owe it to their clients to make sure that this tradeoff is appropriate.

Conversion Options

Even if consumers opt for term life insurance, they often have the option to convert their insurance policy to permanent coverage at a later date. This can be helpful for unhealthy policyholders because the conversion is not contingent on re-taking (and essentially passing) another medical exam.

Upon conversion from term to permanent life insurance, the difference in premiums will depend on the product and the insurance company. While it is common for companies to base premiums for converted coverage on the insured's age at the point of conversion, some insurers will keep the premiums the same unless the owner also wants to make changes to the death benefit. When the conversion doesn't change the policyholder's premiums, it is likely that the insurance company charged the owner in advance for the conversion option. When the conversion results in an increase in premiums based on the insured's attained age, it is more likely that the conversion option was part of the policy all along and didn't force the owner to pay extra for it in advance.

Decreasing Term and Credit Life Insurance

Most types of term life insurance are "level-term" products. A level-term life insurance policy has a death benefit that remains constant throughout the term of the contract. In rarer cases, though, consumers will purchase "decreasing term" insurance.

Decreasing term life insurance has a death benefit that shrinks over time. The death benefit might be designed to drop on a specific schedule, such as upon a certain date, or might be tied to a specific event. Even as the size of the death benefit goes down, the premiums remain the same.

"Credit life insurance," which is purchased in case a borrower dies before paying off a loan, is arguably the most popular form of decreasing term insurance. This type of insurance is actually a form of group insurance that is often offered by banks and other financial institutions. There generally aren't many decisions for individual consumers to make in regard to how the product will

work, and it is not commonly sold by insurance professionals unless they work directly for those financial institutions.

Permanent/Whole Life Insurance

In contrast to term insurance, permanent life insurance is meant to insure someone for the rest of his or her life. There are many variations on permanent life insurance, a few of which will be covered in the next few sections.

Permanent life insurance is intended for individuals whose need for life insurance is unlikely to ever end. This kind of life insurance typically has premiums that don't change (unless the owner makes special arrangements with the insurer) and is capable of remaining in force until the insured reaches the age of 100 or even later. In the event that the insured turns 100 (or another advanced age depending on the policy), the policy's face amount will be paid to the beneficiary. This payment to the beneficiary is sometimes referred to as an "endowment" and releases the insurer from having to pay a death benefit when the insured eventually passes away.

Besides being capable of remaining in force until the insured reaches 100 or later, permanent life insurance differs from term life insurance in the following respects:

- In addition to paying for the death benefit, policyholders with permanent life insurance are also paying premiums that give their life insurance a "cash value."
- Policyholders with permanent life insurance can borrow money from the insurer in an amount close to their policy's cash value.
- Policyholders with permanent life insurance might be able to withdraw a portion of their cash value and still keep their insurance in force. (This is especially common if the owner has "universal life insurance" or "variable life insurance." We will explore these two types of permanent coverage later.)
- Policyholders with permanent life insurance might be entitled to interest that is credited to their cash value at certain points. (Note that this is different from the dividends received from a participating policy (typically sold by mutual companies). A permanent life insurance policy that is non-participating won't be credited with dividends but can still qualify for this other kind of interest.)
- Policyholders who cancel a permanent life insurance policy are entitled to "non-forfeiture benefits," which might include a refund of the policy's cash value or a temporary amount of free insurance.

Since life insurance death benefits are generally exempt from the probate process and can be structured to escape federal estate taxation, permanent life insurance is a common tool for relatively wealthy people who are concerned about estate planning. It's also a common financial vehicle for well-established businesses that are interested in creating long-term succession plans in case an owner dies. Some financial advisers even recommend it as a cushion for investors who keep most of their portfolio in the stock market and other riskier corners of the economy.

A Warning on Terminology

It's important to note that some of the terminology used by the media and financial professionals to describe permanent life insurance can be confusing or inconsistent. For example, many people use the terms "permanent life insurance" and "whole life insurance" interchangeably. Others reserve the term "whole life insurance" for permanent life insurance policies that are essentially as plain as possible. Using the latter definition of "whole life insurance" can be beneficial in cases where the speaker or writer wants to emphasize the difference between a basic permanent life insurance policy and some of the more complex permanent life insurance products (such as universal life insurance and variable life insurance).

Arguments Over Permanent Life Insurance

Despite the positive features of permanent life insurance, it is very common for insurance producers and other financial professionals to engage in fierce debates regarding whether permanent coverage is appropriate for the average person.

Proponents of permanent life insurance tend to point out that the need or desire to leave a death benefit to family members or charities doesn't always go away and that buying a permanent policy ensures that this need or desire can be fulfilled no matter how old or unhealthy the insured eventually becomes. They also often point to the flexibility involved with cash values and the ways in which the cash-value portion of a policy can essentially be used as an interest-bearing savings account for college tuition or some other expensive purchase.

On the other hand, many advisers favor a philosophy known as "buy term and invest the rest." These people believe that the price for permanent life insurance (particularly in the policy's early years) is too expensive for most buyers and that the growth of a policy's cash value is both too slow and too small to justify the cost. The "buy term and invest the rest" strategy recommends that consumers buy term life insurance for the death benefit and put the extra money that they would've spent on permanent life insurance into mutual funds or other interest-bearing opportunities.

The debates about permanent life insurance can get rather heated, particularly since the motives and expertise of people on each side of the argument are often called into question. Those who strongly stress the positives of permanent life insurance are often life insurance producers who claim they know more about these policies than other financial professionals and want to save their clients from the higher risks involved with stocks and mutual funds. Those who favor the "buy term and invest the rest" approach are often financial planners who question whether life insurance agents are recommending permanent coverage in exchange for large sales commissions.

Though the arguments over permanent vs. term insurance can be emotional, reasonable professionals should understand that no product is good or bad for everyone. Each type of insurance, including permanent life and term life, was created in response to a particular need. Since no two people's needs will be exactly the same, it is important to analyze each scenario carefully and admit that every product can be beneficial under the right circumstances.

Cash Value

Permanent life insurance has a cash value, which can be used in a number of ways while the insured is still alive. It can be kept with the insurance company and credited with interest. It can be withdrawn in pieces in order to supplement someone's retirement income. It can even be withdrawn in a lump sum in order to pay for large expenses. When insurance professionals stress the savings component of permanent life insurance, they are referring to the likely growth of the policy's cash value.

Each payment of premiums for permanent life insurance will be split into money meant to cover the cost of the death benefit (known as the "mortality cost"), money meant to cover the insurer's administrative expenses and money meant to be credited toward the policy's cash value.

In general, a policyholder who continues to pay premiums and makes no withdrawals from the cash value will watch the cash value increase over time. However, the degree of increases in the cash value will usually depend on how long the policy has been in force. Since the insurer incurs greater administrative expenses during the early years of a policy, a smaller percentage of the owner's premiums will be earmarked for cash value at that time. Similarly, since it is more expensive to insure older people than younger people, a larger percentage of premiums paid in the later years of a permanent life insurance policy might be devoted to the mortality cost and not to the cash value.

Depending on the type of permanent life insurance being purchased, policyholders may have the ability to access their cash value in a lump sum or in smaller amounts. When they do, the insurance company might have the right to impose a surrender charge that reduces the amount available to the owner. This type of charge is also common in annuity contracts and is designed to prevent insurers from losing money that they would have ordinarily been allowed to invest. The surrender charge might only apply to withdrawals that are beyond a certain percentage of the cash value (such as 10 percent per year) and might only be enforced during the first several years after the policy is issued.

Regardless of any surrender charges, owners might need to wait a few months before their request for a withdrawal is honored. This common practice dates back to the days of the Great Depression and is meant to prevent the insurer from having to surrender a significant amount of assets unexpectedly during a period of economic panic.

This section on cash value is an appropriate place to re-emphasize the important role played by the policy's owner. The right to access or otherwise use the cash value belongs solely to the owner and not to the insured nor to the beneficiary. When a permanent life insurance policy is interrupted by a death, the beneficiary receives the death benefit. The beneficiary does not receive more money if the policy had a cash value and does not receive less money if the cash value is lower than the death benefit. Decisions about what to do with the cash value (including whether to use it to increase the death benefit) are made by the owner.

Policy Loans

Policyholders with permanent life insurance have the option of using their cash value to get a loan from the insurer. Originally, loans to policyholders were offered at a fixed interest rate, generally around 8 percent. In order to protect their solvency, companies have since offered policy loans with variable interest rates that are dependent on an economic index.

Many borrowers find that loans from their insurance company are still cheaper than loans from a bank or other lender. And since the policy's death benefit can serve as collateral for the loan, policyholders wanting to use their cash value in this way usually won't be subjected to a credit check.

Loans from life insurance companies are relatively cost-effective and simple to obtain, but policyholders should be careful not to ignore their repayment obligations. Outstanding debts to the life insurance company will be subtracted from the death benefit. If the borrowed amount is relatively large and has been subject to a significant amount of interest, the beneficiary might not receive enough money to meet his or her needs.

Policy Illustrations

"Policy illustrations" are charts or graphs that are meant to reflect premiums, cash values or other aspects of a life insurance product that can or will change. They are used to help applicants understand the differences between life insurance products and the ways in which those products might or might not meet people's needs.

Though they can certainly be used in sales presentations for term life insurance, policy illustrations are even more important to sales of permanent life insurance because the product itself is often more difficult to understand. The best illustrations supplement a life insurance agent's presentation and help producers set clear expectations regarding how much coverage will cost and how cash value will grow. The worst illustrations paint an overly optimistic picture of future costs and cash values and are often responsible for people buying unsuitable products.

In order to avoid dissatisfied customers and possible legal action, insurance professionals must use illustrations that make a clear distinction between the insurer's projections and its guarantees. Good life insurance professionals accept personal responsibility when they use illustrations and make sure that their verbal explanations reflect the content of these supplementary materials.

Instead of relying on consumers to notice any disclaimers on an illustration, agents should explain the information in the disclaimers as part of their conversation. Above all else, prospects should not be allowed to make a life insurance purchase unless they have been told what is guaranteed and what isn't.

Non-Forfeiture Options

Many years ago, life insurers were under attack for poor market conduct. Among other things, companies were accused of tricking people into buying the wrong type of insurance. Even if the consumer had already paid a significant amount of premiums for an inappropriate policy, a buyer who recognized the error and decided to cancel the coverage got nothing in return. The inclusion of "non-forfeiture options" was part of a larger effort to regain the trust of regulators and the public.

Non-forfeiture options allow policyholders to still utilize their insurance's cash value even if they decide to cancel their coverage. Since these options are tied to cash value, they are not available to people who only have term life insurance.

Upon cancelling a permanent life insurance policy, the owner typically can choose any of the following non-forfeiture options:

- Receive the cash value as a payment from the insurance company.
- Use the cash value to purchase "extended term insurance," which will provide temporary life insurance protection with the same death benefit as the cancelled policy. No future premiums will be required.
- Use the cash value to purchase reduced "paid-up" permanent insurance, which will remain in force for the rest of the insured's life but with a lower death benefit than the cancelled policy. No future premiums will be required.

If given a choice, most consumers are likely to opt for the cash value as a payment from the insurance company. Most insurers, on the other hand, prefer to hold onto the cash value as part of their portfolio and will make extended term insurance the default option.

Variations on Permanent Life Insurance

The first wave of permanent life insurance products generally aligned with the features that have already been described in these materials. Over time, the insurance industry began catering to an audience that was either looking for more flexibility with regard to payment of premiums or willing to take more risks with their investments.

New types of permanent life insurance were introduced in the 1970s and 1980s, allowing for a wide range of options for applicants to choose from. Those options are too numerous to mention in detail here, but certain types (such as universal life insurance and variable life insurance) are too important and too popular for us to ignore.

Universal Life Insurance

"Universal life insurance" is a type of permanent life insurance that is mainly intended to provide flexibility in regard to the required premiums and the size of the death benefit. People with universal life insurance generally have the ability to adjust their premiums or their death benefit at various points in order to suit their needs. For example, a family undergoing some temporary financial stress might be able to reduce their premiums in order to have more money for other important expenses. Alternatively, an adult who purchased universal life insurance while single might decide to increase the death benefit upon starting a family.

These changes to a person's life insurance plan can be done in different ways even if the policyholder has something other than universal life insurance, but universal life makes these kinds of changes simpler.

Buyers of universal life insurance gain a greater understanding of how their premiums are actually spent. At least once each year, policyholders receive a statement from the insurer that shows how much of their payments have been applied to each of the following categories:

- Insurer's administrative expenses.
- Cost of the death benefit (also known as "mortality cost").
- Cash value.

This information can help consumers determine if they're paying a fair amount for the death benefit and can also help them make informed decisions about cash value. For example, an owner who is especially interested in growing a policy's cash value can decide to pay higher premiums. An owner who isn't as worried about cash value and is mainly concerned about the death benefit can decide to lower his or her premiums to an amount closer to the policy's mortality cost.

Despite its flexibility, universal life insurance does have some limits that policyholders can't ignore. When an owner chooses to reduce the required premiums without making proportionate reductions in the death benefit, the premiums that the owner chooses not to pay will come out of the policy's cash value. If the policy's cash value is insufficient to cover this amount, the beneficiary might receive a reduced death benefit. In some cases where cash value is too low, the policy can even lapse, and coverage will end.

There are also limits for policyholders who actually want to increase their premiums. These increases are typically done in order to increase cash values and to allow more of the owner's money to earn tax-deferred interest. The IRS is aware of this strategy and will only allow it to be used up to a certain threshold. If the owner increases premiums to an extremely high amount without also making similar increases to the policy's death benefit, the policy can lose its favorable tax status. In fact, when this occurs, the policy isn't even considered to be life insurance anymore. Instead, it will be deemed a "modified endowment contract."

The line between life insurance and modified endowment contracts can depend on complicated math and IRS rules. It is therefore the insurer's responsibility to enforce maximum limits on premium contributions. The average policyholder isn't expected to keep track of these limits on his or her own.

Variable Life Insurance

Variable life insurance is a form of permanent life insurance that exposes a policy's cash value to market risks in exchange for potentially higher returns. The owner still pays premiums for mortality costs and administrative expenses, and the beneficiary is still guaranteed to receive a death benefit when the insured dies. However, the policyholder (and not the insurance company) has control over how the premiums applied to cash value are invested. This is in contrast to the other forms of insurance we've covered in this chapter, which generally require that the insurer invest premiums in safe places and guarantee that the cash value won't drop due to economic downturns.

Variable life insurance premiums for mortality cost and administrative expenses become part of the insurance company's general account. Premiums applied to cash value, on the other hand, go into a "separate account" for the policyholder. The separation of this money is meant to ensure that bad investment choices by policyholders don't jeopardize the insurance company's solvency.

Money in the policyholder's separate account will be invested in a manner similar to mutual fund contributions. Most insurers offer a variety of investment options, including the chance to put money into bonds, government securities and domestic or foreign stocks. The owner of a variable life insurance policy can invest in several of these options at the same time and move money from one option to another within certain insurer-imposed limits. Any growth or decline in the cash value as a result of the owner's investments won't be taxable until the money is actually withdrawn and paid to the owner.

Variable life insurance can work well for people who want to pay for a death benefit and are comfortable with the uncertainty of long-term investing. People who are generally not comfortable investing in mutual funds and tend to worry about the short-term performance of their portfolios should probably avoid this product. Although variable life insurance has a guaranteed minimum death benefit that won't decline in a bad economy, the insurer will make no guarantees regarding the cash value unless the owner is willing to amend the policy with a potentially expensive rider.

Since variable life insurance transfers risk to the policyholder, it is considered a securities product by state and federal regulators. As a securities product, it cannot be sold unless the applicant first receives a document called a "prospectus." The prospectus is intended to explain the non-guaranteed aspects of the policy and how the product has performed over short and long stretches of time. Variable life insurance products must also be approved for

purchase by the federal Securities and Exchange Commission (SEC).

Life insurance producers who want to sell variable life insurance must also be licensed to sell securities. This includes not only the basic type of variable life insurance described here but also hybrid types of variable life products (such as variable universal life insurance). For more about licensing and regulation pertaining to securities, see the earlier section called "Life Insurance Agents."

Life Insurance Options for Spouses

Special kinds of life insurance exist for married couples who want coverage for both spouses. Though not exactly cheap, these products are generally less expensive than separate policies for each spouse.

"Joint life insurance" pays a death benefit to the surviving spouse when the other spouse dies. It is generally used to help the surviving spouse deal with the financial impact of losing a life partner.

"Survivorship life insurance" only pays a death benefit after both spouses have died. It is generally used as an estate planning tool that can reduce the impact of federal estate taxes.

Industrial Life and Burial Insurance

Decades ago, it was common to find insurance agents going door to door and selling "industrial life insurance." This type of insurance is essentially a small amount of life insurance that is intended to cover small funerals and burial expenses. Premiums for industrial life insurance would be collected on a weekly or monthly basis at the policyholder's home by salespersons known as "debit agents."

Industrial and similar types of very small life insurance policies tended to be marketed heavily in low-income communities because each premium installment was usually no more than a few dollars. But as the years went by, these types of products developed bad reputations among regulators and consumer advocates. While each premium payment may have seemed relatively small, the total amount paid for these policies was widely considered to be deceptively high. Unethical salespeople worsened industrial life's reputation by encouraging people to purchase multiple policies instead of helping them obtain coverage under a single contract.

These days, industrial life insurance is rarely sold. Although similar types of insurance might still be available through the mail, most insurance professionals believe these products are only suitable for elderly or unhealthy applicants who can't obtain life insurance in any other way.

Life Insurance for Children

Some insurance agents advise parents to purchase life insurance on their children. Reasons given for this type of purchase usually include the following rationales:

- Cash-value life insurance on a child can later be used to fund the child's college education.
- Buying life insurance on a child ensures that the child will have coverage as an adult even if he or she eventually develops a serious health condition.

A common life insurance product for children is a "jumping juvenile policy." This product has a relatively small face amount in the beginning but allows the death benefit to increase substantially when the child reaches adulthood.

Some life insurance professionals are skeptical of child-centered life insurance products. Most life insurance purchases are conducted in order to help dependents recover financially from someone's death. Since very few people are dependent on a child for money, it's not always easy to justify a policy on a son or daughter.

At the very least, parents who are considering life insurance on their children may want to first evaluate whether they have enough life insurance on themselves. After all, the financial impact of a parent's death is usually more detrimental to families than the financial impact of a child's death.

Corporate Life Insurance

So far, most of our focus has been on the ways in which life insurance can help individuals and families. There are also cases in which life insurance can be beneficial for a business. Depending on the circumstances, a business might be wise to purchase life insurance on an employee or on an owner.

Key-Person and Corporate Split-Dollar Insurance

A business can suffer major losses when an important employee passes away. Even if the deceased's position is later filled by someone else, the new person might need a significant amount of time to become as skilled and experienced as his or her predecessor. Waiting for the new person to catch up can cost the company a significant amount of money.

"Key-person life insurance" is meant for businesses that are worried about the financial impact of an important employee's death. The business is the owner of the key-person policy and usually lists itself as the beneficiary. Though the employee does not benefit from the policy, the insurance can't be issued without the employee's consent.

A "corporate split-dollar life insurance policy" has potential benefits from both the employee's and business's points of view. With this type of permanent life insurance product, the employee pays the portion of the premiums intended to cover mortality costs. Meanwhile, the business contributes a portion of premiums to fund the policy's cash value. If the employee passes away, the company will receive a death benefit equal to the policy's cash value. Any remaining death benefit will go to a beneficiary designated by the employee.

Buy-and-Sell Plans

"Buy-and-sell plans" aren't a type of life insurance, but they usually require a life insurance component in order to function properly. These plans are made among business partners and are an attempt to eliminate ownership problems when a partner dies.

Life insurance on each partner is often included in these plans as a way for surviving partners to purchase the deceased person's part of the business from the person's heir. Instead of needing to sell assets in order to purchase the deceased partner's share, the surviving partners can buy out the previous owner's heirs with money from the death benefit.

Life Insurance Replacements and Exchanges

Replacing one insurance policy with another must be done with care. When done thoughtlessly, it can cause sick people to lose their coverage and put long-term tax benefits in jeopardy.

Still, the fact that someone already has life insurance doesn't mean there isn't a better, more suitable product out there. Policyholders should be encouraged to review their life insurance needs at least every few years to ensure that they have appropriate coverage.

In general, the IRS allows policyholders to replace one life insurance policy with another without having to pay taxes on the replaced policy's cash value. However, these swaps (known as "1035 exchanges") should only be done upon careful review of relevant tax rules and perhaps with the help of a qualified tax expert.

Even in cases where 1035 exchanges are done correctly, some insurers will impose a surrender charge on permanent life insurance policies. For example, a company might be allowed to keep 10 percent of a policy's cash value if a policy is cancelled within the first year of purchase. Since these charges are set by insurance companies and not by the government, they can vary from company to company or policy to policy. Documentation concerning these charges should be reviewed carefully prior to any exchange.

Practically every state has rules pertaining to life insurance replacement transactions. While these rules have the potential to differ across the country, they usually require that agents provide special disclosure forms and receive signed statements from policyholders.

Life Insurance Tax Issues

In addition to providing potentially significant death benefits to survivors, life insurance is sometimes championed because of its positive tax features. Tax issues related to life insurance will be explained in the next few sections.

Be aware that the information provided here is meant solely as a summary of a much more complicated topic. For more specific details about life insurance and tax rules, you should conduct further research, preferably with help from a qualified tax professional.

Income Taxes

Life insurance death benefits are generally tax-free to the beneficiary. One exception to this rule would be a case in which all or a portion of the death benefit is left with the insurance company and allowed to earn interest. When those death benefits are eventually paid out to the beneficiary, the beneficiary will owe income taxes on the interest.

Dividends received from mutual insurance companies are generally tax-free to the policyholder. This is because these types of dividends are actually considered a return of the owner's premium. Again, there is an exception if the dividends remain with the insurance company and are allowed to earn interest. When the dividends are received by the owner, income tax will be owed on the interest.

Cash values that are accessed by policyholders (in installments or a lump sum) are likely to require some payment of income taxes. The amount of tax owed will depend on the difference between the cash value and the amount of premiums or dividends that the owner gave to the insurer. The difference between those numbers will be considered income and will be subject to federal income tax. However, cash value will grow on a tax-deferred basis until the owner receives it as payment from the insurance company.

Estate Taxes

The federal estate tax can significantly reduce the amount of assets that can be passed along from the deceased to heirs or beneficiaries. This tax is generally due within nine months after someone dies, although it doesn't apply to all people or all kinds of property.

Life insurance policyholders who want death benefits to escape the estate tax must make sure that their policy is set up properly. Life insurance death benefits might be reduced by federal estate taxes if any of the following statements are true:

- The deceased owned the policy at the time of death.
- The deceased didn't own the policy at the time of death but transferred his or her ownership rights to someone else within the past three years.
- The deceased's estate is listed as the beneficiary. (Note that this can subject the life insurance to the sometimes lengthy probate process even if the deceased's estate is exempt from the federal estate tax.)

Despite the effect of estate taxes and its link to life insurance, two important disclaimers should be made here.

First, the federal estate tax is primarily an issue for individuals who have a relatively large amount of assets. In 2021, the estates of people who died with assets less than $11.7 million were not taxed by the federal government. (Be aware that the dollar amount for exemptions from estate taxes tends to change from year to year.) So while estate taxes can be a major concern for many people, the issue is not likely to have a practical effect on the average life insurance applicant.

Finally, if estate taxes are a legitimate worry, the applicant or policyholder is likely to need more financial advice than a typical life insurance agent is qualified to offer. Insurance producers can play an important role in estate planning, but a concerned consumer is likely to also need the services of an experienced attorney or tax professional.

Conclusion

By now, you should be able to comprehend the versatility of life insurance products. There are different kinds of life insurance for a wide range of scenarios. With the help of a trained and dedicated insurance professional, buyers are likely to find a policy that grants them great peace of mind.

CHAPTER 5: ANNUITIES

An annuity is a long-term contractual arrangement in which a consumer 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 person 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 fund-like accounts, 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 72. (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 72.

"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 72. 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 2021, only estates valued at more than $11.7 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 dependents 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 6: 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.

Common LTC Myths

Misinformation is at least partially responsible for the underwhelming amount of long-term care insurance sales in the United States. When presented with the possibility of needing this type of insurance, many prospects deflect the issue by assuming their long-term care needs can easily be addressed through other means.

Let's look at some of the most common excuses people make for not purchasing long-term care insurance and examine the level of truth in each of those excuses.

Common reasons why people claim not to be interested in long-term care insurance are listed below:

- "I'm already covered by regular health insurance:" Major medical insurance might be adequate to pay for skilled care, but it usually covers little to none of the custodial care that many people need.
- "I'm already covered by Medicare:" Medicare might pay for a limited amount of skilled care and even minor amounts of custodial care. However, the program only pays medical bills for a certain number of days and is not entirely suitable for individuals who need long-term care for more than a few months. Also, payment for custodial care might only be possible if a patient first receives skilled care.

- "If I ever need long-term care, Medicaid will pay my bills:" Indeed, Medicaid pays for a very significant amount of long-term care services provided in the United States. But in order to qualify for this Medicaid assistance, individuals often must first get rid of –or "spend down"—most of their assets. This and other eligibility requirements are necessary in order to ensure that Medicaid remains a need-based program intended for the poor. And since many assisted-living communities and nursing homes do not accept Medicaid payments, patients enrolled in the program might have a limited number of options regarding where they can live or which medical providers they can use. (Be very careful not to confuse Medicaid and Medicare. Remember, Medicaid will often pay for long-term care but is reserved for the poor. Conversely, Medicare is available to practically anyone of a certain age but doesn't pay for much long-term care.)
- "The problems associated with long-term care will eventually become too big for the government to ignore. There's likely to be some kind of long-term care insurance program for all Americans at some point, so I don't need to buy insurance for myself:" Indeed, some legislators have attempted to implement federal long-term care insurance programs. But proposed solutions related to long-term care that would help all Americans (including the wealthy and the middle class) have a history of being dead on arrival. Instead of focusing on creating a government program for long-term care, most legislators have tried to create incentives for people to purchase private long-term care insurance.
- "I don't need to worry about long-term care insurance until I'm much, much older:" Long-term care insurance isn't something that is used exclusively by older policyholders. The need for long-term care can arise at practically any time. In fact, according to the National Care Planning Council, roughly 40 percent of long-term care recipients are under the age of 65. (Presumably, many of these younger people are recovering from an accident and will need care for several months as opposed to several years). Although there are reasonable debates about the best age to purchase long-term care insurance, it is generally true that consumers who wait too long will be stuck paying higher premiums or might not be able to obtain coverage at all.
- "If I ever need care, my family will look after me:" We've already highlighted some of the societal changes that have made care from family members less likely and harder to coordinate. But even if issues like geography and time are not significant burdens for well-meaning family members, those family members might lack the patience or physical strength to help with all kinds of necessary care. And in some cases, parents who have a lot of pride or are self-conscious about needing help with sensitive tasks (such as toileting or bathing) might prefer to receive assistance from a paid professional instead of from a close relative.
- "If I buy long-term care insurance, there's no guarantee that I'll actually ever need to use it:" There's some potential truth to this. However, the same statement can be made about several other kinds of insurance that consumers deem important. For example, most homeowners will never experience an event that will destroy their entire home, but this hasn't stopped them from insuring their homes up to its replacement value. Unlike other kinds of financial products that contain guarantees and can actually grow our portfolios, long-term care insurance can be viewed more appropriately as something we purchase in exchange for greater peace of mind.
- "It's too expensive:" This can be a valid statement for some prospects and an invalid one for others. Much depends on the person's specific financial situation, insurance-related objectives, age and health. Consumers who buy from the right company at the right time can get decent coverage at a relatively affordable price. But since there might be a limited window of opportunity for getting a great deal on long-term care insurance, people who have an interest in this coverage should discuss it with an experienced insurance professional as soon as possible.

Standard Exclusions

This chapter will now 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.

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.

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. Someone with a cognitive impairment can usually start receiving long-term care insurance benefits regardless of activities of daily living can still be performed.

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.

Guaranteed Renewable vs. Non-Cancellable Coverage

In most states, long-term care insurance must be either "guaranteed renewable" or "non-cancellable." Though these two terms might seem similar, they are different in some very important ways.

If long-term care coverage is guaranteed renewable, the policyholder has the right to renew the coverage and keep it in force as long as premiums continue to be paid. The insurance company cannot cancel the person's coverage due to the insured's increased age or deteriorating health. The premiums for a guaranteed renewable policy can increase, but the increase must apply to all of the insurer's customers within a particular rate class. In other words, although the insurer can raise prices on a large group of policyholders (such as all policyholders who purchased coverage more than two years ago), it cannot discriminate against a specific policyholder and impose higher prices specifically on that one person.

If long-term care coverage is non-cancellable, both the coverage itself and the cost must remain the same as originally disclosed to the buyer, as long as premiums continue to be paid. Unlike guaranteed renewable coverage, non-cancellable coverage cannot be subjected to unexpected price increases.

Non-cancellable long-term care insurance was available several years ago and was typically purchased with a large, lump-sum premium. Insurance companies eventually realized they had priced these products incorrectly and have since made non-cancellable coverage very difficult to find.

Carriers and producers must be aware of the differences between guaranteed renewable and non-cancellable coverage. Using the wrong term in advertising or in conversations with consumers can create serious confusion and can lead to disciplinary actions.

Inflation Protection

Since the cost of health care is almost certain to rise over time, consumers might struggle to determine whether their benefit limits (daily, monthly or cumulative) will be enough to eventually pay for their care. Insurance companies have responded to this concern by offering various "inflation protection" riders for their long-term care products.

At the time this course was being written, the most common form of inflation protection for long-term care insurance provided a 5 percent increase in a policy's benefit limit every year. Usually, the increase is compounded, meaning the 5 percent increase for a given year will include any 5 percent increases from previous years, too. This form of compounded interest is the opposite of "simple interest." Inflation protection based on simple interest will result in lower increases in daily benefits but will generally be cheaper than protection based on compounded interest.

Other forms of inflation protection might be based on increases in an economic index—such as the Consumer Price Index—rather than on a specific, predetermined percentage. However, it should be noted that this type of index tends to look at inflation across several sectors of the economy and won't necessarily match the level of inflation in health care.

Many financial professionals advise consumers to purchase inflation protection for their long-term care insurance, especially if coverage is purchased at a relatively young age. In fact, some states require inflation protection to be included in long-term care policies unless the consumer signs a waiver and refuses the protection. But regardless of the generally positive opinions surrounding inflation protection, it is still important to conduct a needs analysis for consumers and determine whether this important feature is worth the relatively high cost.

Similarly, it is important to be clear about how inflation protection actually works and to not allow prospects to be confused by its name. Purchasing inflation protection can reduce the risk of coverage not keeping up with inflation, but it does not guarantee that a policy's benefit limit will constantly be increased at the same rate as health care costs.

Future Purchase Options

A "future purchase option" is often viewed as an alternative to inflation protection. When included in a long-term care insurance policy, this feature allows someone to purchase more insurance (such as a higher benefit limit) without needing to medically qualify for it. This can be beneficial for policyholders who bought insurance many years ago, realize they need more coverage and would otherwise not qualify for it based on their worsened health status.

While a future purchase option can solve problems related to insurability, it won't necessarily make additional coverage affordable. When the insured decides to exercise a future purchase option, the price for the additional coverage will be based on the person's age at that point (known as the person's "attained age") and not on the person's age when the initial policy was purchased (known as the person's "issue age").

Consider, for example, someone who buys a policy at age 50 and chooses to include a future purchase option. At age 75, the policyholder realizes he is close to needing long-term care and that his benefit limits won't be nearly enough to fund his expenses. If he opts to exercise the future purchase option, the cost of the additional benefits will be based on him being 75. They will not be based on his issue age (50).

Future purchase options often have limits regarding when they can be exercised. For example, the insurance company might require that the option either be exercised or forfeited by the time the insured reaches a certain age, such as 65 or 70. The option generally cannot be exercised if the insured is already in need of long-term care. In other words, if the policyholder wants to take advantage of this option, he or she must do so while still relatively healthy.

Waiver of Premium

A "waiver of premium" is an important part of a long-term care insurance policy, particularly for people who already need care. Under this provision, the insured is exempt from having to pay premiums once he or she has started to receive benefits from the insurer.

In addition to the financial help that a waiver of premium can facilitate, it provides practical relief, too. Although some individuals who need long-term care might be capable of managing their own finances, others will lack the physical or mental ability to keep track of their bills, including premium-related notices from their insurance company. The waiver makes it less likely that coverage will end when a claimant is most vulnerable.

Free-Look Periods

A "free-look period" gives policyholders a chance to review their recently purchased long-term care insurance policy and get their money back if they notice something they don't like. The deadline for returning the policy to the insurer and requesting a refund of any paid premiums is often set by state rule and might depend (to a certain degree) on the applicant's age. For example, a state might require at least a 30-day free-look period for all long-term care purchases but extend the requirement to 45, 60 or 90 days if the applicant is a senior citizen.

Cancellations and Non-Renewals

For various reasons, a long-term care insurance policy might be cancelled or not renewed. Non-renewal occurs when either the insurance company or the policyholder decides to stop coverage at the end of the policy period (such as at the policy's annual anniversary date). Cancellation, on the other hand, might occur at other times as long as proper notice is provided and other rules are followed.

Policyholders might choose to cancel or not renew their coverage because premiums have become too high. In this case, a state might require that the insurer offer to keep a smaller amount of coverage in place in exchange for lower premiums.

On occasion, insurance will be on the verge of cancellation because the policyholder merely forgot to pay the insurer on time. In addition to sending a warning to people who have missed a premium payment, notice might be given to a friend of family member. The option to alert a friend or family member is often given to applicants when the policy is issued and is meant to avoid situations in which payments are missed due to extended vacations or even the early signs of cognitive impairment.

In relatively rare cases, an insurance company can cancel someone's long-term care coverage with proper notice for

reasons beyond nonpayment. Grounds for cancellation typically only exist if the policyholder misrepresented facts to the insurer when applying for insurance. Depending on state law, an insurer's ability to cancel based on an applicant's misrepresentations might decrease over time. For instance, the insurer might have the ability to cancel based on an unintentional (but still important) misrepresentation if the policy has only been in force for a few months. But once the coverage has been in effect for a few years, the insurer might only be allowed to cancel if the applicant obviously engaged in an intentional type of fraud.

Reinstatement For Cognitive Impairment

You just learned about how the insured has the option of having cancellation notices sent to a friend or family member and how this can manage the possible risk of cognitive impairment. Regardless of whether the aforementioned third-party notice is desired, a policyholder who misses premium payments due to cognitive impairment and ultimately loses coverage is typically allowed to regain the insurance within a certain timeframe. This is known as "reinstatement for cognitive impairment" and is typically possible within the first few months after long-term care coverage has lapsed.

When this option is exercised, the insurer will need to receive a letter from a licensed physician who can verify the impairment. The policyholder will need to pay all premiums that were missed or would have been due during the lapse, but the person won't be charged more or denied coverage because of any changes in his or her health. In other words, both the insurance and the price for it must remain the same, as if the lapse in coverage had never occurred.

Non-Forfeiture Options

Depending on the state where it is purchased, a long-term care insurance policy might automatically include "non-forfeiture benefits" or at least give the policyholder a chance to add them for an additional charge. Non-forfeiture benefits are provided when the policyholder has paid premiums for the insurance but decides to cancel coverage before long-term care services are ever needed. They can be particularly appealing to applicants who worry about paying for a policy that they might never actually use.

Typical non-forfeiture benefits will allow the insured to remain covered for a period of time after cancellation without having to pay any additional premiums. The length and size of the non-forfeiture benefit will be chosen either by the policyholder or the insurer. One option might be to cover the insured for the remainder of the policy's benefit period but to lower the daily benefit. Alternatively, the daily benefit might stay the same but only allow coverage to continue for a brief period of time. Or instead of receiving some kind of reduced coverage, the policyholder might simply receive a partial refund of premiums.

The size and variety of non-forfeiture benefits will depend on what a particular state requires, how much the policyholder has already paid in premiums, and how much the insured is willing to pay for the flexibility of a particular non-forfeiture option.

Conclusion

Insurance producers who embrace service to those who might need long-term care are likely to have plenty of opportunities for successful sales as people work toward retirement. 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 7: 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 2021. 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 roughly 10 years of your lifetime, a significant portion of Medicare will usually be free to you. If you or a spouse hasn't paid taxes for that long, you will likely 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. If you or your spouse have paid Medicare taxes for at least 10 years during your lifetime, you usually 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 2021, the monthly Part A premium was $259 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 $471.

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.

Hospital Care

Part A will pay for a hospital stay if all of the following conditions are met:

- Hospitalization is prescribed by a physician.
- Hospitalization is considered the only reasonable way to care for the person's medical condition.
- The hospital participates in Medicare.
- The hospital's review committee doesn't object to the hospitalization.

If you're about to be discharged from a hospital but think you deserve to stay longer, you can have your case examined by what's known as a "peer review organization." You can't be discharged until the organization makes a decision.

Hospitalization coverage under Part A is generally for cases in which you have actually been admitted to a facility. If you visit an emergency room and are either sent home or kept overnight just for observation, hospital bills will typically be covered by Part B of Medicare instead of by Part A. However, if you go to the emergency room and eventually are admitted to the hospital, Part A will usually pay the bill for emergency care.

Once you qualify for hospitalization, Part A will pay for a semiprivate room, food, medication, x-rays, lab tests and medical equipment that you need while away from home. Patients pay out of pocket for phone and television services. Private rooms will only be covered if they're deemed medically necessary.

Patients are responsible for the first three pints of blood they receive while hospitalized each year, but there's a major exception to this rule. In general, you only need to pay for blood if the hospital had to pay for it first. Blood that's free to the hospital

is free to you. You can also avoid blood costs if you or someone else replaces the amount you use\. These rules about blood are specific to transfusions received as an inpatient at a hospital. Blood received in outpatient settings is covered under Part B at a different rate.

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 2021, patients were responsible for a $1,484 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 $371 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 2021, patients paid a $742 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 2021, Mrs. Smith got into a car accident and spent 80 days in the hospital. She paid $1,484 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 $7,420. ($371×20 = $7,420)

Example 2: In 2021, 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 $1,484 deductible.

Example 3: In 2021, 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 $1,484 deductible.
- A total of $0 for days one through 60.
- A total of $11,130 for days 61 through 90 ($371×30 = $11,130).
- A total of $7,420 for days 91 through 100 ($742×10 = $5,780).
- All hospitalization costs for days 101 through 110.

Example 4: In 2021, 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 $1,484 deductible twice because his 75-day stay at home was long enough to start a new benefit period.

Example 5: In 2021, 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 $1,484 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 2021, 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 $185.50 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 2021, Mrs. Smith got into a car accident and spent 30 days in the hospital and 30 days in a nursing home. She paid $1,484 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 $1,855 for days 21 through 30. ($185.50×10 = $1,855)

Example 2: In 2021, 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 $1,484 Part A deductible.

Example 3: In 2021, 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:

- $1,484 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 ($371×20 = $7,420).
- A $0 copayment for days one through 20 of her stroke-related stay at the nursing home.
- A $3,710 total copayment for days 21 through 40 of her stroke-related stay at the nursing home ($185.50×20 = $3,710).
- $1,484 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 2021, 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.

Home Care

Patients who need skilled care but aren't in a nursing facility might be able to have Medicare pay for treatment in their own home. People who qualify for this level of care can receive it for an indefinite amount of time and often aren't responsible for deductibles, copayments or coinsurance fees. (Patients are required to share in the cost of medical equipment that is provided for home use. We'll cover that topic in another section.)

The benefits and eligibility requirements for home care can seem confusing, particularly since treatment in a private residence can be covered by either Medicare Part A or Medicare Part B. For home care to be covered by Part A, a patient might need to have been in a hospital for at least three days, and home care may need to start within two weeks after the person's discharge from a hospital or nursing home. There's also a 100-visit limit for home care in Part A. These requirements and limits don't apply to Part B's version of home care.

It's important to note, however, that the differences between Part A's home care and Part B's home care are essentially accounting technicalities that don't have much impact on beneficiaries. If you run out of home care benefits under Part A or don't meet the three-day hospitalization requirement, your treatment will be covered by Part B just as it would under Part A. If you aren't enrolled in Medicare Part B, Part A's 100-visit limit and hospitalization requirement for home care will be waived.

No matter if it's covered under Part A or Part B, home care can be difficult to qualify for. If all of the following criteria aren't satisfied, a claim for home care will be denied by Medicare:

- Home care must be prescribed by the patient's physician. (Don't expect Medicare to pay for home care that you set up entirely on your own.)
- Home care must be received from a Medicare-approved agency. (Be sure to verify that an agency accepts Medicare before scheduling treatment for yourself or a loved one.)
- The patient must require skilled nursing care or therapy that can only be provided or supervised by a trained professional. (Activities that can be performed by untrained individuals—help with eating, bathing, dressing, etc.—can be covered in some situations, too. But the patient must be receiving skilled care or therapy at the same time. Someone who only needs help with tasks that don't require special medical training won't qualify for home care benefits.)
- The patient is generally unable to leave home. (This means leaving home would require a considerable amount of effort involving another person or special medical equipment like a wheelchair. The inability to leave can be caused by mental problems as well as physical ones. Infrequent, short trips—as well as visits to adult daycare centers or religious services—are still allowed.)
- The patient doesn't need care every day OR will only need part-time daily care on a temporary basis. (The process for determining the exact limits can be complicated and occasionally flexible. But understand that care will be limited to a number of hours each day and/or a number of days each week. If you need permanent help on a full-time basis, you won't qualify for ANY home care benefits.)

Hospice Care

Part A is also responsible for covering hospice care for people who are terminally ill. Instead of trying to cure the patient, hospice care focuses on managing a person's symptoms so he or she can cope with a terminal illness as peacefully as possible. It is meant to cover a patient's family members, too, by paying for some non-medical services. In addition to medical treatments and supplies, hospice benefits may include grief counseling and homemaker services. It's usually provided in the patient's own home, but it can sometimes be offered in a hospital or in a special hospice facility.

To qualify for hospice care, you first need to be certified as terminally ill by your doctor and one of the heads of your chosen hospice provider. For Medicare purposes, this means you can't be expected to live longer than another six months. However, you won't be penalized in any way if you end up living longer than expected. Your doctor will need to reevaluate your condition every two or three months and determine if you still meet the six-month requirement.

Patients need to actively opt into hospice care by agreeing not to receive treatment that's meant to cure their illness. Treatment unrelated to their terminal illness will continue to be covered in the usual way. For example, if a cancer patient has opted into hospice care and breaks a leg, Medicare will still pay for treatment to cure the broken leg but not to cure the cancer. If patients change their mind and want to try to cure their illness, they can opt out of hospice care at any time and retain their regular Medicare benefits.

The Medicare patient's share of hospice expenses is minimal. There's no deductible to satisfy and no copayments or coinsurance fees except as follows:

- Patients are responsible for a copayment of no more than $5 for prescription drugs.
- Patients are responsible for 5 percent of the daily cost for respite care. (Respite care is care from a medical professional that is designed to give a regular caregiver some time off. Part A will only pay for respite care up to five days at a time, but the total number of five-day stints for each patient is unlimited.)

Part A Enrollment Periods and Late Fees

Each part of Medicare has rules regarding when people can enroll. The rules for Part A are simpler than those related to other parts of Medicare, but they're still important to know if you want to avoid penalties and remain insured.

Enrolling in Part A is simplest for people who are 65 and already receiving Social Security retirement benefits. In fact, these people don't need to do anything to join the program. The federal government enrolls them automatically and does the same for the disabled.

If you're scheduled to be automatically enrolled in Part A at age 65, the government will send you an informational packet three months ahead of time. The packet will include a red, white and blue Medicare card with your name, gender, and ID number on it and will also indicate which parts of Medicare (Part A and/or Part B), you're enrolled in. If you are automatically enrolled, your Medicare coverage starts on the first day of the month of your 65th birthday unless you were born on the first day of the month. If you were born on the first of the month, your coverage will start on the first day of the previous month. If you receive a Medicare card but don't want to enroll in Part A or Part B, you need to contact Social Security and send the card back.

That simple process of automatic enrollment applied to most seniors during most of Medicare's history, but it's likely to become less common among future seniors. Beginning with people born after 1937, Social Security's minimum age for full retirement benefits has increased beyond 65, making it more likely that people will work longer and become eligible for Medicare before choosing to go on Social Security. If a person is 65 and isn't receiving Social Security (or is under 65 and has end-stage renal disease), enrollment in Medicare isn't automatic. He or she needs to take some initiative and might only be allowed to enroll in Part A during a specific timeframe.

If you're turning 65 and don't plan on receiving Social Security just yet, your first chance to enroll in Part A will take place during a seven-month period near your birthday. Here's how those seven months are broken down:

- The three months prior to the month you turn 65.
- The month you turn 65.
- The three months after the month you turn 65.

Assuming you enroll during that period, your first day with Part A will depend on the month of your enrollment. For an example of how this works, let's think of a woman whose birthday is on September 15:

- If she enrolls during the three months prior to her birth month, her Part A coverage will start on the first day of her birth month (September 1).

- If she enrolls during her birth month (September), her Part A coverage will start on the first day of the following month (October 1).
- If she enrolls during the month after her birth month (October), her Part A coverage will start on the first day of the second month after her enrollment (December 1).
- If she enrolls during her last two months of eligibility, her Part A coverage will start on the first day of the third month after her enrollment (February 1 if she enrolls in November, or March 1 if she enrolls in December).

The same math would be used to figure out the starting day for people with other birthdays. Just remember that if you were born on the first of the month, your birth month for Medicare purposes is actually the previous month.

Most people who aren't receiving Social Security will still enroll in Part A when they turn 65. After all, as long as they've paid enough taxes into the system, this portion of Medicare doesn't cost them anything. Still, there are some seniors who will let their seven-month enrollment period pass them by. For example, a person who needs to pay a premium for Part A might decide that the cost isn't worth the benefits. And of course, there's always going to be a few people who would like to get Part A but simply forget to enroll.

The options for people who miss their seven-month enrollment period at age 65 will depend on whether Part A is free to them or requires a monthly premium. If you put off your Part A enrollment but have paid enough taxes to get it at no additional cost, you can enroll in Part A at any time after your seven-month enrollment period and avoid any penalties. If you do, Medicare might agree to pay your medical bills from as far back as six months before your actual enrollment date.

Restrictions exist for people who delay enrolling in Part A and are required to pay a premium for it. If you can't get Part A for free and miss your seven-month enrollment opportunity, you won't be able to join Part A until an annual enrollment period from January 1 through March 31. (Benefits would start on July 1.) You'll also be charged an additional 10 percent for every year that you could've enrolled in Part A but didn't. The late penalty will last for twice the number of years that you waited.

Let's imagine your grandfather turned 65 in 2019 and didn't enroll in Part A because he would've had to pay a monthly premium for it. He decided to enroll in 2021, but his lateness resulted in some penalties. Instead of paying $259 per month, his monthly premiums were increased by 20 percent for a total of $310.80. Since he waited two full years to enroll, the 20 percent penalty was scheduled to continue for another four years.

Seniors who would ordinarily be penalized for late enrollment can avoid the extra premiums if they're in one of the following situations:

- They're covered through their employment or their spouse's employment. (In this case, seniors can enroll in Part A at any time until the eighth month after employment ends or the eighth month after they lose coverage through the employment, whichever happens first. Even if they lose their job and continue their insurance through COBRA, they'd have to sign up for Part A within eight months of becoming unemployed.)
- They're doing volunteer work overseas and are covered by a tax-exempt organization. (Their ability to avoid late penalties would expire six months after their return to the United States.)
- They're insured through the Veterans Administration or the military's TriCare program. (The relationship between Medicare and military health plans won't be addressed in much detail in this material. You should contact Medicare if you have questions about this topic.)

If you work for a small business and don't sign up for Part A and/or Part B, you might end up with less insurance than you need. Under federal law, health plans for companies with fewer than 20 employees don't always cover Medicare-eligible people in the same way that they cover other group members. Seniors who want to stay on their employer's insurance should talk to their insurance company before declining any part of Medicare.

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 2021 Part B monthly premium for most Medicare recipients was $148.50. Higher-income beneficiaries pay more than other Medicare recipients.

Once treatment has been received under Part B, patients are responsible for paying a deductible and coinsurance fees. The deductible ($203 in 2021) 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.")

If you're automatically enrolled in Part B, your benefits will start at the same time as Part A. They'll continue until you stop paying the monthly premium or you contact Social Security to opt out. If you stop paying the premium, benefits will end after a 90-day grace period, which begins on the first day of the month after a bill is sent out. If you opt out by contacting Social Security, they'll stop on the last day of the month following the month of your cancellation. (Cancelling on April 15, for example, would result in benefits stopping after May 31.)

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.

Enrollment Periods and Late Fees

Although Part B is optional, many people will be enrolled in it automatically. In most cases, Part B enrollment will be automatic for 65-year-olds who are already receiving Social Security and for people who've qualified for Medicare Part A as a result of a disability. If they don't want Part B, they must follow the instructions contained on their Medicare card. Otherwise, their monthly Part B premiums will be deducted from their Social Security payments.

Other groups of potential beneficiaries will only be covered by Part B if they actively enroll in it. This rule applies to people who are 65 but not receiving Social Security, people who have end-stage renal disease and people who live in Puerto Rico. Also, while they are not required to join Medicare, anyone who wants Medicare Part A and is required to pay a premium for it must also enroll in Part B.

Individuals who aren't automatically enrolled in Part B can only opt into the program during specific enrollment periods. For 65-year-olds who are not receiving Social Security benefits, their initial enrollment period starts three months prior to the month of their 65th birthday and extends to three months after their birth month. Someone who was born on September 15, for example, would have an initial open enrollment period from June 1 through December 31 of the year they turn 65.

The day when Part B coverage begins for a 65-year-old will depend on when the enrollment actually occurs. Here are the potential starting dates for someone whose birthday is on September 15:

- If enrollment occurs within the three months prior to the birth month (June through August), coverage would begin on the first day of the birth month (September 1).
- If enrollment occurs during the birth month (September), coverage would begin on the first day of the following month (October 1).
- If enrollment occurs during the month after the birth month (October), coverage would begin on the first day of the second month after enrollment (December 1).

- If enrollment occurs during the second or third month after the birth month (November through December), coverage would begin on the first day of the third month after enrollment (February 1 if enrollment occurs in November, or March 1 if enrollment occurs in December).

Seniors who let their initial enrollment period pass without enrolling in Part B won't get another chance to enroll until an annual open enrollment period. The annual enrolment period lasts from January 1 through March 31. Anyone who enrolls in Part B during the annual enrollment period will not be covered until July 1. This enrollment period is also open to disabled people who still qualify for Medicare but declined Part B when it was first offered to them.

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 2021. Since the 2021 base monthly premium for most people that year was $148.50, Medicare would've billed the person an extra 20 percent for a monthly total of $178.20. (The total premium would be slightly higher for people with a higher-than-average income.)

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. According to the Social Security Administration, the eight-month rule might not apply to someone whose employment or group coverage ends during the person's initial enrollment period (the seven-month period around the person's 65th birthday).

Many Medicare-eligible Americans who remain employed are misinformed about the relationship between Part B's late enrollment rules and COBRA coverage. Under federal COBRA rules, former employees are allowed to remain insured by their former employer's group plan for several months if they agree to pay for the insurance themselves. Although COBRA ensures that many unemployed people can remain insured, it doesn't stop the eight-month clock for enrolling in penalty-free Part B. The clock only stops or becomes a non-issue when the person is insured through current employment or the current employment of a family member.

The starting date for coverage that's obtained during the eight months after losing employment or losing other group coverage will depend on when Medicare enrollment actually occurs. If enrollment occurs during the first month, Part B will start on the first day of that month. If enrollment occurs during any of the seven remaining months, coverage will start on the first day of the month after enrollment. For example, if someone is insured by an employer's group plan, is laid off in January and enrolls in Part B during that same month, coverage would begin retroactively on January 1. If the same person were to wait to enroll until March, insurance under Part B would start on April 1.

People who already have Part B can cancel it at any time. When they do, their insurance will stop at the end of the month after the month in which they contacted Medicare. Medicare can cancel someone's Part B insurance if a beneficiary goes three months without paying the required premiums. Grace periods beyond 90 days can be granted in special circumstances, such as when the beneficiary is temporarily incapacitated.

Anyone who is thinking of cancelling or declining Part B because they have coverage through another group plan should discuss the matter with their employer or their company's HR department before making a decision. Companies employing less than 20 workers sometimes provide fewer benefits to plan members who are eligible for Medicare.

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. Medicare Advantage plans are not allowed to spend more than 15 percent of premium dollars on administrative costs.

Pros and Cons of Medicare Advantage

Choosing between original Medicare and a Medicare Advantage plan is one of the most important decisions a senior will have to make. Advantage plans are particularly popular among relatively young Medicare recipients who don't have many health issues. Here are some of the reasons why:

- A Medicare Advantage plan might cover items or treatments that original Medicare won't. Examples often include eyeglasses, hearing aids, dental care and gym memberships.
- Medicare Advantage plans often require copayments, such as $10 or $20 for each office visit. These fees may be smaller, or at least more predictable, than the percentage-based coinsurance fees in original Medicare.
- Medicare Advantage plans must have a cap on a patient's out-of-pocket expenses.
- Since many Advantage plans cover prescription drugs, patients often don't need to purchase a separate Part D plan for their medications. (You'll read more about the Part D program in a little while.)
- Depending on the plan and the services provided, deductibles in Medicare Advantage might be lower than in original Medicare.
- Someone enrolled in Medicare Advantage might pay lower premiums than someone in original Medicare who tries to obtain similar coverage. (To obtain similar coverage, the person in original Medicare might need to pay the Part B premium, a Part D premium and a Medigap supplemental insurance premium.)

In spite of those positive benefits, most people choose not to enroll in Medicare Advantage. Here are some reasons why original Medicare might be preferred:

- Many Medicare Advantage plans require that patients see doctors who are in the insurer's network. This can be a problem if a patient spends time in multiple parts of the country or simply wants more choices.
- Insurers with Medicare Advantage plans can decide to leave the market. This is a common concern whenever federal subsidies to Advantage plans are changed.
- Many Medicare Advantage patients need referrals before they can see specialists.
- People in Medicare Advantage plans generally don't have access to Medigap policies that could act as supplemental insurance.
- Since there's very little standardization in Medicare Advantage, consumers may have a hard time comparing available plans.
- Although premiums might be lower in Medicare Advantage, seriously ill patients might have lower medical bills overall if they have original Medicare and a Medigap policy. Cost differentials will depend on the specifics of an Advantage plan and the kind of needed care.

Enrollment Periods

Like original Medicare, Medicare Advantage plans don't allow year-round enrollment. If someone wants to join a plan or wants to drop coverage and return to original Medicare, certain deadlines must be met.

The initial enrollment opportunity for someone who wants to join an Advantage plan occurs during the seven-month period around the person's 65th birthday or the person's 24th month of receiving disability payments from Social Security. For people who already have Part A but are signing up for Part B between January and March as late enrollees, enrollment in Medicare Advantage can be done from April 1 through June 30. (Remember, in order to join Medicare Advantage, the person must be enrolled in Part B.)

From October 15 through December 7, insured individuals can make changes related to Medicare Advantage for the coming year. During this annual enrollment period, the following actions can be taken:

- An insured can switch from one Medicare Advantage plan to another.
- An insured can switch from Medicare Advantage back to original Medicare.

- An insured can switch from original Medicare to Medicare Advantage.

People in Medicare Advantage also have the chance to switch back to original Medicare from January 1 through February 14. However, certain actions cannot be taken during this enrollment period:

- An insured cannot switch from original Medicare to Medicare Advantage.
- An insured cannot switch from one Medicare Advantage plan to another.
- An insured cannot switch from an MSA plan back to original Medicare.

There are many other deadlines related to Medicare Advantage for people in relatively specific situations. We won't go into detail about them here, but you should know they exist. Here are some events that might entitle someone to a special enrollment opportunity regarding a Medicare Advantage plan:

- Turning 65 while already on Medicare because of a disability
- Moving to a new address
- Returning to the United States after living abroad
- Entering, living in, or leaving a nursing home
- Returning from prison
- Losing Medicaid eligibility
- Losing other coverage from employment
- Losing coverage from another Medicare Advantage plan
- Losing drug coverage that's as good as Medicare's drug coverage
- Being on Medicare and Medicaid at the same time
- Receiving incorrect information from a federal employee and having it affect an enrollment decision

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 income above a federally set amount (in 2021, $87,000 a year for one person or $174,000 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.

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.

Enrollment Periods and Late Penalties

Even though it is optional, Part D should not be refused without careful consideration. As is the case with other parts of Medicare, enrollment is only allowed during specific timeframes every year or in special circumstances. And like Part B, Part D has a late enrollment penalty.

If people at first decline Part D but want it at a later date, they will pay an extra 1 percent of premiums for every month of delayed enrollment. The 1 percent penalty is based on the base premium for Part D, which is calculated by the government each year. In 2021, the base premium was roughly $33 per month, which translated to an extra 33 cents for each month of late enrollment. The 1 percent penalty will be applied for as long as the person has Part D.

To avoid the late enrollment penalty, people in Medicare must either enroll in Part D when it's first available to them or have gone no more than 62 consecutive days without "creditable coverage." Creditable coverage is prescription drug coverage that's considered as good as or better than Part D. Examples of creditable coverage might be coverage from an employer, coverage from the Veterans Administration and coverage from a union.

Unlike Part B, Part D is only automatic for people who are dually eligible for Medicare and Medicaid. Even someone who is turning 65 and already receiving Social Security benefits won't be enrolled automatically. The times when Part D enrollment is allowed (including those times when a penalty might be enforced) are very similar to the enrollment periods for Medicare Advantage. In fact, you should keep in mind that many Medicare Advantage plans (if they cover drugs) are also part of Part D.

The initial enrollment period for people turning 65 lasts for seven months and includes the three months prior to their birth month, the three months after their birth month and their actual birth month. Disabled people get their first chance to enroll during a period that lasts from their 21st month of receiving Social Security payments through their 27th month.

People who declined Part B at first but decide to sign up for it during the annual enrollment period from January 1 through March 31 will also have a chance to enroll in Part D from April 1 through June 30 of that year.

From October 15 through December 7, insured individuals can make changes related to their drug coverage for the coming year. Allowable changes during this period are listed below:

- An insured can switch from a Medicare Advantage plan without drug coverage to a Medicare Advantage plan with drug coverage.
- An insured can switch from a Medicare Advantage plan with drug coverage to a Medicare Advantage plan without drug coverage.
- An insured can join a Part D plan outside of Medicare Advantage.
- An insured can switch from a Part D plan outside of Medicare Advantage to another Part D plan outside of Medicare Advantage.
- An insured can drop drug coverage entirely.

From January 1 through February 14, a person can switch from a Medicare Advantage plan (with or without drug coverage) to original Medicare and enroll in a Part D plan outside of Medicare Advantage. (Switches from an Advantage plan involving a medical savings account are still prohibited.) In this situation, overage under the Part D plan will start on the first day of the month following the enrollment.

Other enrollment periods are allowed when people find themselves in special circumstances. Here are several events that can trigger a temporary enrollment opportunity for Part D (possibly with a penalty for late enrollment):

- Turning 65 while already on Medicare because of a disability.
- Moving to a new address.
- Returning to the United States after living abroad.
- Entering, living in, or leaving a nursing home.
- Returning from prison.
- Losing Medicaid eligibility.
- Losing other coverage from employment.
- Losing coverage from another Medicare Advantage plan.
- Losing drug coverage that's good as Medicare's drug coverage.
- Being on Medicare and Medicaid at the same time.
- Receiving incorrect information from a federal employee and having it affect an enrollment decision.

Before making any decisions about Part D, Medicare-eligible individuals should contact their current health plan. If they're leaning toward not enrolling in Part D, they need to determine if their current drug coverage is creditable. If they're thinking about dropping their current prescription coverage and enrolling in Part D, they should ask if the switch to Part D will make them (or their dependents) ineligible for other benefits from their current plan.

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 2021, 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.

- **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.
- **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.
- **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 high amount, 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 high amount, 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.

Medicare and Group Health Insurance

With more and more seniors continuing to work beyond their 65th birthday, the relationship between Medicare and employer-provided group insurance has become an increasingly important issue. Seniors with private group health insurance can usually put off their Medicare enrollment and avoid paying penalties, but that doesn't mean they'll be adequately insured.

Before making any decisions regarding Medicare enrollment, people who are insured through a private group health plan should contact a plan representative and ask how the plan deals with people who are eligible for Medicare. At the very least, answers to the following questions should be obtained:

- Will the plan continue to provide the same level of coverage to someone who is eligible for Medicare? (A plan might reduce coverage for people who are 65 or older even if they continue to work.)
- Are retirees allowed to remain in the plan (either on their own or as the spouse of a current employee), and are they provided the same level of coverage as current employees? (Many plans don't cover former employees who have retired.)
- If Medicare-eligible employees remain in the plan, will the plan be their primary insurer or their secondary insurer? (Primary insurance is billed first. Secondary insurance usually only pays for care that isn't covered by primary insurance.)
- If a Medicare-eligible person chooses not to enroll in Medicare, will the group plan still cover treatment and services that would have normally been covered by Medicare? (Seniors might not be covered in this scenario if the group plan is supposed to be secondary insurance.)
- If Medicare-eligible members are allowed to remain in the plan, is the plan's prescription drug coverage considered "creditable coverage" in regard to Medicare Part D? (Having creditable coverage allows seniors to delay enrollment in Part D without paying penalties.)
- If a Medicare-eligible person's family members are insured by the plan, will they lose their coverage if the person leaves the plan? (If someone insures his or her family through the same plan and then leaves the plan, the entire family might lose their insurance.)

Answers to those questions are especially important for people whose insurance is from an employer with fewer than 20 employees. By law, plans covering these people are usually considered secondary to Medicare. If a plan is secondary to Medicare, it might only cover Medicare-eligible members for things that Medicare isn't supposed to pay for.

Plans for companies with 20 or more employees cannot offer less coverage to a senior who is still working and can continue to be the person's primary insurance. Rules may be different for retirees and the disabled.

Help With Premiums

Individuals with low incomes may be eligible for help with their Medicare premiums. Depending on their financial situation, they might even be able to have their deductibles, copayments and coinsurance fees eliminated or greatly reduced.

The federal government provides low-income subsidies for millions of seniors in Medicare Part D. Part D subsidies for the poor are commonly referred to as "Extra Help." To be eligible for Extra Help, an applicant must live in one of the 50 states or the District of Columbia and must not have assets or income that total more than a certain amount. In 2021, the limit on income was approximately $19,320 ($26,130 for married couples), and the limit on assets was roughly $15,000 ($30,000 for married couples.) The figures are adjusted periodically to reflect changes in the federal poverty line.

Some valuable items, such as a person's home, car and life insurance policies, are not counted toward the asset requirements for Extra Help. Higher incomes are allowed for the following individuals:

- People who reside in Alaska or Hawaii
- People who have dependents living with them
- People who continue to work

Unless they're already on Medicaid or receiving benefits from Social Security because of their low income, Medicare beneficiaries usually won't receive Extra Help unless they actively apply for it. Government officials have estimated that as many as one-third of Part D recipients are eligible for this financial assistance.

Low-income people might also qualify for help from a Medicare Savings Program (MSP). Whereas Extra Help provides subsidies related to Part D, MSPs are meant to cover costs associated with Part A or Part B. The extent of the assistance and the rules regarding eligibility differ by state.

Funding the System

Medicare's financial future has been a major concern for several years. Although it would be inappropriate for us to make any predictions here regarding the program's sustainability, you won't be able to fully understand Medicare unless you know how it's paid for.

Money for Part A comes mainly from payroll taxes that are paid by employees, employers and people who work for themselves. Under 2021 rules, most employees paid 1.45 percent of their income to fund Part A, and their employers were responsible for an additional 1.45 percent. People who were self-employed were responsible for the entire 2.9 percent tax.

An extra 0.9 percent of Medicare tax is owed for people who earn more than $250,000 as a married couple filing joint tax returns and $200,000 for single people. Taxpayers at that level are also scheduled to be charged a 3.8 percent Medicare tax on investment income (not counting income from retirement accounts.) Neither of those extra amounts applies to the employer's portion of the payroll tax.

Parts B and D of Medicare are paid for with general government funds and premiums from enrollees. Money for Part C comes from a combination of sources that are also used to fund the other parts of Medicare. If money that's intended to be spent on Medicare isn't needed to pay the program's current expenses, it's deposited into a trust fund.

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. Turn to page 118 to enroll and submit your exam(s). You may also enroll and complete this course online:

InstituteOnline.com

Your certificate will be issued upon successful completion of the course.

FINAL EXAM

1. The Personal Auto Policy was designed for _____.
   A. motorcycles
   B. business vehicles
   C. large trucks
   D. private passenger vehicles

2. _____ insurance covers motorists when they cause another person to suffer bodily injury or property damage.
   A. Auto liability
   B. Medical payments
   C. Uninsured motorist coverage
   D. Homeowners personal liability

3. In essence, medical payments coverage in an auto policy is like health insurance that only pays if the insured person is _____.
   A. hurt in an auto accident
   B. hit by a bicycle
   C. harmed by an uninsured driver
   D. injured while a pedestrian

4. An accident victim's insurance company can get its money back by suing the at-fault driver and/or negotiating with the at-fault driver's insurer thanks to a process called _____.
   A. subrogation
   B. stacking
   C. contingent liability
   D. loss valuation

5. Unlike liability insurance, property insurance on a driver's own car is usually _____.
   A. mandatory
   B. optional
   C. inexpensive
   D. based on accident history

6. Property coverage on a driver's own vehicle will likely be mandatory if the owner _____.
   A. is under 21
   B. is over 55
   C. has a car loan
   D. has homeowners coverage from the same carrier

7. "Collision coverage" is for damage that is sustained when a car _____.
   A. hits an animal
   B. is stolen by a non-family member
   C. is damaged by a weather event
   D. collides with another object

EXAM CONTINUES ON NEXT PAGE

8. An item's actual cash value is its _____.
   A. replacement cost
   B. replacement cost minus depreciation
   C. manufacturing cost
   D. original market value

9. After most accidents, drivers with property coverage on their vehicle will be compensated in an amount equal to the cost of _____.
   A. buying a brand-new vehicle
   B. repairing the vehicle
   C. renting a car on a permanent basis
   D. the vehicle's full replacement cost

10. In the event that someone with an auto loan has a totaled vehicle,_____ can help pay the difference between the remaining loan balance and the vehicle's actual cash value.
   A. gap insurance
   B. rental insurance
   C. medical payments coverage
   D. motor carrier insurance

11. Drivers generally remain insured by their own insurance while driving _____.
   A. business vehicles
   B. large delivery trucks
   C. other people's cars with the owners' permission
   D. other people's cars without the owners' permission

12. With respect to auto insurance, driving to and from work is generally _____.
   A. excluded from coverage
   B. considered business use
   C. still considered to be personal use
   D. intended to be covered only by business auto insurance

13. Unless special arrangements are made, drivers who use their personal vehicles as part of a ride-sharing service will usually have little or no personal auto insurance at the point when they _____.
   A. sign up to drive for the service
   B. purchase a new vehicle
   C. are fired by the service
   D. make themselves available to potential riders

14. _____ insurance replaces a portion of people's income when they are too sick or too hurt to do their job.
   A. Disability
   B. Credit life
   C. Long-term care
   D. Business overhead

15. A few disability products are accident-only policies and do not cover losses brought on by _____.
   A. gunshot wounds
   B. chronic muscular problems
   C. head injuries
   D. sickness

16. By only paying benefits when a disabled person actually loses income, disability insurance, to a certain extent, follows the _____.
   A. law of large numbers
   B. pooling of risks
   C. principle of indemnity
   D. principle of utmost good faith

EXAM CONTINUES ON NEXT PAGE

17. In general, _____ disability insurance pays benefits when people cannot perform the duties required by any job that would be suitable for them, based on their education, experience and training.
    A. own-occupation
    B. any-occupation
    C. accident-only
    D. dread-disease

18. In most states, _____ insurance is purchased by employers as part of a group plan.
    A. personal auto
    B. Medicare prescription
    C. short-term disability
    D. personal property floater

19. Most disability policies have a _____, which explains how the elimination period is applied when disabilities go away for a while and then reoccur.
    A. free-look period
    B. recurrent disability clause
    C. workers compensation clause
    D. social insurance rider

20. In disability insurance, the benefit amount will be based mainly on a worker's _____.
    A. savings
    B. mortality risk
    C. salary or wages
    D. work history

21. In homeowners insurance, Coverage A insures a person's _____.
    A. dwelling
    B. personal belongings
    C. rented property
    D. auto liability

22. By default, standard forms of homeowners insurance will only reimburse people for their personal property's _____.
    A. full replacement cost
    B. actual cash value
    C. future market value
    D. trade-in value

23. _____ are those expenses the homeowner encounters as a direct result of not being able to use his or her home.
    A. Salvage costs
    B. Coinsurance fees
    C. Additional living expenses
    D. Accelerated benefits

24. In general, a person who _____ does not take reasonable steps to ensure the safety of other people or their property.
    A. acts negligently
    B. is an "additional insured"
    C. creates contractual liability
    D. violates the coinsurance clause

25. In _____insurance, the insurer's obligation to pay defense costs is usually greater than its obligation to pay damages or settlement costs.
    A. property
    B. liability
    C. life
    D. health

EXAM CONTINUES ON NEXT PAGE

26. Contrary to popular belief, a renter's personal property is generally _____.
    A. always covered at full replacement cost
    B. insured by default in most leases
    C. re-insured by local property tax authorities
    D. not covered by the landlord's insurance policy

27. In order to sell variable life insurance, the seller must have a _____ issued by his or her state and must pass the appropriate national exam pertaining to securities.
    A. valid business license
    B. life insurance license
    C. accident and health license
    D. insured fidelity bond

28. The _____ is the person or entity who will receive death benefits when the insured passes away.
    A. policyholder
    B. annuitant
    C. beneficiary
    D. next of kin

29. The ability to transfer a life insurance policy's ownership rights to someone else is known as _____.
    A. rescission
    B. assignment
    C. revocation
    D. post-claims underwriting

30. _____ give people who canceled their life insurance a chance to regain it under special conditions.
    A. Reinstatement clauses
    B. Cost-of-living adjustments
    C. Waivers of premium
    D. Certificates of insurance

31. The ways in which death benefits can be paid to beneficiaries after the insured's death are called _____.
    A. dividend options
    B. settlement options
    C. policy riders
    D. insuring agreements

32. The _____ can be a person, business, charity, trust or estate.
    A. measuring life for an annuity
    B. beneficiary on a life insurance policy
    C. recipient of long-term care benefits
    D. certificate holder in a group health plan

33. Under the most common type of incontestability clause, the insurance company has only two years from the policy's effective date to _____.
    A. approve an application
    B. pay valid claims
    C. increase insurance premiums
    D. investigate potentially false information on the original application

34. Under a _____, the insurance company is allowed to adjust the policy's face amount (effectively, the death benefit) if the applicant's stated age or gender turns out to be incorrect.
    A. suicide clause
    B. full contract clause
    C. loss payable clause
    D. misstatement of age or gender clause

EXAM CONTINUES ON NEXT PAGE

35. _____ exclusions tend to be part of life insurance policies when the United States is engaged in dangerous international conflicts.

    A. War
    B. Aviation
    C. Cancer
    D. Conversion

36. Policyholders who have a “participating policy” are eligible for _____.
    A. riders
    B. dividends
    C. accelerated death benefits
    D. cost-of-living adjustments

37. Since dividends from life insurance are commonly used to offset future premiums and as a factor in long-term financial planning, it is very important to note that they are _____.
    A. guaranteed
    B. always taxable
    C. never guaranteed
    D. fully refundable

38. Transactions called _____ allowed terminally ill individuals to sell their in-force life insurance policies to investors in exchange for several thousands of dollars.
    A. viatical settlements
    B. business overhead policies
    C. stop-loss agreements
    D. force-placed agreements

39. _____, which is purchased in case a borrower dies before paying off a loan, is arguably the most popular form of decreasing term insurance.
    A. Whole life insurance
    B. Credit life insurance
    C. Industrial life insurance
    D. Increasing term insurance

40. _____ are charts or graphs that are meant to reflect premiums, cash values or other aspects of a life insurance product that can or will change.
    A. Riders
    B. Endorsements
    C. Policy illustrations
    D. Declarations pages

41. _____ life insurance is a type of permanent life insurance that is mainly intended to provide flexibility in regard to the required premiums and the size of the death benefit.
    A. Term
    B. Credit
    C. Universal
    D. Participating

42. _____ life insurance is a form of permanent life insurance that exposes a policy’s cash value to market risks in exchange for potentially higher returns.
    A. Whole
    B. Term
    C. Variable
    D. Key-person

EXAM CONTINUES ON NEXT PAGE

43. _____ insurance pays a death benefit to the surviving spouse when the other spouse dies.
    A. Decreasing term
    B. Increasing term
    C. Joint life insurance
    D. Survivorship life insurance

44. A common life insurance product for children is a _____.
    A. jumping juvenile policy
    B. credit life policy
    C. viatical settlement
    D. life settlement

45. A(n) _____ is a long-term contractual arrangement in which a consumer 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. annuity
    B. double-indemnity rider
    C. permanent life insurance contract
    D. buy-and-sell agreement

46. _____ 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.
    A. Fixed
    B. Variable
    C. Immediate
    D. Indexed

47. If long-term care coverage is _____, both the coverage itself and the cost must remain the same as originally disclosed to the buyer.
    A. tax-exempt
    B. non-cancelable
    C. renewable
    D. state-approved

48. Many Medicare Advantage plans require that patients _____.
    A. pay no copayments
    B. seek federal approval before having surgery
    C. see doctors who are in the insurer's network
    D. pay entirely out of pocket for all ambulatory care

49. In 2006, Medicare introduced Part D, which allows Medicare beneficiaries to receive _____.
    A. hospital care
    B. hospice care
    C. respite care
    D. prescription drug coverage

50. 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 _____ policy.
    A. Medigap
    B. floater
    C. partnership
    D. tax-qualified

END OF EXAM

Turn to page 118 to enroll and submit your exam(s)

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MAIL or FAX:

1. **The answer sheet for both exams is on the next page. A duplicate copy is on the back cover of the book.**
2. **Remove the answer sheet from the book.**
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						50. Ⓐ Ⓑ Ⓒ Ⓓ

COURSE TWO: Principles for Insurance Professionals: Second Edition (11 Credit Hours)

1. Ⓐ Ⓑ Ⓒ Ⓓ	8. Ⓐ Ⓑ Ⓒ Ⓓ	15. Ⓐ Ⓑ Ⓒ Ⓓ	22. Ⓐ Ⓑ Ⓒ Ⓓ	29. Ⓐ Ⓑ Ⓒ Ⓓ	36. Ⓐ Ⓑ Ⓒ Ⓓ	43. Ⓐ Ⓑ Ⓒ Ⓓ
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