Life & Health Insurance Advisor

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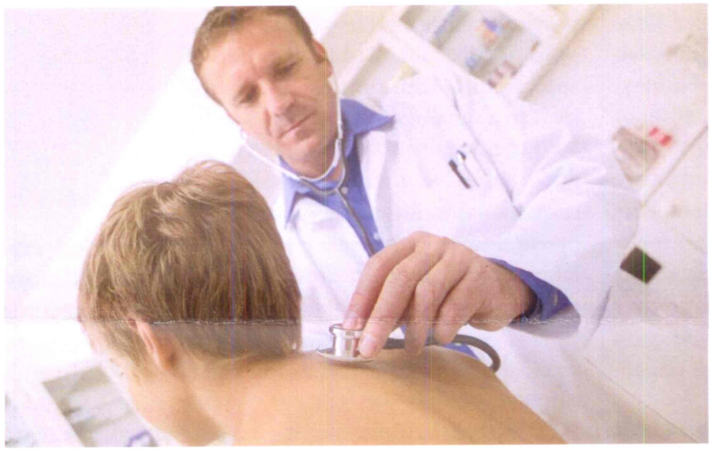
Healthcare Reform: What You Need to Know Now

As you know, on March 23, 2010, President Obama signed into law the largest healthcare reform bill in decades, the Patient Protection and Affordable Care Act. Many of its major provisions do not go into effect until 2014, but here are some that might affect your family's individual health plan during 2010.

Effective June 21, 2010

Temporary high-risk pool: Section 1101 of the new law establishes a "temporary high risk health insurance pool program." The program will provide health insurance coverage to currently uninsured individuals with pre-existing conditions. The law directs the U.S. Department of Health and Human Services (HHS) to carry out the program directly or through contracts with states or private, non-profit entities.



To be eligible for coverage through the pool, individuals must be U.S. citizens or legal residents, have a pre-existing medical condition and have not had "creditable coverage" for the previous six months. The law requires plans to cover at least 65 percent of healthcare costs.

At this point, we cannot say how much plans will cost. The law requires premiums to be set "as if for a standard population," meaning your premiums will be the same as for healthy individuals of your age, geographic area and tobacco use status.

As far as plan design is concerned, plans must cover pre-existing conditions; the U.S. Department of Health and Human Services will determine what other minimum benefits plans must include. Plans must limit out-of-pocket spending for individuals to $5,950 and for families to $11,900 in 2010, excluding premiums.

Currently, most states have high-risk health insurance pools; the law would extend risk pool protection nationally and reduce the costs of risk pool coverage for many participants.

The law provides $5 billion dollars to subsidize the costs of coverage through the high-risk pool. However, many experts worry that the premiums will not cover the cost of insuring individuals and families in the

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This Just In...

Now that the dust has settled on healthcare reform, what will the new legislation mean for your family?

You won't be able to purchase health insurance through the American Health Insurance Exchange until 2014, so nobody can say for certain how much coverage will cost. However, the Kaiser Family Foundation has created a calculator that estimates premium costs. If you are under 65 and purchase your own individual coverage, plug your information into the calculator to see what you might be paying for your coverage in 2014. http://healthreform.kff.org/SubsidyCalculator.aspx

Be sure to select the "final legislation" option at the top of the calculator. Please note the calculator uses 2009 dollars and does not include subsidies and out-of-pocket costs, such as deductibles and coinsurance.

The *Washington Post* has an online tool that allows you to plug in your information and see how healthcare reform will affect your family's tax bill. See www.washingtonpost.com/wp-srv/special/politics/what-health-bill-means-for-you/?wpisrc=nl_persfin.

National Long-Term Care Program Available in 2011

Largely overlooked in the debate about healthcare reform, the Patient Protection and Affordable Care Act also created a voluntary national long-term care insurance program. This becomes effective in January 2011. What will coverage under this program look like? Should you buy it?

The healthcare reform law incorporated the Community Living Assistance Services and Supports Act, or the CLASS Act. This created the CLASS program, a national, voluntary insurance program for "purchasing community living assistance services and supports" for "individuals with functional limitations."

In other words, the CLASS program will provide benefits to enrollees who need assistance performing two or more common daily living activities such as dressing, bathing, toileting, taking medications and eating, or who require substantial supervision to protect themselves from harm due to cognitive impairment. To qualify for benefits, enrollees must pay premiums into the program for at least five years and have been actively working for at least three of those years, and they must receive certification from a medical professional that they are expected to remain disabled for more than 90 days.

The CLASS program will pay a benefit of "not less than an average of $50 per day," scaled to functional ability, and paid on a daily or weekly basis. Beneficiaries will be able to use these funds to purchase nonmedical services and supports needed to maintain independence at home or in another residential setting of their choice in the community. This includes home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support.

Enrollees will be able to coordinate benefits under the CLASS program with any supplemental coverage purchased through a Health Insurance Exchange established under the Patient Protection and Affordable Care Act. (These will be available in 2014.)

To enroll in the program, you must be over age 18 and "actively employed." The law defines "actively employed" rather loosely—you must receive taxable wages or self-employment income, and be actively reporting to work and physically able to perform your job (in other words, not disabled at time of application). You cannot be hospitalized, in a nursing home or care facility for the mentally retarded or mentally ill, or confined to a prison or other correctional facility. Otherwise, unlike private insurance, there are no underwriting requirements, so even those in poor health will be able to obtain coverage.

The law allows employers that choose to offer the program to automatically enroll employees unless they opt out. Participation is optional for employers. If your employer elects not to participate, if you are self-employed or have more than one employer, you will be able to enroll on an individual basis.

Premiums paid and benefits received under the CLASS program will receive the same tax treatment as those for long-term care insurance bought on the private market. You will be able to deduct premiums paid as a qualified medical expense to the extent that they, along with your other qualified out-of-pocket medical expenses, exceed 7.5 percent of your adjusted gross income. For the self-employed, you can deduct premiums as an expense as long as you made a profit—medical expenses need not exceed 7.5 percent of income. The maximum amount of long-term care premium you can deduct depends on your age at the end of each tax year. For 2010, the maximum deduction ranges from $330 for individuals 40 or younger to $4,110 for individuals 71 and older.

Should You Participate?

The authors of the CLASS Act wanted to provide greater access to long-term care insurance and reduce costs to Medicaid, the only federal program that provides long-term care. However, the Act as written has some serious flaws.

The Congressional Budget Office (CBO) said, "In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. Individuals with health problems…would be more likely to participate than those in

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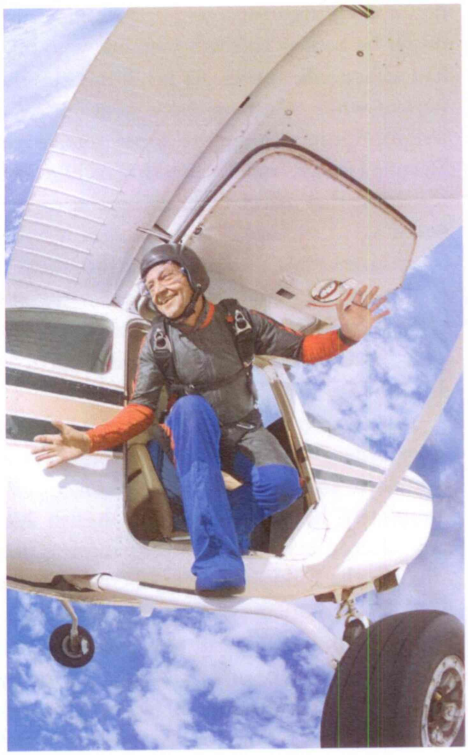
How Impaired Risk Policies Turn "No Sale" into Valuable Coverage

Years ago, a health problem or high-risk occupation or hobby meant an almost certain rejection on your life insurance application. But today, some insurers are willing to cover high-risk individuals. It's often just a matter of knowing which ones.



When you apply for any type of insurance, your application will undergo the underwriting process. Based on the information in your application and any related reports, the insurer will evaluate the risk you present, decide whether it will accept that risk, how much it will charge you for coverage, and whether it will put any limitations on your coverage.

The "underwriting factors" a life insurer considers include your age, gender, health, tobacco use and other health-related habits, occupational or lifestyle hazards, driving record and family medical history. Insurers sometimes deny life or health insurance to applicants deemed an "impaired risk." Insurers define an impaired, or substandard, risk as a person whose health, hobbies or habits make him or her more risky to insure. Factors that could push you into this category include:

- ✔ Health problems, such as coronary disease, strokes, diabetes or depression
- ✔ Unhealthy habits, such as smoking, unsafe driving, alcoholism or drug abuse
- ✔ Risky occupations or hobbies, such as race car driving or extreme sports

Being an impaired risk doesn't automatically mean an insurer will reject your application. However, you will likely pay more and your policy might exclude specific conditions or activities. And while some insurers will accept certain impaired risks, others won't.

If you suspect a health or lifestyle factor could affect your insurability, you will want to talk to your agent before applying for coverage. Most U.S. and Canadian life and health insurers are members of the Medical Information Bureau (MIB). When a person applies for an individually underwritten insurance policy with a member insurer, that insurer will report to MIB any information that is of significance to your health or longevity. Member insurers can access your private, coded MIB file with your permission, which you usually must provide on the appli-

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What to Do When an Insurer Rejects Your Application

You're in good health , but the insurer rejected your application for individual life or health insurance. What should you do now?

First, ask the insurer for a letter detailing the reason(s) for its denial. Sometimes an insurer will reject an application that contains incomplete or illegible information. In that case, you can resubmit your application.

Sometimes mistakes happen. An underwriter misinterprets a test result or the wrong tests are attached to your file. If the insurer denies you coverage on the basis of test results, make sure the tests cited are the ones you were asked to take.

Medical records can also be incorrect. Underwriters check your Medical Information Bureau (MIB) report when you apply for coverage. If you were denied coverage on the basis of MIB information, contact MIB for a free copy of your report at 866-692-6901. MIB will provide you with "the nature and substance of information, if any, that MIB may have in its consumer files pertaining to you." You have the right to correct any inaccurate or incomplete information in your record.

If you were denied on the basis of a diagnosis, ask your physician for help. Is your condition under control? Less serious than typical cases? Your doctor could submit additional documents to support your case.

If you were denied coverage on the basis of information on your credit report, check with the three major credit bureaus: Equifax, Transunion and Experian. You have the right to obtain a copy of your report if you are denied insurance or other services on the basis of its contents. For information, contact the applicable credit bureau.

You can also obtain one free credit report per year from all the credit bureaus. We highly recommend doing this to avoid situations like this, as well as fraud. For information, see https://www.annualcreditreport.com. ■

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pool, even with the subsidy. Although the healthcare reform law included some cost-control measures, most of those will not be implemented until later years, and their effectiveness will be unknown until then.

The pools will be dissolved in 2014, when the health insurance exchanges become operational.

Effective September 23, 2010

(Calendar year plans must comply by January 1, 2011. The following provisions apply to all group and individual plans.)

Dependent coverage: All plans must permit coverage for insureds' adult children to age 26 unless they are eligible for employer coverage. Currently, most plans cut off adult children by age 23.

Pre-existing condition exclusions: Plans must remove any pre-existing condition exclusions for children up to age 19.

Lifetime dollar limits: Insured and self-insured plans must eliminate lifetime dollar limits. Currently, most group plans cap lifetime benefits at $1 million to $2 million.

New and non-grandfathered plans will have to ensure the following provisions apply:

Claim appeals process: Plans must have a process that allows insureds to appeal coverage determinations and denied claims.

Emergency services: Plans must cover emergency services without prior authorization.

Preventive services: Plans must cover specified preventive services (such as recommended immunizations and screenings for women) without cost-sharing. In other words, you will not have to meet a deductible or pay coinsurance for your policy to cover these services.

Primary care providers: HMO and PPO plans must allow insureds to designate a pediatrician or ob/gyn as a primary care provider.

Effective January 1, 2011

HSA/Archer MSA changes: Individuals with a Health Savings Account or Archer Medical Savings Account can currently use their accounts to pay for over-the-counter drugs not prescribed by a doctor on a tax-free basis. You will no longer be able to do this after January 1. In addition, the tax penalty on distributions from HSAs and MSAs that you do not use for qualified medical expenses will increase to 20 percent (from 10 percent for HSAs and 15 percent for Archer MSAs). This penalty is in addition to the ordinary income tax you will pay account distributions.

Community health centers: The healthcare reform bill seeks to expand access to health care in communities where it is needed most by increasing funding to $11 billion over five years, starting in fiscal year 2011.

Other provisions go into effect later in 2011 and in following years; look for more information in upcoming issues. ■

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better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases. This effect has been termed the 'classic assessment spiral' or 'insurance death spiral.' The problem of adverse selection would be intensified by requiring participants to subsidize the $5 premiums for students and low-income enrollees....[and] there is a very serious risk that the problem of adverse selection would make the CLASS program unsustainable."

So, should you enroll? The CLASS program is intended to provide baseline coverage, not comprehensive coverage. Its proposed minimum benefit of $50 a day will barely make a dent in nursing home costs, now averaging $70,000 per year for a private room. Private long-term care insurance can be tailored to your needs, with limits high enough to cover a stay in a private nursing home. You can also buy policies that are guaranteed renewable, meaning the insurer cannot cancel your coverage—no matter what your health status—as long as you pay premiums. For a review of your long-term care insurance options, please contact us. ■

RISK—*continued from Page 4*

cation. When your report shows an insurer has declined coverage or offered a "rated" policy, it acts as an automatic red flag on your application.

Insurers vary greatly on the types of risks they are willing to accept. For example, some might be willing to cover insureds who have had cancer diagnoses under some circumstances while rejecting those who are overweight. Others might be more tolerant of lifestyle factors, such as smoking or high-risk activities, that affect insurability. An experienced agent or broker can steer you toward the insurers most likely to cover you—which might not be the high-volume, nationally known insurers. In extreme cases, an impaired risk specialist can help your agent in this process.

Once we've identified a few insurers likely to consider your application favorably, you will need to complete an application. Be completely honest about your health history and/or activities. Hiding information might make it impossible to obtain coverage if an insurer uncovers it during underwriting. Omitting material facts can also lead to a policy rescission, or unilateral cancellation by the insurer. Although rare, most rescissions occur when the insured files a claim—and needs the coverage most.

Once you and your agent have completed your application, the agent will obtain an attending physician's statement, or APS. This includes detailed information about your health condition and treatment. Some insurers or underwriters will use only a summary of the APS. In this case, an agent might use the services of a specialist—usually someone with underwriting experience—to write the APS summary so it properly highlights the positive aspects of your health history. Your physician can submit additional medical information with the APS, including progress reports and medical tests, which can provide a better picture of your current health and insurability.

For information on applying for life insurance coverage, please contact us. ■