Group Health Insurance

Now that you have examined the different types of health plans, you can further focus on health plans available in group insurance. In this section, you will learn about characteristics of group health insurance, eligibility factors, and provisions that apply exclusively to group coverage. You will also learn about small employer group medical plans, and marketing considerations for health insurance providers.

TERMS TO KNOW

Creditor — a lender of funds
Debtor — a borrower of funds
Extension of Benefits — a provision that allows coverage to continue beyond the policy's expiration date for employees who are not actively at work due to disability or who have dependents hospitalized on that date (coverage continues only until the employee returns to work or the dependent leaves the hospital)
HIPAA — The Health Insurance Portability and Accountability Act is a federal law that protects health information
Persistency — the tendency or likelihood of insurance policies not lapsing or being replaced with insurance from another insurer
Self-funded programs — a noninsured plan that uses a trust fund to pay for employees' health care expenses directly
Underwriting — risk selection and classification process

A. Characteristics Of Group Insurance

In a group policy, the contract is between the insurance company and the group sponsor (the employer, union, trust, or other sponsoring organization), as opposed to the individual policy, where the contract is between the insurance company and the insured.

1. Group Contract

In group insurance, the policy is called the **master policy**, and is issued to the policyowner, which could be the employer, an association, a union, or a trust.

2. Certificate of Coverage

The individuals covered under a group insurance plan are issued evidence of coverage in the form of **certificates of insurance**, or certificates of coverage. The certificate of insurance cannot contain provisions or statements that are unfair, misleading or deceptive. The certificate tells what

is covered in the policy; how to file a claim, how long the coverage will last, and how to convert the policy to an individual policy.

Know This! The policyowner (employer) receives the master policy; each insured receives a certificate of insurance.

3. Contributory vs. Noncontributory

The same as group life insurance, group health insurance may be either contributory or noncontributory. With a **contributory** plan the eligible employees *contribute* to payment of the premium (both the employee and employer pay part of the premium). If a plan is contributory, at least 75% of all eligible employees must participate in the plan. If the plan is **noncontributory,** 100% of the eligible employees must be included, and the participants do not pay part of the premium. The employer pays the entire premium. The reason for these participation requirements is to guard the insurer against adverse selection and to reduce administrative costs.

B. Types Of Eligible Groups

In order to qualify for group coverage, the group must be formed for a purpose other than obtaining group health insurance. In other words, the coverage must be incidental to the group. There are generally 2 types of groups eligible for group insurance: employer-sponsored, and association-sponsored.

1. Employment-related Groups

With an **employer-sponsored group**, the employer (a partnership, corporation or a sole proprietorship) provides group coverage to its employees. Eligible employees usually must meet certain time of service requirements and work full-time. The same as group life insurance, group health insurance may be either contributory or noncontributory.

Individual Employer Plans

The individual employer normally will provide insurance coverage to all full-time employees. The employer can specify within some limitations how many hours are considered full time, and whether both salaried and hourly employees will be covered. The employer can legally exclude a particular group of employees, like union or part time, from the eligible class of employees.

Multi-Employer Trusts (METs) or Welfare Arrangements (MEWAs)

A **Multiple-Employer Trust (MET)** is made up of two or more employers in *similar or related businesses* who do not qualify for group insurance on their own. Before HIPAA defined small employers, many small companies were unable to get health insurance at a reasonable cost due to the fact that there weren't enough people in the company to insure. In situations like this, several small companies banded together to create a large pool of people so that the insurance company will provide coverage. This group of employers

jointly purchase a single benefits plan to cover employees of each separate employer.

A noninsured plan may operate without the services and funds of an insurance company. Once the trust fund is established, it can pay for employees' health care expenses directly (self-funding). The trustee has charge of the funds and all financial activities occur through it. As with any self-funded program, the employer assumes legal responsibility for providing coverage, and the employee has no conversion right upon leaving the group coverage.

Multiple Employer Welfare Associations (MEWAs) can be any entity, other than a duly admitted insurer, that establishes an employee benefit plan for the purpose of offering or providing accident and sickness or death benefits to the employees of **at least 2 employers**, including self-employed individuals and their dependents.

A Multiple-Employer Welfare Arrangement (MEWA) is similar to an MET, except that MEWAs are groups of employers that pool their risks in order to *self-insure*. These groups could be sponsored by an insurance company or an independent administrator who may help a MEWA to design a plan or handle the administration. Groups can be from the same or related industries because of the Law of Large Numbers/Similar Risks.

Today, the terms have become blurred and MEWAs and METs are generally known as interchangeable plans. They are considered risky if not fully insured. Some METs/MEWAs are only partially insured, and the individuals or employers retain full responsibility for any debt if not fully insured.

2. Customer Groups (Depositors, Creditor-debtor, Other)

Creditor group insurance, also called credit life and credit disability income insurance, is a specialized use of group life and group health insurance that covers debtors (borrowers). It protects the lending institution from losing money as the result of a borrower's death or disability. The contract owner is the creditor, such as a bank, a small-loan company, or a credit union. Generally, the debtor is the premium payor, but the lending institution is the beneficiary of the policy. If the debtor dies or becomes disabled, the insurance proceeds are paid to the creditor to liquidate the indebtedness. The amount of insurance cannot exceed the amount of indebtedness.

C. Employer Group Health Insurance

The majority of all health insurance in force today is provided on a group basis. The cost of group health insurance is lower than the cost for individual coverage since the administrative costs and selling expenses found in group health insurance are far less.

Know This! Group health plans typically cost less than individual plans.

1. Insurer Underwriting Criteria

Generally underwriting for group health insurance is similar to underwriting for individual health insurance coverage, but the underwriter evaluates the group as a whole rather than each individual member. The group's risk profile determines whether the group will be accepted or rejected. As with any type of underwriting, the underwriter tries to avoid adverse selection. *Adverse selection* describes the tendency of poorer risks seeking out insurance protection.

Group underwriting criteria help insurers determine the acceptability and premium to be charged, and to minimize the possibility of adverse selection. The following are considered in group health insurance underwriting:

- Certificates are guaranteed issue with no individual underwriting;
- Premiums are determined by age, sex and occupation of the entire group;
- The reasons for forming the group are other than purchasing insurance;
- A certain participation level must be maintained;
- There is a flow of new members through the group; and
- There is an automatic determination of benefits which is not discriminatory (everyone has the same coverage).

Characteristics of Group

One of the differences between group underwriting and individual underwriting is that in groups of 50 or more, medical information cannot be required of plan participants. In small groups even one bad risk can have an impact on the claims experience of the group. That's why in some states, insurers may allow some individual underwriting in small groups they insure.

Persistency Factors

Persistency rate for a group of policies means the ratio of the number of policies that continue coverage on a premium due date to the number of policies that were in force as of the preceding due date. The persistency rate usually improves with policy duration. In health insurance, persistency is important for the following main reasons:

- Expenses are higher during the first year than in subsequent years because of the costs of issuing the policy and certificates of insurance, and higher first-year commissions; and
- Claim rates usually increase as the age of the insured increases.

The underwriter takes persistency into consideration because groups that change insurance companies every year do not represent a good risk.

Administrative Capability

The per-capita administrative cost in group health insurance is less than the administrative cost found in individual coverage.

2. Eligibility for Coverage

Group health plans commonly impose a set of eligibility requirements that

must be met before an individual member is eligible to participate in the group plan. It is common that in order to be eligible, the employee must be full time (usually 30 hours per week), and have been employed by the employer from 1 to 3 months.

Annual Open Enrollment

A **30-day open-enrollment period** is available once a year to employees who reject coverage during the initial enrollment period and later wish to have coverage or to add dependent coverage. Evidence of insurability is not required during the open-enrollment period.

Know This! Evidence of insurability is NOT required during the annual open enrollment period in group policies.

Probationary Period

If an employee/dependent applies for coverage after the open enrollment period, they may have to satisfy a **probationary period** and/or prove insurability.

Employee Eligibility

Employer group health insurance generally requires that to be eligible for coverage an employee must be a full-time employee, working in a covered classification, and must be actively at work.

Under the Affordable Care Act (ACA), employers must extend coverage to all employees who work more than 30 hours per week. In addition, small and large employers may not be denied coverage for failure to satisfy the minimum participation or contribution requirements.

Dependent Eligibility

Employer group health insurance generally requires a dependent of an employee to be

- A spouse;
- A child younger than the limiting age, including natural children of the insured, stepchildren, children legally placed for adoption, and legally adopted children; and/or
- Disabled children who are incapable of self-support because of a physical or mental disability, and are dependent upon the insured for support and maintenance.

Most insurers cover domestic or same-sex partners whether or not a state has a domestic partner or civil union law.

3. Coordination of Benefits Provision

The purpose of the coordination of benefits (COB) provision, found only in group health plans, is to avoid duplication of benefit payments and overinsurance when an individual is covered under multiple group health insurance plans. This provision limits the total amount of claims paid from all

insurers covering the patient to no more than the total allowable medical expenses.

The COB provision establishes which plan is the **primary** plan, or the plan that is responsible for providing the full benefit amounts as it specifies. Once the primary plan has paid its full promised benefit, the insured submits the claim to the **secondary**, or **excess**, provider for any additional benefits payable (including deductibles and coinsurance). In no case will the total amount the insured receives exceed the costs incurred or the total maximum benefits available under all plans.

Loss - Amount covered by Primary Plan = Amount covered by Secondary Plan

If all policies have a COB provision, the order of payments is determined as follows:

- If a married couple both have group coverage in which they are each named as dependents on the other's policy, then the person's own group coverage will be considered **primary**. The **secondary** coverage (the spouses' coverage) will pick up where the first policy left off.
- If both parents name their children as dependents under their group policies, then the order of payment will usually be determined by the **birthday rule**, i.e., the coverage of the parent whose birthday is earlier in the year will be considered primary. Occasionally, the **gender rule** may also apply, according to which the father's coverage is considered primary.
- If the parents are divorced or separated, the policy of the parent who has custody of the children will be considered primary.

Know This! Coordination of benefits provision ensures that benefits are not paid in excess of the total losses incurred.

4. Change of Insurance Companies or Loss of Coverage

Employees actively at work on the date coverage is transferred to another insurance carrier are automatically covered under the new plan, and they are exempt from any probationary period. Employees not actively at work on the date coverage is transferred must be included in the new plan, but their benefits can be limited to the prior plan's level until they return to work.

Coinsurance and Deductible Carryover

Coinsurance and deductibles may be carried over from the old plan to the new plan. The purpose of coinsurance and deductible carryover provisions is to credit expenses incurred so as to not penalize the insured.

Pre-existing Conditions

No-loss/no-gain statutes involve the theory of indemnification and the concept of placing the insured in the same economic position after a loss as the insured was in prior to a loss. When changing health insurance, benefits must be paid for ongoing claims regardless of pre-existing conditions.

As defined by the Pennsylvania Code, a *pre-existing condition* is a disease or

condition for which medical attention has been received within **90 days** immediately prior to becoming covered under the group contract. The condition must be covered after the individual has been insured for more than 12 months under the group contract.

A pre-existing condition exclusion cannot be acceptable in blanket or group student accident and sickness insurance and group mortgage disability insurance.

Events that Terminate Coverage

Group insurance policies provide for a termination of benefits in the event of certain occurrences.

Generally, coverage will terminate **for an employee** on the earliest date in which one of the following occurs:

- Employment terminates;
- The employee ceases to be eligible;
- The date the overall maximum benefit for major medical benefits is received;
- The end of the last period for which the employee has made the required premium payments comes about; or
- The master contract is terminated.

Coverage will terminate **for a dependent** on the earliest date in which one of the following situations occurs:

- The dependent fails to meet the definition of a dependent;
- The overall maximum benefit for major medical benefits is received; or
- The end of the last period for which the employee has made the required premium for dependent coverage passes.

Extension of Benefits

When a group policy is discontinued, the policy must provide for a reasonable **extension of benefits** to any covered person who is totally disabled at the time the group policy is terminated.

Continuation of Coverage under COBRA

The **Consolidated Omnibus Budget Reconciliation Act of 1985** (**COBRA**) requires any employer with 20 or more employees to extend group health coverage to terminated employees and their families after a qualifying event. **Qualifying events** include the following:

- Voluntary termination of employment;
- Termination of employment for reasons other than gross misconduct (e.g. company downsizing); and
- Employment status change: from full time to part time.

For any of these qualifying events, coverage is extended up to **18 months.** The terminated employee must exercise extension of benefits under COBRA within **60 days** of separation from employment. The employer is permitted to collect a premium from the terminated employee at a rate of no more than 102% of the individual's group premium rate. The 2% charge is to cover the

employer's administrative costs.

For events such as **death** of the employee, **divorce** or legal separation, the period is **36 months** for the dependents.

It is important to remember that COBRA benefits apply to group health insurance, not group life insurance. In addition, unlike the conversion privilege in which the individual converts coverage to an individual health insurance policy, COBRA continues the same group coverage the employee had and the employee pays the group premium that the employer paid (or employer and employee paid if the plan was contributory).

Note that under the Patient Protection and Affordable Care Act, coverage for children of the insured must extend until the adult child reaches the **age of 26** (unless the child qualifies as a disabled dependent). The same age limit applies to COBRA coverage for eligible children of the insured. In addition, in the event of loss of dependent child status under the group plan, the dependent child qualifies for a maximum period of continuation coverage of **36 months.**

There are also several **disqualifying events** under which the COBRA benefits may be discontinued. These include failure to make a premium payment, becoming covered under another group plan, becoming eligible for Medicare, or if the employer terminates all group health plans.

Know This! Coverage for dependents under COBRA may be extended to 36 months in the event of the employee's divorce or death.

Conversion Privilege

Terminated employees are permitted to convert their group health coverage to individual insurance **without evidence of insurability** if the termination was voluntary or involuntary, except for termination due to gross misconduct. This option must be initiated during the conversion period, which is within **31 days** of termination of employment. The insurer is allowed to evaluate the individual in order to determine the appropriate premium, either standard or substandard, but they may not deny coverage based on this evaluation. The converted policy neither needs to provide the same benefits as the group, nor will it have the same premium. The premium for an individual policy usually will be higher.

Know This! If failed to initiate conversion to individual coverage within 31 days, a terminated employee must undergo a new individual approval process, which may require a medical exam.

After a group plan coverage terminates, each employee must be given a notice that describes the conversion privilege. The notice must be given between 15 days and 30 days following the plan termination. After the notification, the certificate holder or the certificate holder's dependents must be given at least 31 days to exercise the conversion privilege.

The premium rate for an individual policy is limited to 120% of the approved

premium rates for comparable group coverage.

D. Chapter Recap

This chapter explained the key principles of group health insurance. Let's recap some of the important points:

GROUP INSURANCE

Characteristics of Group Insurance	• Group formed for a purpose other than obtaining group health insurance • *Master policy* - issued to the group sponsor • *Certificates of insurance* - evidence of coverage for the insureds • Experience rating: premium based on group as whole • Community rating: premium based on insurer claims experience
Types of Eligible Groups	• *Employer sponsored* - individual or Multiple Employer Trust (MET) • *Association* - alumni or professional
Marketing Consideration	• *Advertising* - truthful and not misleading • *Jurisdiction* - coverage for more than one state; approved in issuing state
Underwriting	• Every eligible member of group must be covered regardless of physical condition, age, sex or occupation • Evidence of insurability generally not required • 30-day open enrollment period • Probationary employees must work a total of 30 hours per week
Provisions	• Conversion to individual coverage - within 31 days without evidence of insurability • Coordination of benefits • Change of insurers - carryover of coinsurance and deductibles

COBRA

Qualifying Events	• Voluntary termination of employment • Termination of employment for reasons other than gross misconduct (e.g. company downsizing) • Employment status change: from full time to part time
Length of coverage	• 18 months – after qualifying event • 36 months – for dependents after events such as death of the employee, divorce or legal separation