Chapter 1 Medicare History

Medicare is a federal health insurance program intended to help protect the elderly by ensuring that they can get medical insurance coverage at an affordable rate after age 65. It also provides coverage for certain people younger than 65 who are disabled or suffer from end-stage renal disease. The federal government funds Medicare through payroll tax contributions, general tax revenues, and premiums paid by those who are enrolled in the program. Of all the great social programs, Medicare is arguably one of the most successful—it is the nation's largest single health insurance program and covers about 61 million Americans.

Medicare Act of 1965
The federal government's entry into the health care and health insurance arena came about in 1965 with the creation of the Medicare program. Though the program has undergone a number of adaptations over the years, its mission remains unchanged: to ensure that the elderly and disabled are provided with a way to obtain and pay for needed health care and health services. It is a basic entitlement program and a significant and core component of our nation's health care system.

When Medicare was created in 1965, it represented a troubled compromise, patched together, despite the incompatible goals of those who enacted the legislation. Its supporters, concerned about rapidly rising medical costs, wanted to create a plan that would protect older people on fixed incomes from a system that forced them to spend all of their personal resources on medical care before being eligible for funds from public assistance. Opponents of the program argued for a voluntary health insurance program that would be supported by government funds.

Even those who favored Medicare disagreed on many issues. For example, many of Medicare's advocates did not want older people to regard the program as charity and insisted that its benefits be identical for everyone regardless of income. Others feared that an attempt to provide comprehensive insurance to the entire elderly population would dilute the benefits, making it impossible to offer extensive coverage to those who were most in need.

What emerged from this heated congressional debate was the Medicare Act of 1965, which identified age as its principal eligibility requirement. Everyone age 65 and over could sign up for Medicare with no medical tests to determine need. To satisfy those in Congress who were concerned about funding such a sweeping program, the plan was designed to provide only partial coverage. At that time, medical costs were not nearly as high as now, and Medicare usually covered a large share, if not most of a beneficiary's bill.

Medicare - 1970s to Present
In 1972, Medicare was expanded to cover the severely disabled and people with end-stage renal disease. Also in the 1970s, responsibility for administering the Medicare program was given to the Health Care Financing Agency. In 2001, the name of this agency was changed to Centers for Medicare and Medicaid Services (CMS). (CMS is part of the Department of Health and Human Services.) The change included more than a name change. This agency was given control of several government medical care programs, including Medicare and Medicaid, and the Children's Health Insurance Program (CHIP). CMS's mission is to control health care costs associated with the programs assigned to it. The agency makes the rules and regulations that standardize payments for services, defines what type of care is reasonable for various health care needs, and supervises the certification of Medicare providers. CMS effectively controls all Medicare operations, including the four parts of Medicare:

-Part A—Hospital Insurance
-Part B—Medical Insurance
-Part C—Medicare Advantage
-Part D—Prescription Drug coverage

Some of the most significant changes to the Medicare program occurred in 2003 and 2008. In 2003, the Medicare Prescription Drug Improvement and Modernization Act (MMA 2003) was enacted; in 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA 2008). The former introduced prescription drug coverage to the Medicare program and established new Medicare Advantage (MA) plans. The latter provided for a number of changes with respect to low-income subsidy qualification, Private Fee for Service plan restructuring, special needs plans redefinition, physician payments, Medicare Advantage marketing guidelines, and Medicare Advantage plan payment reductions.

The Patient Protection and Affordability Care Act of 2010

The Patient Protection and Affordability Care Act of 2010 (PPACA) created the first large-scale reorganization of health care coverage and delivery in the United States. The act has come to be known simply as "ACA." While most of the act dealt with health care changes for those under age 65, some provisions included minor changes in Original Medicare and more particularly in Medicare Advantage and Medicare Part D. Of significance is the fact that ACA called for a $116 million reduction in Medicare Advantage spending and presumably would cut another $500 billion from Medicare spending over ten years by reducing the growth of payments to providers.

ACA Changes to Original Medicare

There were two important changes in Original Medicare, both of which became effective January 1, 2011. First was the elimination of the deductible and coinsurance for most preventive services under Part B, which covers physician services. The second major change was to provide coverage for annual no-charge wellness visits, during which the beneficiary receives a personalized plan prevention service (PPPS). This annual wellness doctor visit is available every year after a Medicare beneficiary has been in the program for one year and has received his or her original "Welcome to Medicare" physical.

ACA Changes to Medicare Advantage

The changes to Medicare Advantage dealt primarily with a cutback in Medicare payments to MA plans. The objective was to bring MA spending in line with Original Medicare's fee-for-service payment structure. The cuts began in 2012 and may result in higher MA plan premiums and a reduction in the benefits offered by most plans, although the plans must retain the same statutory benefits as Original Medicare. Also, a limitation on out-of-pocket costs for MA plan enrollees was set at $6,700 per year for "in-network" services, or $10,000 per year for "out-of-network" services.

ACA Changes to Part D

ACA made a very significant change to the Medicare Part D (Prescription Drug) program. Part of the act called for less plan availability to reduce confusion for both enrollees and agents. (Currently in 2020, there are over 946 plans.) However, the biggest change was a reduction in the "donut hole," which was the point at which a plan participant had to pay 35 percent of his or her prescription drug costs for brand-name drugs and 44 percent for generic drugs.

The ACA called for a complete elimination of the donut hole over a span of ten years. Incremental reductions started in 2011 with a 50 percent discount on brand-name drugs and a 7 percent discount on generic drugs. (As of 2020, both of those discounts had increased to 75 percent.) Because the full retail price of the drugs (including the discount and plan participation) is credited to the donut hole expense, the enrollee arrives sooner at the catastrophic benefit level (when Part D coverage pays for almost all listed prescription drug costs, with only a small co-pay—$3.60 for generics or $8.95 for all other drugs—or at a 5 percent expense to the enrollee, whichever is higher). Income-based Part D premiums were also introduced, and high-income enrollees are now charged more in a manner similar to Part B high-income premiums.

Skyrocketing Costs
As medical costs have increased, the federal government's outlays for Medicare have soared. Costs to Medicare beneficiaries have also skyrocketed. Along with the rising costs of physician fees, other expenses have risen far in excess of general inflation. In 1966, for example, the Medicare Part A deductible for hospitalization was set at $40, which represented the average cost of a day in the hospital. By 1990, this deductible had soared to $592, and in 2020, it had reached $1,408. History indicates that it will continue upwards under the present Medicare system.

Soaring Enrollment Numbers
The number of people enrolled in the Medicare program has increased by almost 170 percent since it began. As we move further into the twenty-first century with the arrival of more and more baby boomers into the Medicare system, and as the population continues to age, these numbers will soar because of improvements in health care techniques and increases in longevity. The Census Bureau has predicted that 20 percent of the population will be 65 or older by 2030—an estimated 78 million people who will be eligible for Medicare. In 2020, there were roughly 65 million people on Medicare.

And because older people account for over a third of all hospital stays, everyone may face the possibility of some substantial medical bills while covered by Medicare, thus increasing the cost of Medicare delivery.

Recent Changes
The Medicare Part B premium became somewhat of an issue in mid-2015, when MedPAC, a governmental agency designed to keep an eye on Medicare expenses, determined that the Part B premium needed to be raised for 2016. However, because federal law states that increases in Part B premiums are limited to cost-of-living (COLA) increases in Social Security benefits and because there was no COLA increase in Social Security benefits for 2016, the Part B premium could not be raised for most Medicare beneficiaries (about 70 percent). These beneficiaries were "held harmless" against any premium increase. The remaining 30 percent of enrollees were required to shoulder a premium increase of $121.80 per month in 2016.

In 2017, another anomaly was created, again due to a very small COLA increase of .3 percent in Social Security benefits. The solution was to create a three-tiered schedule of Part B premium payments for 2017:

-Tier 1–the "hold harmless" enrollees paid a premium of $109 per month
-Tier 2–those who were new to Medicare in 2016 paid a premium of $127 per month
-Tier 3–those new to Medicare in 2017 paid a premium of $134 per month

Those in these tiers amount to about 70 percent of enrollees. The remaining 30 percent of enrollees paid an even higher monthly Part B premium. Among the 30 percent are:

-Those who do not collect Social Security benefits (and do not have Medicare premium deductions taken from their benefits)
-Dual eligible beneficiaries whose premiums are paid by Medicaid
-Those beneficiaries who pay an additional income-related premium (IRMAA)

Employing different tiers for Medicare Part B premiums is not a new concept; Part B premium differences had been in force a few years before 2013.

The annual Part B deductible, in the meantime, rose to $198 for 2020.

Services Medicare Does Not Cover
Medicare Part A does not pay for convenience items such as telephones and televisions provided by hospitals or skilled nursing facilities, nor does it pay for private rooms (unless medically

necessary) or private duty nurses.

The only type of nursing home care Medicare pays for is skilled care in a skilled nursing facility (SNF) for rehabilitation, such as recovery time after a hospital discharge. Medicare does not pay if an insured needs only custodial services (help with daily living activities like bathing, eating, or getting dressed).

With only a few exceptions, Original Medicare does not pay for prescription drugs outside of the hospital or a doctor's office. MMA 2003 enacted Part D to cover prescription medications. Also, with the exception of the annual wellness visits, routine physical examinations or services not related to treating illness or injury are not covered. Part B does not pay for dental care or dentures, cosmetic surgery, routine foot care, hearing aids, eye examinations, or eyeglasses (except for one pair after eye surgery). Except for certain limited cases in Canada and Mexico, Medicare does not pay for treatment outside the United States.

Chapter 2 Medicare Eligibility

Medicare was originally targeted to people over age 65 on the assumption that they would be retirees and would be without the benefit of employer-sponsored medical care. The program has never covered people who take early Social Security retirement, although it does cover pre-65 individuals who are qualified for Social Security disability.

Because Medicare was designed to complement federal retirement benefits, eligibility is tied closely to eligibility for Social Security benefits. As with Social Security, the availability of coverage is determined by an applicant's age and the length of time the applicant (or his or her spouse) has worked in employment qualified under the Social Security Act regulations. People can qualify for and receive Medicare without enrolling for Social Security at age 65. They simply enroll in Medicare Part A and pay the Part B premium as if they had also enrolled in Social Security.

Generally, people are eligible for Medicare if they meet the following requirements:

-They or their spouses worked for at least ten years (40 quarters) in Medicare-covered employment. (Medicare-covered employment means employment that requires paying FICA taxes to Social Security and Medicare.)

-They are 65 years old. A person can also qualify for coverage if he or she is a younger person with a disability or with chronic kidney disease.

-They are citizens (by birth or naturalization), permanent residents of the United States, or they are legal resident aliens who have lived in the United States for at least five years.

Part A—Premium Free (for Most)
"Qualifying" Social Security wages are earnings on which Social Security payroll taxes or Social Security self-employment taxes are paid. Whichever work situation applies, the number of Social Security credits needed for Medicare coverage is the same. As a general rule, a person needs to have accumulated 40 quarters of qualified credits to be entitled to Medicare coverage.

With regard to the number of Social Security credits needed to qualify for Medicare coverage, a self-employed person is treated on the same basis as a person who is not self-employed.

Coverage and benefits under Part A require payment of monthly premiums if the applicant has not qualified via the 40-quarter rule. For instance, in 2020, for those who didn't qualify for premium-free Part A coverage, and for those with less than 30 quarters of coverage, the monthly premium for Part A was $458 per person. For those with 30 to 39 quarters of covered employment and for certain disabled persons with 30 or more quarters of covered employment, the premium was $252

per month.

An individual can get Part A at age 65 without having to pay monthly premiums if he or she meets the following requirements:

-He or she is already receiving retirement benefits from Social Security or the Railroad Retirement Board.

-He or she is eligible to receive Social Security or Railroad Retirement benefits but has not yet filed for them.

-He or she or his or her spouse had Medicare-covered government employment.

-He or she has received Social Security or Railroad Retirement disability benefits for 24 months.

-He or she is a kidney dialysis or kidney transplant patient.

Part B—Premiums Required
Coverage and benefits under Part B require payment of monthly premiums. Those who delay purchasing Part B beyond their initial eligibility period are assessed a 10 percent penalty for each full 12-month period that the person could have purchased Part B but failed to sign up for it.

Accuracy of Employment History
Accuracy of employment history is the key to obtaining Medicare benefits. The Social Security Administration keeps all records on file based on W-2 employer-reported earnings and Schedule SE self-employment taxes reported. Generally, federal workers employed after 1983 are eligible for Medicare in the same way that private industry workers are—because they have paid the Medicare hospital insurance part of the Social Security tax. Federal workers employed before 1983 may qualify to have their work credited toward Medicare eligibility under special provisions of the regulations. State and local government workers became eligible for Medicare-qualified employment in 1986.

There are also special regulations covering people who were employed in domestic work, farm work, or religious organizations that were exempt from Social Security tax payments. All of these atypical situations must be evaluated on a case-by-case basis with a Social Security representative.

Basic Enrollment

A person is enrolled in Medicare either:

1. Automatically
2. Active Application

Automatic Enrollment
Those who are not yet 65 but are already receiving Social Security or Railroad Retirement benefits do not have to apply for Medicare—they are enrolled automatically in both Part A and Part B and will automatically be eligible for benefits at age 65. Approximately three months before their sixty-fifth birthday, they will receive a Medicare card in the mail. If they do not want Part B, then they must reject Part B coverage by notifying CMS of their desire not to enroll at that time.

Disabled individuals are automatically enrolled in both Part A and Part B of Medicare beginning in their twenty-fifth month of disability. They will receive the card in the mail about three months before they are entitled to Medicare.

Enrollment by Application
If enrollees are not receiving Social Security or Railroad Retirement benefits, or if they require regular dialysis or a kidney transplant, then they need to actively apply for Medicare three months before turning 65, which is the beginning of the seven-month initial enrollment period. By applying early, they can avoid a possible delay in the start of their Part B coverage. Application can be made by contacting any Social Security Administration office, or by going to Medicare.gov and enrolling personally. If an enrollee or his or her spouse worked for a railroad, he or she should contact the Railroad Retirement Board.

Initial Enrollment Period
The initial enrollment period is seven months. It begins three months before an enrollee turns 65, includes the month the enrollee reaches age 65, and lasts for the next three months. This is the initial enrollment period for both Parts A and B.

If an individual does not enroll in Parts A or B during this initial seven-month period, then he or she will have to wait to enroll until the next general enrollment period. General enrollment periods are held January 1 to March 31 of each year, and Part A and B coverage starts July 1 of that year.

Delaying Enrollment
If an individual delays enrolling in Medicare by 12 months or more, his or her premiums generally will be higher. As noted, Part B premiums increase 10 percent for each 12-month period that the person could have enrolled but did not, except in special cases, referred to as special enrollment periods. Under these special circumstances, the enrollee can delay Part B enrollment without having to pay higher penalized premiums.

If enrollees are age 65 or over and have group health insurance based on their (or their spouse's) current employment, or if the enrollee is disabled and has group health insurance based on his or her current employment or the current employment of any family member, then the enrollee has a choice:

He or she may enroll in Part B at any time while covered by the group health plan. Delaying enrollment past age 65 while still working and while covered by a group plan will not result in an increase in Part B premiums.

He or she can enroll in Part B during the eight-month enrollment period that begins the month after employment ends or coverage under the employer plan ends, whichever comes first. The coverage under the employer group health plan is considered "creditable" coverage, which allows the applicant to enroll in Medicare without a penalty.

If a person enrolls in Part B while covered by an employer plan or during the first full month when not covered by that plan, Part B coverage begins the first day of the month the person enrolls. If he or she enrolls during any of the seven remaining months of the special enrollment period, then coverage begins the month after enrolling. If the person does not enroll by the end of the eight-month period, then he or she will have to wait until the next general enrollment period that begins January 1 of the next year. The beginning of the month that the recipient enrolls is also the first month that he or she is entitled to the Medicare supplement open enrollment (guaranteed issue) period, which lasts for six months.

Even if a person continues to work after turning 65, he or she should consider signing up for Part A of Medicare if the person qualifies for premium-free Part A. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be advisable to sign up for Part B if the person has health insurance through his or her employer. He or she would have to pay the monthly Part B premium, and this would also trigger the six-month Medicare supplement open enrollment period, which cannot be changed or restarted. If an employer has 20 or more employees, the group health plan would be the primary payor and Medicare the secondary payor.

In this case, the person could find value in Part B if the group health plan has high deductibles or coinsurance amounts. If an employer has fewer than 20 employees, Medicare would be the primary payor and the group plan would be secondary. Therefore, it might not be advantageous for the employee to enroll in Part B.

Consumers will not be penalized for delaying Medicare as long as they enroll within eight months of losing employer-provided coverage or retiring, whichever comes first.

Another enrollment factor to consider is whether a person has a health savings account (HSA) and wants to continue to make contributions to the HSA. Enrollment in any part of Medicare makes a person ineligible to contribute further to an HSA.

An individual must enroll in (or keep) Part B coverage if he or she wants to be able to join any of the Medicare Advantage managed care plans, Medicare medical savings accounts, Medicare supplement plans, or other Medicare health insurance options.

In summary, a person turning 65 or older can delay taking Part B if:

-He or she or his or her spouse (of any age) continues to work, and/or
-He or she is covered under a group health plan from that current employment

If a person does not have group health plan coverage based on current employment, and he or she delays taking Part B, the Part B monthly premium will increase by 10 percent for each 12 months that he or she could have had Part B and did not enroll in Part B.

If a person does not enroll in Part B when they should have and did not have creditable coverage, then he or she will only have a chance to sign up for Part B once a year—the general enrollment period—between January 1 and March 31. The Part B insurance will start in July of that year. If a person chooses to delay taking Part B because he or she currently has group health plan coverage, then the person may be able to avoid paying this higher premium by signing up for Part B while he or she has this creditable group coverage in place. The person can also sign up within eight months after the employment ends or the group health coverage ends, whichever comes first.

A note of caution: Under Medicare rules, COBRA is not considered to be creditable coverage. Consequently, delaying enrollment in Medicare Part B because one has COBRA will not avoid the Part B late enrollment penalty.

Medicare Cards
Once enrolled, insureds receive a Medicare card imprinted with their name and Medicare number, which they should show to providers whenever receiving medical care. This will ensure that a claim for payment is sent to Medicare. The card shows what coverage the insureds have (Part A, Part B, or both) and the date the coverage started. Insureds should also present to the provider their Medicare supplement company card, if they have such coverage. Those enrolled in a Medicare Advantage plan should present their MA plan card to the provider; these individuals do not have to show their Medicare card. Further, insureds should make sure to use their exact name and Medicare number. If the insured is married, then the spouse will also have his or her own card and Medicare number.

As a point of caution, under no circumstance should Medicare beneficiaries ever let anyone else use their Medicare cards. They should keep the number as safe as they would a credit card number. When traveling, insureds should take the Medicare card and/or their Medicare Advantage or Medicare supplement card with them and have it handy when calling about a Medicare claim. If a card is lost, the Social Security Administration should be contacted right away.

New, Safer Medicare Cards
Beginning in April 2018, Medicare started issuing Medicare cards without Social Security numbers on them. The reason behind the new cards was to prevent theft of an enrollee's personal information. The new Medicare cards have a computer-generated number that even recipients will not be able to detect or understand. The process was completed in 2019.

Basic Benefits and Benefit-Related Information

Medicare allows recipients to choose the way they receive their benefits. Recipients are enrolled automatically in the Original Medicare plan, which is the traditional payment-per-service arrangement. If they want to stay with the Original Medicare plan, they do not have to do anything.

Starting in 1999, Medicare offered more ways (other than Original Medicare Parts A and B) to receive benefits through other health plan choices. Choices that became (and remain) available include:

-Medicare managed care plans (such as health maintenance organizations, or HMOs)
-Preferred provider organizations (PPOs)
-Provider sponsored organizations
-Private fee-for-service plans (PFFSs)
-Medical savings account plans (MSAs)

All of the above are components of various Medicare Advantage plans. Again, no matter what other health plan choices a recipient makes, he or she is still in the Medicare program.

Benefit Periods and Reserve Days
Medicare calculates its hospital (Part A) coverage in benefit periods and reserve days. Understanding these terms helps to untangle the rules governing the length and frequency of hospital stays, and the deductibles that apply to different situations.

Benefit Period
The hospital Part A benefit period begins on the day an insured is admitted to the hospital and ends when he or she has been out of the hospital or other covered facility for 60 consecutive days. So, an insured could actually have two separate hospital visits within the 60 days and only pay the deductible once, because it is in the same benefit period. On the other hand, an insured could accumulate several benefit periods (and incur several deductibles) in a year.

For example, assume a patient is admitted to the hospital in January with pneumonia. That constitutes the first benefit period and the first deductible. Then, six months later in July, the patient is admitted to the hospital with a broken hip. That is the second benefit period and will require payment of another deductible. In December, the patient is admitted to the hospital with another malady—that would be the third benefit period and would require payment of a third deductible.

Reserve Days
With the exception of hospice care, the number of benefit periods that an insured can use is unlimited. However, if an insured has to stay in the hospital for more than 90 days, the days beyond the 90th day fall into a special category called reserve days.

During every benefit period that an insured uses, Medicare pays one amount (all but the deductible) toward the first 60 days of an admitted hospital stay and a lesser amount (coinsurance) toward the next 30 days, and an additional lesser amount for the following 60 days. The amount that Medicare will pay the hospital is determined by a code number assigned to a certain diagnostic related group (DRG). Medicare predetermines the DRG payment amount according to the zip code in which the hospital is located. After the 60-day hospitalization and the

additional 30-day coinsurance period, insureds may use some or all of their reserve days, and for that, Medicare pays another amount. A Medicare beneficiary is entitled to only 60 reserve days in a lifetime.

Basic Deductibles
A deductible is the amount insureds must pay for health care before Medicare begins to pay. Each benefit period for Part A has a deductible, as does each calendar year for Part B. These deductible amounts can (and do) change every year.

Part A Deductible
For example, in 2020, the Part A deductible was $1,408 per benefit period for admitted patients. After the insured (or the Medicare supplement policy) pays this deductible, Medicare then pays all approved Part A expenses for the first 60 days. Because the Part A deductible applies to each benefit period, it is possible that a person (or their insurance company) may have to pay more than one deductible in a year if he or she is admitted to a hospital more than once outside of the 60-day benefit period. Based on the example provided earlier in which a patient experienced three separate benefit periods in one year, this person would have had to pay a total of $4,224 for the three deductibles (assuming the hospital stays took place in 2020).

Part B Deductible
In 2020, the calendar year Medicare Part B deductible was $198. In other words, the beneficiary is responsible for the first $198 of approved expenses for physician and other medical services and supplies for the year. After he or she has met the annual deductible, Medicare generally pays 80 percent of all other approved charges for covered services for the rest of the year. The insured (or the insured's Medicare supplement policy) is responsible for the other 20 percent co-payment and/or an additional 15 percent charge that certain physicians may add to their bills. Home health services under Part B have no deductible or coinsurance. Medicare Advantage policies also treat this deductible differently.

Basic Co-Payments
The patient is also responsible for co-payments. Co-payments are the payments that the beneficiary or his or her health insurance (in addition to Medicare) must make to cover expenses that Medicare does not pay.

There are various references to "co-payments" and "coinsurance" in Medicare literature. Co-payments are a set dollar amount, while coinsurance is a percentage of a charge. You will see references to each in Medicare and in Medicare Advantage plans.

Basic Claims
Several years ago, Congress decided that one of the ways to control Medicare costs was to have all claims filed similarly and, at some future date, electronically filed. So Congress mandated that medical service providers, including doctors, must file Medicare claims directly from their offices for all their Medicare patients. This attempt at cost control actually had a beneficial effect for consumers—it eliminated much paperwork for Medicare recipients.

Also eliminating both Medicare and Medicare supplement claim paperwork is the procedure now known as automatic claims. For insureds who have Medicare supplement policies, the Medicare carrier files the claims for the insured with his or her Medicare supplement insurer after the carrier processes the original claim. In the case of a Medicare Advantage enrollee, the provider bills the plan, and Medicare carriers are not involved.

One of the most serious problems affecting the Medicare program over the years has been the problem of improper claims and benefit payments made by Medicare. Although Medicare claims it works hard to address the problem of improper claims, as well as duplicate and overpayment of claims, the problem of waste, fraud, and abuse in the system still accounts for as much as $60

billion a year, according to its own government sources.

Part A Claims
Billing for services that constitute Part A expenses is done directly between the health care provider and a Medicare administrative intermediary. The insured is not responsible for filing the claim and should not be billed by the provider before Medicare reviews the claim. A hospital may ask the insured to pay the deductible and any noncovered expenses at the time of discharge; however, this is unlikely if the insured presents his or her Medicare Part A identification card.

After making a determination on the claim, Medicare will send the insured a statement called a Medicare Summary Notice, or MSN, once every three months. This form carries a prominent notice stating: "This is not a bill." The form contains information about the action that Medicare took regarding the claim. It will indicate the following:

-The name of the person or organization who furnished the medical services
-The dates that the services were rendered
-The date of the notice
-The claim number and the claimant's Medicare number, name, and address
-The amount of the Medicare benefits that were used in paying the claim; the services provided;
-The benefit days used; the noncovered charges; the deductibles and coinsurance
-The amount, if any, that the insured is responsible for paying, or whether that information has
-Been forwarded to a Medicare supplement company
-The phone number and address of the Medicare intermediary that processed the claim
-The Customer Information Service Box
-Appeals information

If the insured is responsible for a payment, the notice will state the amount and the reason—the deductible, for example—for the balance due. Insureds should not make a payment based on this statement; the provider will bill them separately for the charges indicated if the charges have not already been paid or forwarded to the Medicare supplement company.

In a Medicare Advantage plan, enrollees will be treated differently. The Medicare Advantage plan will send an "Explanation of Benefits" for claims for Parts A and B and a separate "Monthly Prescription Drug Summary" for any prescriptions drugs utilized in that month.

Part B Claims
Part B claims may be more confusing to the patient. The medical care provider is still responsible for billing Medicare, but there are a number of possible variations. The provider may or may not be a participating provider, and he or she may or may not accept assignment. Both situations influence the amount that the insured or his or her insurance plan must pay.

When insureds seek treatment from a doctor or other medical provider, they provide their Medicare identification number to the provider. The provider makes a copy of the insured's Medicare card. After treating the insured, the provider bills Medicare on behalf of the insured. Although insureds can pay the provider at the time of service, they don't need to do this, because the insured has given the provider his or her Medicare identification card.

If the insured does not pay the provider, then Medicare will pay the provider directly. If the insured does pay the provider, then Medicare will send the reimbursement directly to the insured.

Under federal law, the medical care provider must file the claim for the insured. The claim will then automatically be referred to the insured's Medicare supplement carrier, if he or she has one. If the insured is in a Medicare Advantage plan, the provider sends the claim to the plan. Processing the Medicare claims and payments are contracted claims processing companies that have a contract with the federal government. The organizations handling Part A claims from

hospitals, skilled nursing facilities, home health agencies, and hospices are called intermediaries. The organizations that handle Medicare Part B claims are called carriers. Sometimes the same organization handles both Part A and Part B claims, but the insured will still receive separate notices.

For Part B claims, Medicare sends a notification to the patient in the form of an MSN (Medicare Summary Notice). This form has the same purpose as the MSN that is sent after review of Part A claims. The MSN form for Part B looks differently and is slightly more complicated to read and understand. Either form may also be a benefit denial letter.

Medicare Summary Notice
It is important to read Medicare Summary Notices carefully—again, the MSN is not a bill. Insureds should study the MSN carefully and make sure that they received the services, medical equipment, or supplies for which Medicare was billed. If the insured has any questions, he or she should contact the carrier or intermediary listed on the front of the notice. If insureds disagree with a claims decision, they have the right to file an appeal; they should follow the instructions on the notice for filing. In addition, if insureds find and report a charge on the MSN that they did not receive and Medicare paid for, they may be eligible for a reward. In fact, CMS announced that it would increase the reward for whistleblowers who report Medicare fraud and whose tips lead to the recovery of Medicare overpayments. Whistleblowers can receive up to 15 percent of any amount recovered as a result of their tips, with a cap of $9.9 million on payouts.

Insureds should note the following on their MSNs:

-The date the MSN was sent
-The customer service information box, if they have questions about their MSNs
-Their Medicare number, which should match the number on their Medicare cards
-Their name and address—If this information is incorrect on the MSN, then insureds should contact -both the Medicare intermediary shown on the MSN and the Social Security Administration immediately.
-The "Help Stop Fraud" message—States how to protect themselves and Medicare against fraud and abuse.
-Inpatient claims on their Part A Hospital Insurance
-Outpatient claims on their Part B Medical Insurance—Includes services provided, the amount charged, the amount Medicare approved, the amount Medicare paid the provider, and the amount
-The patient or his or her Medicare supplement company may be billed.
-Dates of service—These dates show when services were provided, and insureds can use these
-Dates to compare with the dates shown on their hospital bills.
-Claim number—Each claim is assigned a claim number, which insureds may be asked to provide when calling about their MSNs.
-Benefit days used—Shows the number of days used in the benefit period for Part A only.

Claims Records
Also, it is important that insureds keep track of their MSNs and the medical claims filed and paid. Sometimes providers bill insureds for more than they are entitled to collect. The total amount due from a patient is not always readily apparent at the time the service is rendered. A provider may ask the insured to pay the co-payment or deductible amounts at the time of the service. This amount is based on the fee the provider expects to receive from Medicare, which may or may not be accurate.

The only way to protect against overpaying a provider on a claim is for insureds to be aware of and to fully understand Medicare's claim decision, and to keep a log of all payments (MSNs) made by Medicare, the insured, and any other insurance carriers involved, such as a Medicare supplement company. This is no small task—in fact, in the late 1990s, two articles appeared in the New England Journal of Medicine that indicated as high as 90 percent of hospital billings were in

error, usually in favor of the hospital. Again, it may be financially rewarding to an insured who finds an MSN error.

Medicare Fraud

Medicare fraud is an intentional deception or misrepresentation that an individual knows to be false and carries out with the knowledge that the deception could result in the payment of an unauthorized Medicare benefit. Some examples of Medicare fraud are:

-Intentionally billing for services that have not been provided
-Receiving kickbacks or bribes
-Intentionally billing non-covered services as covered services
-Committing forgery (unauthorized use of a person's signature)

Medicare is taking strong action to combat fraud and abuse in key areas. The goal is to make sure Medicare only does business with legitimate providers and suppliers who will provide Medicare beneficiaries with high-quality services. The effort to prevent and detect fraud, abuse, and waste is a cooperative one that involves CMS as well as Medicare beneficiaries, Medicare contractors, providers, and state and federal agencies, such as the Office of the Inspector General, the Department of Health and Human Services, the FBI, and the Department of Justice. MIPPA 2008 and the ACA created several programs that gave legal teeth to the prevention and detection of fraud in Medicare dealings and provided for statutory criminal jail sentences for offenders.

Insureds should be suspicious if the provider tells them that:

-The test is free, and the provider only needs the insured's Medicare number for the provider's records.
-Medicare wants the insured to have the item or service.
-The provider knows "how to get Medicare to pay for it."
-The more tests the provider provides, the cheaper those tests are.
-The equipment or service is free.

Insureds should be suspicious of providers who:

-Routinely waive co-payments without checking on the insured's ability to pay
-Advertise free consultations to Medicare beneficiaries
-Claim they represent Medicare
-Use pressure or scare tactics to sell costly medical services and diagnostic tests
-Bill Medicare for services that the insured does not recall receiving

Consumer Tips

The following is a list of tips that clients can use to help prevent fraud:

-Do not give out your Medicare health insurance claim number except to your doctor or other Medicare providers.
-Do not allow anyone except appropriate medical professionals to review your medical records or to recommend services.
-Do not contact your physician to request a service that you do not need.
-Be careful in accepting Medicare services that are represented as being free.
-Be cautious when you are offered free testing or screening in exchange for your Medicare card number.
-Be cautious of any provider who maintains that they have been endorsed by the federal government or by Medicare.

Avoid a provider of health care items or services who tells you that the item or service is not usually covered, but they know how to bill Medicare to get it paid.

Health care fraud, whether against Medicare or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs. The Medicare recipient must remember the importance of eliminating fraud in the program. That is why Medicare developed financial rewards for recipients who report fraud.

Medicare and its contractors actively work to prevent attempts to defraud Medicare and to support investigations and prosecutions of such defrauders. Many of the successful law enforcement actions were begun through Medicare contractors and regional office staff who identified problems and issues and through contractors' referrals to the HHS Inspector General.

The Recovery Audit Contractor (RAC) Program
MMA 2003 created a three-year temporary program—the Recovery Audit Contractor (RAC) program—which became a permanent program as of January 2010. The RAC program is designed to protect Medicare payments of questionable claims in four major areas:

-Duplicate payments
-Fiscal intermediary mistakes
-Medical necessity
-Coding problems (more accurately "upcoding" to a higher Medicare reimbursement level)

The RAC program has made great strides in saving Medicare money, but it is not without its critics in the medical field who feel the program is too aggressive and essentially punishes providers who make simple mistakes. For instance, the RAC will visit a hospital to determine if a patient was coded as "Admitted," thereby making the patient stay a Part A claim. If the RAC determines that the stay should have been coded "Under Observation," making the service a Part B claim (covered at a lesser amount of 80 percent), they will want reimbursement of their Part A claim money. This may seem like an insignificant matter, but for several years, hospitals have had to appeal these claims. By mid-2018, the number of such appeals had accumulated to 600,000.

Other Programs
The False Claims Act introduced the concept of dealing with those who abuse or game the Medicare system, and goes further than the RAC program. Simply, when outright fraud is discovered, the False Claims Act gives legal teeth to indictment, arrest, and prosecution of fraudsters. During the first decade of 2000, the main perpetrators of Medicare fraud were found in the durable medical equipment and home health care provider market.

On May 20, 2009, Health and Human Services took further measures with a new high-level task force called Health Care Fraud Prevention and Enforcement Action Team, whose main emphasis is to arrest and prosecute fraudsters with longer prison sentences as a goal. In addition, the Fraud Enforcement and Recovery Act of 2009 included insurance operations in its recovery goals.

In 2011, Medicare announced that it had abandoned its "pay and chase" technique of paying providers first, then trying to recover fraudulent payments. Medicare now requires more careful background checks on providers before instituting payments, and in some cases, requires bonding of the provider.

Fraud or Abuse?
Fraud and abuse have the same effect: they steal valuable resources that should go toward beneficiaries' Medicare benefits. Fraud robbed the Medicare system of more than $200 billion during the first 15 years of this century, according to the Department of Health and Human Services Office of the Inspector General. Others claim the cost is much more. Their assertion is that Medicare overpays through fraud, overpayment, duplicate payment, waste, and abuse as much as $60 billion per year. The primary difference between fraud and abuse is the person's

intent. Was the person aware that he or she was committing a crime?

Fraud as defined by CMS is an intentional deception or misrepresentation that someone makes, knowing it is false, that could result in the payment of unauthorized benefits. A scheme does not have to be successful to be considered fraudulent.

Abuse involves actions that are inconsistent with sound medical, business, or fiscal practices. Abuse directly or indirectly results in higher costs to the Medicare program through improper payments that are not medically necessary.

Working closely together to identify fraud and abuse are:

-The Centers for Medicare and Medicaid Services
-Medicare enrollees
-Fellow Medicare contractors
-The Department of Health and Human Services Office of Inspector General
-The FBI
-The United States Attorney's offices—Department of Justice
-Local, county, and state law enforcement jurisdictions

In the process, these groups and individuals develop cases to refer to federal law enforcement authorities. They also support civil and/or criminal prosecutions, recover lost money, and eliminate bad providers from the Medicare system.

Fraud and abuse can take many forms. Some common forms may include but are not limited to:

-Billing for services or supplies never provided
-Misrepresenting the services rendered
-Misrepresenting the diagnosis to justify payment for services
-Altering claim forms to obtain a higher payment amount
-Soliciting, offering, or receiving a kickback, bribe, or rebate
-Making secret, unlawful agreements between a supplier, beneficiary, and/or other health care
-Provider that result in higher costs or charges to Medicare
-Deliberately applying for more than one payment for the same service
-Unlawfully completing a certificate of medical necessity
-"Upcoding" by providers to receive a higher payment for services than would be allowed by entering the proper DRG code
-Falsifying documents
-Misrepresenting the place of service

Penalties for Fraud
The United States Attorney's Office targets fraudulent health care providers for civil and/or criminal prosecution. Among the penalties are these:

-The False Claims Act provides for fines of up to $10,000 and damages up to three times the amount of the fraudulent submission. Violators may serve up to five years in prison.

-The anti-kickback provisions of the Social Security Act provide for fines of up to $25,000 and up to five years in prison.

-Civil monetary penalties provide for fines of up to $50,000 and damages up to three times the amount of the fraudulent submission.

-The Racketeer Influenced and Corrupt Organizations (RICO) Act has recently been used in Medicare fraud cases. Those convicted criminally can be sentenced to up to 20 years in prison.

Civil conviction under RICO provides for asset forfeiture.

-The Health Insurance Portability and Accountability Act (HIPAA) created a new crime called health care fraud. This crime allows for up to 10 years in prison, up to 20 years in prison if serious bodily injury results, or up to life in prison if death occurs.

-The Department of Health and Human Services Office of Inspector General can also exclude a health care provider from all government-paying programs, including the Medicare system.
The Recovery Audit Contractor Program became a permanent program as of January 2010. Also, in 2011, CMS began inspecting contractors themselves to see if they had developed consistent incorrect patterns of payment.

-In May 2009, HHS developed the Health Care Fraud Prevention and Enforcement Action Team to arrest and prosecute fraudsters with longer prison sentences.

-The Fraud Enforcement and Recovery Act of 2009 included insurance companies in its goal of protecting Americans from fraudulent activities of securities and banking entities.
In 2011, CMS began a program to investigate overpayments in Medicare Advantage and Medicare Part D programs.

Combined, these laws and the efforts of the agencies to enforce them have recovered billions of dollars and resulted in the prosecution and imprisonment of countless individuals—both within the medical industry and outside of it.

Medicare's Customer Service

CMS worked with the Office of the Inspector General to help design messages that would better enable beneficiaries to identify any potential fraud or abuse of the program. The result is a simple, easy-to-read format that all users agree is the most useful tool developed to date to inform beneficiaries about actions on their Medicare claims.

Telephone Service and Internet Service

When they need information, the majority of Medicare beneficiaries use the telephone as their principal source of help and information. Medicare receives over 25 million telephone calls per year with questions about billing and understanding the Medicare program.

To continually review, renew, and improve their approaches as new activities emerge, CMS developed an overall Medicare beneficiary telephone customer service strategy that also includes standards and performance measures to evaluate the effectiveness of customer service. The strategy incorporates feedback on customer service goals and expectations from beneficiaries, CMS staff, carriers, fiscal intermediaries, quality improvement organizations, state health insurance assistance programs, and the Social Security Administration (SSA).

The Continuous Improvement Quality Call Monitoring initiative is an effort to develop a systematic national approach to ensuring the quality of the Medicare contractor beneficiary telephone service. This initiative provides CMS with a direct way to ensure that all call centers handling Medicare inquiries adhere to acceptable performance standards, including waiting time, call-backs, transfers, busy signals, hours of operations, etc.

Each year, CMS publishes a booklet titled "Medicare and You" for beneficiaries. The book lists numerous scenarios throughout its content that address handling questions or complaints that beneficiaries may have regarding a multitude of Medicare situations. The book also includes advice enrollees can follow if they suspect fraud. The Medicare website, www.medicare.gov, is listed frequently, as are the Medicare Helpline toll-free number, 1-800-Medicare, and the State Health Insurance Assistance Program office.

Enrollments in Medicare are surging as more baby boomers reach age 65. The most logical first step is to contact the Social Security/Medicare office in one's local district to obtain enrollment information. However, Social Security has been reducing public office hours as well as locations, and has been advising applicants to enroll directly at medicare.gov. Enrollment was a simple and quick process that could be completed over the Internet, but in 2018, certain security measures were put in place that, unfortunately, can make the process more cumbersome. Applicants must now answer a series of "identity" questions that are intended to protect Social Security and Medicare benefits from being utilized by people who are not eligible to sign up for them—usually through false identities. Consumers who want to work with a "live" person should contact their local Social Security-Medicare office.

Chapter 3 Original Medicare

A misconception about Medicare is that it will pay all of a senior's health care costs. Medicare was designed only to assist with those expenses.

The three important topics are these:

-What it covers
-What it does not cover
-How seniors can find private insurance coverage to pay for the difference

The following health plan choices are currently available throughout the Medicare system:

-The Original Medicare plan (Parts A and B)
-The Original Medicare plan with a supplemental insurance policy
-Private managed care plans (Medicare Advantage, or Part C) that have contracts with Medicare. In 2006, Medicare Advantage plan choices were expanded to include regional preferred provider organization plans (PPOs). MMA 2003 created regional PPOs, or RPPOs, which helped ensure that beneficiaries in rural areas as well as urban areas would have multiple choices of Medicare health coverage.
-Medicare Prescription Drug Coverage (Part D)

Original Medicare

Most people have both Medicare Part A and Medicare Part B coverage. This is called Original Medicare. This combination provides all the hospital and medical coverage that is available under Medicare. The two parts of the Medicare program are intended to work together to give participants a broad range of coverage, although it is not total coverage. Medicare Part A and Part B are responsible for different types of expenses; they are also subject to different types of deductibles, co-payments, and other benefit limitations. In reality, it is as if the insured were covered by two different insurance companies, or a third, if you consider Medicare Advantage.

For Medicare to cover medical care, it must be medically necessary or considered appropriate for the treatment of an insured's medical condition based on the usual standards applied by the health care profession. This determination is usually made by the attending physician but is subject to approval by Medicare. Usually Medicare will not pay for any care that is not considered mainstream or medically proven to be beneficial. Most alternative types of health care, such as acupuncture, are not covered.

Experimental procedures generally are not covered either. If Medicare refuses to pay for something because they judge it not medically necessary or consider it experimental, then the insured has the right to appeal the decision.

Medicare Part A—Hospital Insurance

Medicare Part A benefits are also referred to as Medicare Hospital Insurance, which is the basic coverage that all Medicare recipients have. Part A is financed directly through Social Security taxes. The funds are withheld from a worker's paycheck and forwarded to Medicare. Since its inception, the "pay ahead" funds have been deposited in what is known as the hospital insurance or HI trust fund. The HI fund has been heavily utilized over the last decade, and several major government arms, including the Social Security and Medicare Board of Trustees, have repeatedly warned Congress of a total depletion of the fund sometime before 2030 unless significant changes are made to Medicare Part A.

Part A helps pay for four kinds of medically necessary hospitalization as defined by the CMS:

-Inpatient care in a general or psychiatric hospital
-Inpatient care in a skilled nursing facility
-Home health care
-Hospice care

Part A does not pay for the doctors who attend the patient under Medicare while in the hospital, or for specialists such as anesthesiologists, psychiatrists, or surgeons. Instead, Part B covers these costs. Nor does Part A pay for long-term care such as that provided in a nursing home or intermediate care facility.

If a patient is not admitted as an inpatient to a hospital, the claim becomes a Part B claim, indicating an "observation" or outpatient coding.

Hospital Admission

During an approved hospital admission, Medicare will help pay for the following inpatient hospital services:

-Semi-private room (two or more beds)
-Meals received in the hospital, including any special dietary requirement
-General medical and surgical nursing care
-Special unit nursing care (intensive care, cardiac care)
-Rehabilitation services, such as physical therapy
-Prescription drugs (provided and/or administered in the hospital)
-Medical supplies
-Lab tests
-X-rays and radiotherapy
-Blood transfusions, except for the first three pints
-Operating and recovery room charges
-Other medically necessary services and supplies

For an expense to be covered by Medicare Part A, the following must apply:

-A physician must prescribe the care, and the patient must be coded as "admitted."
-The treatment can only be provided in a hospital.
-The hospital must participate in the Medicare program.
-The treatment cannot have been denied by a quality improvement organization (QIO) or Medicare intermediary.

No Limit on Number of Benefit Periods

There is no lifetime limit on the number of benefit periods allowed for each Medicare recipient. Within each benefit period of 60 days, the insured is responsible for a Part A deductible, which is $1,408 in 2020. There is no coinsurance for days 1 to 60. For days 61 to 90, Medicare pays all but $352 per day (in 2020). From the 91st day and beyond, Medicare pays all but $704 per day (in

2020). During this latter period, the patient must use his or her 60 lifetime reserve days. Once the lifetime reserve days are used, the patient (or the patient's Medicare supplement policy, or Medicare Advantage policy) is responsible for any additional days. After a period of 365 days, the patient is responsible for all charges.

The Prospective Payment System (PPS) and Diagnostic Related Groups (DRGs)
As hospital charges grew at unprecedented rates during the 1970s and 1980s, Medicare agencies saw a need to change the way in which hospital bills were handled and redesigned the process of paying for Medicare-approved hospital stays.

To contain hospital Medicare costs, and because of the geographic and demographic variation in hospital charges, a new type of system was instituted by Medicare—the prospective payment system (PPS). PPS involves paying a hospital a preset amount for a certain number of days of care for each diagnosis rather than each hospital submitting bills for a patient's stay. This saves Medicare and hospitals a great deal of manpower and time, because there is not a system of passing bills and payments back and forth.

Hospital payments are based on a formula called diagnostic related groups, or DRGs. DRGs are a system of coding hospital procedures or services. During the first few years of employing the DRG classification system, there were approximately 700 defined DRG codes. By 2014, that number increased to over 100,000 codes because CMS determined that more specific codes related to each malady or injury were needed. By October 1, 2015, that number increased to 140,000 because of Medicare's requirement for another updated installation of a program known as ICD-10. (It is expected that the number of codes will decrease to 78,000 at some point in 2020, with ICD-11.)

Medicare allows a hospital a certain predetermined payment for diagnoses within certain diagnostic groups. For example, the DRG system allows eight days of hospitalization for a broken hip. Moreover, the payment is predetermined by CMS per zip code in the U.S. for that diagnosis and is paid to the hospital regardless of whether the patient is hospitalized for the duration of the fixed number of days allowed by the particular DRG. Some patients are discharged from the hospital before the full number of days the code allows has passed, and some stay longer. Regardless, the hospital is paid for the predetermined number of days the code allows.

Knowing that some patients would not be fully recovered to return home after certain hospital procedures—surgery, stroke, lingering sickness, etc.—but also knowing that the patient did not really need expensive hospital care, the trade-off was in transferring the patient to skilled nursing facilities to receive skilled nursing care. Thus, using the DRG system spurred an incredibly rapid growth in the nursing home industry, as terminology such as extended care, swing units, and skilled care facilities became commonplace. What was originally intended as a cost-saving measure to get people out of expensive hospital beds became costly itself, as people now were forwarded to expensive nursing home beds (although these were not as expensive as hospital beds).

In short, the implementation of the Prospective Payment System and the Diagnostic Related Group codes spawned a new growth industry—that of skilled care and skilled nursing facility care.

Skilled Nursing Facility (SNF) Care Covered by the Original Medicare Plan
Skilled care in a skilled nursing facility is not considered the same as custodial care in nursing homes, assisted care facilities, or intermediate care facilities, although one location may incorporate all three types of services. Skilled nursing facilities can be part of a hospital complex or entirely separate.

A skilled nursing facility offers nursing and/or rehabilitation services that are medically necessary to a patient's recovery. The services provided are not custodial in nature. Custodial services are

those that assist a patient with personal needs, such as dressing, eating, bathing, and getting in and out of bed. Medicare does not pay for these and similar services. An exception is when these services are included as part of the necessary daily medical care being provided on an inpatient basis, where they are a routine and necessary adjunct to the medical care. By contrast, skilled nursing care includes services such as intravenous injections, tube feeding, administering oxygen, and changing sterile dressings on a wound. Any service that could be safely done by a nonmedical person (or the insured him- or herself) without the supervision of a registered nurse is not considered skilled care.

In a skilled nursing facility approved by Medicare, for skilled care only, Medicare covers the following:

-A semiprivate room (two or more beds to a room)
-Meals, including special dietary requirements
-Rehabilitation services, such as physical, speech-language, and occupational therapy
-Administration of prescription drugs and intravenous injections
-Other medically necessary services, equipment, and supplies used in the facility
-Skilled nursing care
-Medical social services—help with care needs, including activities of daily living
-Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that are not availed at the SNF

To be covered, the patient must:

-Require daily skilled care that can only be provided as an inpatient in this type of facility
-Be certified by a doctor or appropriate medical professional as requiring these services on a daily inpatient basis
-Have been a hospital inpatient (as opposed to being in the hospital for observation) for at least three consecutive days (not counting the day the patient is released) before being admitted to the skilled nursing facility
-Be treated for the same illness or condition for which he or she was a patient in the hospital
-Be admitted within 30 days of discharge from the hospital

Coverage in a skilled nursing facility is limited to a maximum of 100 days per benefit period. Under the Original Medicare program, the first 20 days are paid for, with no deductible or coinsurance. However, the patient is then responsible for daily co-payments after the twentieth day. The patient (or his or her insurance company) must be alerted that these daily co-payments are sizeable and should not be taken lightly. They really amount to deductibles. For 2020, the daily SNF co-payment was $176 for days 21 through 100.

Limited SNF Coverage

With respect to Medicare's coverage for SNF care, people must understand that Original Medicare pays only for skilled care and will pay the full amount for the first 20 days only.

From the twenty-first to the one-hundredth day of skilled care only, the daily co-payment has grown each year in the same way that the Part A deductible has grown. Medicare Advantage plans will differ in the benefit payments allowed, and some may not require hospitalization. Moreover, Medicare supplement policies that include an SNF care benefit only cover what Medicare covers—and that is skilled care only. Again, SNF care must be related to a hospital admission of at least three days, not counting the day of dismissal. Patients who are admitted to a hospital for observation may find that any follow-up care or treatment in a skilled nursing facility will not be covered by Medicare.

Admitted vs. Observation Status

The "admitted" vs. "observation" status has surfaced as a serious issue for people who, upon leaving a hospital, learn that they were not "admitted" and thus do not qualify for the skilled care benefit. In 2009, this predicament happened to over a million people. By 2011, the number had grown to 1.4 million people, and by 2012, 1.8 million people were impacted. The problem may become worse as Medicare tightens its rules regarding admittance versus observation. CMS provides lesser payment to hospitals for an "observational" stay, making it a Part B function as opposed to an "admitted" stay, and it has been particularly mindful of "upcoding" by hospitals in order to receive higher payments. The patient is caught in a precarious state, not knowing if he or she will receive the skilled care benefit.

MOON Notice
In one of the most subtle, yet significant, measures that CMS has announced in years, the agency instituted what has become known as the "MOON" notice. Prior to October 1, 2016, hospitals did not have to inform patients that they were coded as being "observational" in the hospital, rather than being "admitted." Since millions of people over the years have complained about not knowing they were not admitted (and thereby losing the extended care benefits of skilled care in an SNF), Medicare adopted the "Medicare Outpatient Observation Notice" (MOON), and now requires that hospitals provide a notice to any patient staying longer than 24 hours in the facility if he or she were coded as "observational" and why.

The start date of delivering the MOON notice to patients was October 1, 2016. Patients or their representative must sign the notice, and the hospital must verify that it was given.

The "admitted" versus "observational" hospital stay problem still continues, despite implementation of the MOON notice. One troublesome issue remains the standards by which hospitals determine admitted or observational status for patients.

Home Health Care Covered Under Part A
Home health care services are provided through licensed public or private organizations that are Medicare-approved. The services are generally provided by a visiting nurse or a home health care aide and are medically necessary services, not personal care or housekeeping services. Medicare approval of the home health care agency means that the organization meets certain Medicare standards necessary for reimbursement. It does not signify any type of warranty of the individuals performing the services.

Many people confuse the term "home health care" with the term "home care." They are two different things, with two different meanings. Home care means services of a personal (nonskilled) care provider for assistance with activities of daily living (such as eating, bathing, dressing, continence, and transferring from a bed or chair) or incidental activities of daily living (such as housekeeping, laundry, bill-paying, grocery shopping, etc.). In contrast, home health care addresses the needs of an individual for professional care: that of a registered nurse, licensed practical nurse, physical therapist, speech therapist, occupational therapist, or doctor for medically necessary in-home visits.

An easy way to remember the distinction is as follows: home care means personal services; home health care means professional services. Medicare covers home health care; it does not cover home care.

Covered Home Health Care Services
The following types of home health care services are available:

-Part-time or intermittent skilled nursing services (registered and practical nurses)
-Physical therapy
-Speech language pathology therapy
-Occupational therapy

-Home health-aide services—A home health aide does not have a nursing license but serves to support any services that the skilled care nurse provides. Medicare covers home health-aide services only if the patient is also getting skilled care, such as nursing care or other therapy. The home health-aide services must be part of the plan of care to qualify for home care for the patient's illness or injury.
-Other medically necessary services for ongoing care
-Medical social services
-Durable medical equipment (such as hospital beds and wheelchairs) at 80 percent of their cost
-Certain medical supplies, such as wound dressings

Medicare does not pay for the following:

-24-hour-per-day care at home
-Meals delivered to the home
-Homemaker services like shopping, cleaning, and laundry
-Personal care given by home health aides (like bathing, using the toilet, or help in getting dressed) when this is the only care needed

The only home health care covered under Part A must be associated with inpatient hospitalization or a skilled nursing facility care. In addition, the duration of home health care coverage is limited to 100 days.

Qualifying for Home Health Care Payments
To qualify for Medicare home health care payments, the following requirements must be met:

-The patient must be confined to the home (homebound). Reasonable allowance is made for trips to a barber, beautician, visits to family members, or church services.
-A physician must certify the medical necessity and must prescribe the program of care (plan of care).
-The services must be provided by a participating Medicare-approved home health care organization.
-The patient must need at least one of the following:
    -intermittent skilled nursing care
    -physical therapy
    -speech language pathology or occupational therapy services

The maximum number of visits per week and the maximum number of hours per day that a patient can receive skilled nursing services and home health-aide service do have limitations. The patient pays no deductible or coinsurance for home health care services but has a co-payment of 20 percent of the Medicare-approved amount for durable medical equipment.

Hospitalization for Mental Health Care Under Part A
Payment for inpatient mental health care is limited, but during the course of covered treatment, the types of charges allowed are similar to those of a regular hospital inpatient stay.

Medicare coverage for inpatient mental health care covers the following:

-Semiprivate room (two or more beds)
-Meals received in the hospital, including any special dietary requirements
-Nursing care
-Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy
-Prescription drugs dispensed during the hospital stay
-Medical supplies

-Lab tests
-X-rays and radiotherapy
-Blood transfusions, except for the first three pints
-Other medically necessary services and supplies

To be covered:

-A physician must prescribe the care.
-The treatment can only be provided by a hospital, which may be a normal acute care hospital, an inpatient rehabilitation facility, a critical access care hospital, or a long-term care hospital.
-The hospital must participate in the Medicare program.
-The care cannot have been denied by a quality improvement organization (QIO) or Medicare intermediary.

Medicare benefits for treatment in a freestanding psychiatric hospital are limited to a lifetime maximum of 190 days. If an insured receives mental health care in addition to other medical treatment as part of a regular hospital stay, this limitation does not apply. Deductibles and co-payments are the same as for a regular inpatient hospital stay.

Mental Health Care Under Part B
For outpatient Part B mental health services, Medicare had traditionally paid 50 percent of the costs, leaving the patient responsible for the other 50 percent. MIPPA 2008 changed this: beginning in 2010, the coinsurance payment that a patient pays for outpatient mental health services was decreased gradually until it reached 20 percent in 2014. This brings the coinsurance rate for mental health services to the same level as those for other Medicare services. Again, the same requirements for Medicare-approved physicians and facilities apply. (Since 2014, the co-pay for outpatient mental health care is 20 percent for the patient; Medicare pays the remaining 80 percent.)

Medicare will pay for mental health services for conditions such as anxiety or depression on an outpatient basis, including visits with a psychiatrist, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, or clinical social worker, and for substance or alcohol abuse and lab tests. The Part B deductible applies for diagnosis or treatment for visits to a doctor or other health care provider to diagnose the condition or change a prescription. It also applies for outpatient treatment, such as counseling or psychotherapy.

Under Medicare, mental health services include "substance abuse." Substance abuse and addiction, particularly to opioids and other prescription drugs, as well as illegal and illicit drugs, have become a major problem in America, and is prevalent even among Medicare beneficiaries. There has been a great demand on health care providers and insurance companies to combat the abuse. Much of the cost of treatment is relegated to mental health services, which means that Medicare is receiving and paying for a much higher number of drug-related mental health cases than it originally planned for.

Hospice Care
Hospice care is for terminally ill patients—those with fewer than six months to live. Hospice care is covered under Part A. In addition, special provisions of the Medicare Hospice Care program allow for the payment of some expenses not ordinarily covered by Medicare, such as homemaker services. A physician must certify that the patient is terminally ill and has six months to live, but the patient can be recertified for another six months and continue to receive coverage for hospice care.

Hospice care includes the following:

-Physician services
-Nursing care
-Prescription drugs, subject to a nominal co-pay, for symptom control and pain relief
-Medical social services and medical support services
-Home health aide and homemaker services
-Physical therapy
-Occupational therapy
-Speech therapy
-Dietary and other counseling
-Short-term respite care of up to five consecutive days (Inpatient respite care allows time off for the person who regularly provides care in the home. The patient pays 5 percent of the Medicare-approved amount for inpatient respite care.)
-Medical supplies and certain durable medical equipment
-Spiritual and grief counseling
-Drugs and items and services needed for pain relief and symptom management

To qualify for Medicare to pay for hospice care:

-The terminal nature of the patient's illness must be certified by a physician (in a face-to-face interview) and the hospice medical director. The hospice medical team can prescribe care at home or in a Medicare-approved hospice facility and for short-term inpatient stays for pain and symptom management. The hospice certification will be reviewed every 90 days.
-The anticipated life expectancy must be six months or less.
-The patient must choose to use hospice care benefits rather than regular Medicare coverage for the treatment of the terminal illness (the usual Medicare coverage is still available for medical expenses not related to the terminal illness).
-The care must be provided by a hospice care agency that is approved by Medicare.
-A patient's physician must certify the terminal nature of the illness at the beginning of the first 180-day period and again at the beginning of the second 180-day period. If the patient chooses to do so, he or she may discontinue participation in the hospice care program and switch back to regular Medicare coverage.

The hospice care program has no deductibles but does require a co-payment for prescription drugs of $5 per prescription. Inpatient respite care has a co-payment of 5 percent of the Medicare-approved rate. Reimbursement under the hospice provisions applies only to treatment of the terminal illness. Medical treatment for other conditions are paid based on the usual Part A and Part B provisions.

As part of the MIPPA 2008 overhaul of the Medicare supplement array of products, a hospice benefit was added to all Medicare supplement policies as a part of the basic (core) benefits of all supplement policies sold after June 1, 2010.

Part B—Medical Insurance

Medicare Part B, Medical Insurance, is also called voluntary supplementary medical insurance (SMI) and is financed by payments from the federal government through Medicare and by monthly premiums paid by people enrolled in the plan. Part B helps pay for doctor's bills, outpatient services, and other medical services and supplies not covered by Part A. Part B also covers a multitude of preventive services.

It does not matter where medical services are received—at home, in a hospital, in a doctor's office, or in some other medical facility. All costs are subject to the same annual deductible ($198 in 2020) and the same coinsurance payments in any calendar year. The benefit period under Part B is a calendar year benefit period, in contrast to the Part A 60-day benefit period.

Medicare Part B covers the following:

-Outpatient hospital services (Note that coding a hospital stay as "observational" versus "admitted" Will cause the stay to become a Part B claim.)
-Outpatient medical and surgical services and supplies
-Doctor's services (not routine physical exams)
-Outpatient drugs (those received in a doctor's office or hospital outpatient setting)
-X-rays, MRIs, CAT scans, EKGs, lab tests, diagnostic tests, and clinical laboratory services, HIV -Screenings, and pulmonary rehabilitation
-Ambulatory surgery center facility fees for approved procedures and outpatient chemotherapy
-Second surgical opinions and surgical dressing services
-Ambulance transportation for medically necessary services when other transportation would endanger the insured's health
-Breast prostheses after a mastectomy
-Physical therapy
-Occupational therapy
-Speech therapy
-Home health care (costs not covered by Part A) for medically necessary and skilled nursing care or medical social services
-Blood transfusions, except for the first three pints
-Mammograms and Pap tests
-Outpatient mental health services
-Artificial limbs and eyes, prosthetic devices, and their replacement parts
-Arm, leg, and neck braces
-Durable medical equipment (walkers, wheelchairs, oxygen equipment)
-Kidney dialysis, services, and supplies, kidney disease education services, and kidney transplants
-Heart, liver, lung, kidney, pancreas, intestine, bone marrow, and cornea transplants under certain conditions and when performed at Medicare-certified facilities and immunosuppressive drugs
-Medical supplies (surgical dressings and casts)
-One pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens
-Travel outside of the United States with limitations, such as on board a ship within the territorial waters of the United States. Medicare may pay for inpatient care received in a foreign country in certain cases: (1) in case of an emergency, if a foreign hospital is closer than the nearest U.S. hospital; (2) while traveling through Canada en route to Alaska and a Canadian hospital is closer than a U.S. hospital; and (3) if a foreign hospital is closer than a U.S. hospital, regardless of whether an emergency exists
-Urgently needed care

Preventive Care:

-Screening for prostate cancer
-Colorectal cancer screenings and abdominal aortic aneurysm screening
-Mammography and breast exams
-Pap smears and pelvic exams, including cervical and vaginal cancer screening
-Bone-mass density loss
-Flu shots (one per season) and pneumonia inoculations
-Hepatitis B vaccinations
-Diabetes services and supplies and foot exams and treatment for diabetes-related nerve damage
-Certain chiropractic services (subluxation)
-Medical nutrition therapy services
-One-time initial preventive physical exam (the "Welcome to Medicare" benefit) within 12

months of when a person with Medicare first becomes enrolled in Medicare Part B (the Medicare deducible does not apply to this benefit)
-Yearly wellness exam, starting 12 months after the "Welcome to Medicare" exam (there is no deductible or co-pay for this service if it is intended to develop or update a personalized prevention plan based on current health and risk factors)
-Screening blood tests for early detection of cardiovascular diseases
-Diabetes screening tests for people at risk for diabetes and diabetes self-management training
-Alcohol misuse screenings and counseling
-Depression screenings
-HIV screenings
-Nutrition therapy services
-Obesity screenings and counseling
-Sexually transmitted infections screening and counseling
-Some oral anti-cancer drugs and certain drugs for hospice patients and certain durable medical Equipment such as nebulizers or external infusion pumps
-Bone mass measurements
-Glaucoma screening
-Hearing and balance exams
-Services of practitioners such as clinical social workers, physician assistants, and nurse practitioners
-Cardiovascular screenings every five years to test cholesterol, lipid, and triglyceride levels to prevent a heart attack or stroke and outpatient implantable automatic defibrillator surgery
-Cardiac rehabilitation programs
-Vaccinations—shots for flu, pneumococcal pneumonia, hepatitis B
-Tobacco use cessation counseling to stop smoking, if ordered by a doctor

Part B Deductible
As noted, Medicare Part B requires the insured to pay a deductible in each calendar year. This deductible is calculated against the Medicare-approved amount, which can be different from the amount billed by the insured's doctor or other medical provider. After the insured has met the deductible, Medicare pays for 80 percent of the approved charges. The patient is responsible for the remaining 20 percent as a co-payment. (This is where a Medicare supplement plan or a Medicare Advantage plan assists the beneficiary by covering some or all of the deductible and co-payment and coinsurance amounts.) Additionally, the insured is responsible for an additional 15 percent that some physicians may charge. Most of the preventive screening procedures are not subject to the Part B deductible and/or the 20 percent deductible.

What Part B Does Not Cover
Part B does not cover the following:

-Outpatient prescription drugs (For this benefit, Part D Prescription Drug coverage must be purchased)
-Routine physical examinations beyond the annual wellness visits
-Eye glasses (except for one pair of standard frames after cataract surgery)
-Custodial care
-Dental care
-Dentures
-Routine foot care
-Hearing aids
-Orthopedic shoes
-Acupuncture
-Long-term care

Limiting Charges
In Medicare parlance, physicians and other providers are either "participating" or "nonparticipating." A participating physician or provider is one who has agreed to accept Medicare's assigned allowance as payment in full for all services delivered to a Medicare beneficiary. (This is referred to as "accepting assignment," meaning that a physician will accept the 80 percent paid by Medicare and the 20 percent paid by the beneficiary.) A nonparticipating physician or provider is one who can choose, on a claim-by-claim basis, whether or not to accept assignment. Nonparticipating physicians can charge a patient more than the Medicare-approved amount, but only up to a limit: 115 percent—that is, 15 percent more—of the Medicare allowable amount that nonparticipating providers are paid.

Rates

Each January 1, Medicare premium rates, deductibles, and coinsurance amounts change. Effective for 2020, the rates were:

-Part A deductible—$1,408 per benefit period
-Hospital coinsurance—$352 a day for days 61 to 90 in each benefit period
-Hospital coinsurance—$704 a day for days 91 to 150 for each lifetime reserve day
-Total of 60 lifetime reserve days—nonrenewable; stays the same
-Skilled nursing facility deductible—$176 per day for days 21 through 100 (for each benefit period)

In 2020, the Part A Hospital Insurance premium was $458 per month for people who have fewer than 30 quarters of Medicare-covered employment.

This Part A premium is paid only by individuals not otherwise eligible for premium-free hospital insurance. In addition, individuals with 30 to 39 quarters of coverage have a Part A premium of $252 (2020).

Part B Premiums and the Hold Harmless Rule
The "standard" monthly premium for Part B coverage for 2019 is $144.60, which most people will pay. The Part B premium has varied in the past few years due to the "hold harmless" rule. This rule ensures that Social Security benefits—from which Part B premiums are taken for most people—will not be reduced from one year to the next due to increases in Part B premiums. Conceivably, this could occur if an annual cost-of-living (COLA) increase in Social Security benefits was very low (or, as has been the case in some past years, 0 percent). This could result in Medicare beneficiaries having their Social Security benefits reduced to pay for increased Medicare premiums.

For any year, if the Social Security COLA is not large enough to cover the full amount of any increase in the Medicare premium, an individual will be "held harmless" and his or her premium increase would be the same as the increase in his or her Social Security benefits.

The hold harmless rule does not apply to:

-Those who are receiving Medicare for the first year
-Those whose incomes exceed certain amounts
-Those whose Medicare premiums are paid by their state's Medicaid program

Part B Premium Increases for High-Income Earners
Medicare Part B premium increases for higher income beneficiaries were included in MMA 2003. This process is known as means testing (income-related) and went into effect in 2007. About 5 percent of current Part B enrollees are subject to higher premium amounts based on their income. The regulations for high-income earners are known as Income Related Monthly Adjustment Amounts (IRMAA). The following are the amounts for 2020:

Part B Premiums for Higher Income Earners (2020)

Single Filers	Joint Filers	Monthly Premium
$87,000 – $109,000	$174,000 – $218,000	$202.40
$109,000 – $136,000	$218,000 – $272,000	$289.20
$136,000 – $163,000	$272,000 – $326,000	$376.00
$163,000 – $500,000	$326,00 - $750,000	$462.70
$500,000 +	$750,000 +	$491.60

Rates are different for beneficiaries who are married but file a separate tax return from their spouses. For these separate filers who have earnings of more than $85,000, the monthly Part B premium in 2020 is as follows:

Part B Premiums for Higher Income Earners
(Married, Filing Separately)

Income	Monthly Premium
$87,000 – $413,000	$462.70
$413,000 +	$491.60

Medicare Part B premiums are deducted from the insured's Social Security, Railroad Retirement, or civil service retirement benefits. If an insured does not receive any of these—for example, if the insured is not yet eligible for or not yet claiming Social Security retirement benefits—Medicare will bill him or her every three months for the Part B premium.

Emergency Services
Emergency services are covered inpatient or outpatient services furnished by a provider who is qualified to furnish emergency services and who is needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

-Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
-Serious impairment to bodily functions
-Serious dysfunction of any bodily organ or part

It is important that the insured notify his or her primary care physician or contracting medical group of an emergency medical condition so that they can be involved in managing the insured's health care, and transfer can be arranged when the insured's medical condition stabilizes. The arrangements will depend on the distance involved to the service area to receive follow-up care through the insured's primary care physician. However, follow-up care will be covered out of the service area as long as the care required continues to meet the definition for either "emergency services" or "urgently needed services."

Producers should understand that admission to an emergency room is not the same as admission

to a hospital. While it is quite possible that a patient in an emergency room will be sent to the hospital, this does not mean that a person is "admitted" to the hospital. Admittance must be done by a hospital doctor, and then the question of whether the individual is admitted or "under observation" may arise.

Medicare pays for ambulance services when an insured must be taken to a hospital or skilled nursing facility, and transportation in any other vehicle would endanger his or her health. Medicare pays for the ambulance mileage to the nearest hospital or skilled nursing facility that provides the services needed. Medicare does not pay for ambulance transportation to a doctor's office. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if the patient needs immediate and rapid ambulance transportation that ground transportation can't provide.

Appeals and Grievances

The Medicare insured has the right to appeal any decision about Medicare services. This is true whether he or she is in Original Medicare, a Medicare Advantage plan, or a Part D plan. If Medicare does not pay for an item or service an insured has been given, or if the insured is not given an item or service that he or she thinks should have been received, then the insured can appeal.

Appeal Rights under the Original Medicare Plan

If insureds are enrolled in the Original Medicare plan, they can file an appeal if they think Medicare should have paid for, or did not pay enough for, an item or service they have received. If they file an appeal, they must ask the doctor or provider for any information related to the bill that might help their case. The appeal rights are printed on the back of the Medicare Summary Notice, which is mailed to the insured from the company that administers claims for Medicare. The notice will also tell insureds why the bill was not paid and what appeal steps they can take.

There are five steps to filing an appeal:

1. Copy the original Medicare Summary Notice (MSN) that shows the item to be appealed.
2. Circle the items in dispute on the notice and write an explanation of the disagreement.
3. Sign and include the phone number and the Medicare number of the patient.
4. Send the copy to the Medicare contractor's address listed on the notice.
5. The appeal must be filed within 60 days of the date the notice is received and must be in writing.

If the patient needs help filing the appeal, they can call 1-800-Medicare, can ask the state Health Insurance Program, or can call the provider to help get a representative appointed to assist during the appeal process.

Appeal Rights under Medicare Advantage Plans

If the insured is in a Medicare Advantage managed care plan, he or she can file an appeal if the plan will not pay for, does not allow, or stops a service that the insured thinks should be covered or provided. If an insured thinks that his or her health could be seriously harmed by waiting for a decision about the service, he or she may ask the plan for what is called a fast decision. The plan must answer the patient within 72 hours.

Further, the Medicare managed care plan must tell the insured in writing how to appeal. After the appeal has been filed, the plan will review its decision. Then, if the plan does not decide in the insured's favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. Insureds should see the plan's membership materials or contact the plan for details about Medicare appeal rights. The insured may also contact Medicare to order a copy of "Medicare Appeals."

If insureds have concerns or problems with their plan that are not about payment or service requests, they have a right to file a complaint. In addition, if a person has received a denial regarding a Part D matter, he or she can call the toll-free Medicare number (or visit Medicare's website) and institute a single appeals process.

There are actually five levels to a complete appeal process. The first level is as described above; the second level (in case of a denial) is to appeal to an outside Independent Review Organization; the third level is to appeal to an Administrative Law Judge; the fourth level is an appeal to a Medicare Review Council; the fifth level is to initiate civil action, to be heard in a federal district court.

The Insured Is Protected While in the Hospital
Whether the insured is in the Original Medicare plan or in a Medicare Advantage plan, he or she is protected while in the hospital. If the insured is admitted to a Medicare participating hospital, he or she should be given a copy of "An Important Message from Medicare." It explains the rights of the hospital patient. If insureds have not been given this document, they should ask for it. However, hospitals must now present the document to the patient within 48 hours of admission.

The message contains the following information:

-"You have the right to get all of the hospital care that you need, and any follow-up care after you leave the hospital."
-"What to do if you think the hospital is making you leave too soon."
-"If you have questions about this, call the Quality Improvement Organization (QIO). [Their number is on the message.] You may be able to stay in the hospital at no charge while they review your case. The hospital cannot force you to leave before the QIO makes a decision."

Other Medicare Insured Rights
In addition to the appeals and rights just listed, insureds can appeal their Medicare Prescription Drug plan's decisions. Written explanations, exceptions, and coverage determination instructions are available in the "Medicare and You" booklet distributed each year to recipients by CMS.

Other Medicare rights are to:

-Get information and have questions about Medicare answered
-Get emergency room or urgently needed care services
-See doctors, specialists (including women's health specialists)
-Participate in treatment decisions
-Know treatment choices
-Get information in a culturally acceptable manner in certain circumstances, and get information in an understandable way from Medicare and health care providers
file complaints (grievances), such as quality of care complaints
-Not be discriminated against
-Have the right to privacy in personal and health information

Medicare as Secondary Payor—Coordination with Group Health Insurance
Medicare as a secondary payor and/or in coordination with retiree group health plans was addressed in MMA 2003, not only with respect to Medicare Advantage plans, but particularly as to how the Part D benefits of Medicare coordinate with existing employee (retiree) group health plans. The objective of MMA 2003 was to allow retirees with existing prescription drug benefits of the group plans (which may have been as good as or better than Part D) to stay in these plans and not switch to a stand-alone Part D plan or a Medicare Advantage plan. Employers, on the other hand, were seeking ways to cut the expenses of Medicare-age retirees in group health plans; each year since 2006, they have been removing age 65+ retirees from their group health

plans. Many large employers have moved these retirees to group Medicare Advantage plans or group Medicare supplement plans.

Some people who have Medicare have other insurance (not including Medicare supplement policies), such as employer-sponsored group health insurance for the beneficiary or a spouse. The employee may still be working and want to continue to work, or the employee may be retired.

Order of Payment
When a person is covered by both Medicare and an employer-sponsored group plan, questions may arise regarding which plan provides primary and/or secondary coverage. The order of payment depends on the size of the employer group—whether it is over or under 20 employees. If an employer has less than 20 covered employees, Medicare becomes the primary payor and the group's health insurance becomes the secondary payor. If the group has 20 or more employees, the group health insurance becomes the primary payor and Medicare becomes the secondary payor. Agents are sometimes asked questions about the best advice to give to an employee with respect to enrolling in Part A and Part B. Here are some helpful scenarios:

-Even if still working, an employee is eligible for Medicare Part A and Part B if the employee is 65 or older and has earned the qualifying 40 quarters of coverage. (Do not confuse this with an application for Social Security—the employee may wish to continue working and not apply for Social Security retirement benefits yet.) Because they are two different programs, enrolling in Part A of Medicare has nothing to do with receiving or not receiving Social Security or Railroad Retirement benefits. The employee would be eligible for Part A regardless of whether he or she chooses to begin receiving Social Security or Railroad Retirement benefits. Also, the employee may be covered by his or her own or spouse's group health insurance plan.

-Acceptance or rejection of Part B is a different matter. As noted earlier, if the employee is covered by a group plan, the size of the group dictates which payor—the group plan or Medicare—is the primary payor. For employers with 20 or more employees, the group plan is the primary payor for those who are entitled to Medicare. For employers with fewer than 20 employees, Medicare is the primary payor for enrollees who are entitled to Medicare.

Thus, for those who are part of an employer plan with fewer than 20 employees, rejecting Part B might make sense because Medicare would be the primary payor, and the employee would be paying for the Part B premium as well as perhaps part of the group insurance premium. Because a year's premiums for Part B will be substantial compared to the Part B deductible and coinsurance, this might not constitute prudent use of dollars, considering that the group health plan will be paying a substantial part of the bill. In any event, the employee may sign up for Part B at any time during employment or within eight months after leaving employment (or the group health plan) without penalty.

-If an employee is in a group of 20 or more employees, signing up for Part B may make sense given the group plan's coinsurance requirement and deductibles, which may be quite high. Because the group health plan would be primary, the remaining amount of a Part B claim could well be covered by the secondary payor—Medicare—and may make the premiums spent for the purchase of Part B very worthwhile.

-If the employee is covered by a spouse's group health plan, the employee should consult his or her employee benefits or human resources director (or that of the spouse) for advice on whether to utilize Medicare in combination with the employer's (or spouse's employer's) health plan. In some cases, the employer may require the employee to enroll in Part B before the group health insurance will pay.

-The secondary payor pays only if there are costs the primary payor didn't pay.
Keep in mind that even if a person has both Medicare and employer-sponsored group coverage,

not all of his or her health care costs may be covered.

-Delaying enrollment in Medicare due to coverage under an employer's plan could affect enrollment in Part D. Those who want prescription drug coverage under Part D must enroll in a Part D plan within a certain time after becoming eligible for Medicare; delaying Part D enrollment could result in a permanent surcharge penalty on Part D premiums. However, the penalty can be avoided if an individual has creditable coverage, such as through an employer-provided plan. For employer-provided or union-provided drug coverage to be considered "creditable," its actuarial value must at least equal the actuarial value of basic Part D coverage. Medicare will make the determination as to whether a person's previous group coverage was "creditable" or not.

Employees can also be covered by Medicare if they are under age 65 and they:

-Have Medicare because of permanent kidney failure
-Have an illness or injury covered under workers' compensation, the federal black lung program, no-fault insurance, or any liability insurance
-Have been certified by Social Security as disabled prior to age 65

If the insured matches any of these descriptions and he or she has other insurance along with Medicare, then the other insurance will often be the first payor on his or her health claims, and Medicare will be secondary. Insureds should tell their doctors, hospitals, and all other service providers about their other insurance. Their claims can then be sent to the right insurer first. In such cases, he or she will only receive benefits that the employer group plan does not cover but that Medicare will cover. A special rule applies if the insured has or develops end-stage renal disease (ESRD).

If a person has any no-fault or liability insurance (or payment from a liable third party) available to him or her, then benefits under that plan (or from that liable third party) must be applied to the costs of health care covered by that plan. Where Medicare has provided benefits, and a judgment or a settlement is made with a no-fault or liability insurer (or liable third party), the person must reimburse Medicare. However, his or her reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers' compensation for treatment of a work-related illness or injury should also be applied to covered health care costs by this plan.

If the person has or develops ESRD and is covered under an employer group plan, he or she must use the benefits of that plan for the first 30 months after becoming eligible for Medicare. ESRD Medicare is the primary payor after this coordination period. However, if the person's employer group plan coverage was secondary to Medicare when he or she developed ESRD because it was not based on current employment as described previously, then Medicare continues to be the primary payor.

Chapter 4 Medicare Advantage & Part D

Coverage under Medicare is similar to that provided by private insurance companies: it pays a portion of the cost of medical care. Often, deductibles and coinsurance (partial payment of initial and subsequent costs) are required of the beneficiary, thus the need for additional insurance coverage.

Part A of Medicare is financed largely through federal payroll taxes paid into Social Security by employers and employees. Part B is financed by monthly premiums paid by Medicare beneficiaries and by general revenues from the federal government. In addition, Medicare beneficiaries themselves share the cost of the program through co-payments and deductibles that are required for many of the services covered under both Parts A and B. Thus, the beneficiary can choose how to receive care.

A beneficiary can also choose to receive Medicare coverage and care through a Medicare Advantage plan by filing an enrollment form. Once the choice is made, the beneficiary generally must receive all of his or her care through the plan to receive Medicare coverage. Beneficiaries can also change their minds, disenroll from their Medicare Advantage plans, and return to Original Medicare.

Medicare Part C - Medicare Advantage

Under the Balanced Budget Act of 1997, Congress passed a law that made many changes in the Medicare program. This law included a section called Medicare+Choice (renamed Medicare Advantage, or MA, in 2003) that created new health plan options called Part C. A person enrolled in a Part C Medicare Advantage plan is still assured all of the basic benefits of Original Medicare—Parts A and B. In addition, Part C helps cover preventive care services to help the insured stay healthy at no extra cost and several MA health plan choices.

Medicare+Choice expanded options for receiving Medicare coverage through a variety of managed care plans, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs), and through new mechanisms such as Medicare medical savings accounts. The Medicare Modernization Act of 2003 changed the name of Medicare+Choice to Medicare Advantage (MA).

To be eligible for the Medicare Advantage choices, an insured must have Medicare Part A (Hospital Insurance), and/or be eligible for Medicare Part B (Medical Insurance), and must not have end-stage renal disease. The choice of plans is up to each individual. No matter what an insured decides, he or she will still be in the Medicare program and will receive all the Medicare-covered services.

Medicare Advantage provides an alternative way for beneficiaries to receive and pay for Medicare coverage, services, and benefits. Essentially, it combines into a single plan the payment for the costs for an individual's Medicare coverage with the delivery of the Medicare services and benefits. Medicare Advantage plans are offered by private insurance companies that contract with hospitals, physicians, and health care service providers. All Medicare Advantage plans must cover all of the benefits of traditional Medicare Parts A and B; they may also offer additional benefits. MA enrollees are actually considered outside of traditional Medicare; therefore, when they go to a provider, they present their Medicare Advantage ID card rather than their red, white, and blue Medicare card.

Growth of Medicare Advantage Plans

Since its inception in 1965, Medicare has provided a set of coverage and due-process protections so that all beneficiaries could expect the same basic level of health insurance. As a consequence, all beneficiaries—rich or poor, well or sick—had a common interest in making the program work. This system resulted in the evolution of an imperfect, but functional, basic health insurance program for all people age 65 and over and those under age 65 who are disabled or suffering from end-stage renal disease. But, as time progressed and medical expenses rose far above normal inflationary rates, the program became extremely expensive. Thus, in reaction to rising costs, and in an attempt to curb them, Congress and Medicare developed Medicare Part C.

During the late 1990s, an increasing number of Medicare beneficiaries transferred their health needs to managed care plans. The Medicare managed care benefit was different from the traditional Original Medicare fee-for-service ongoing plan, but basic coverage generally remained the same. Some Medicare Advantage plans (HMOs and PPOs) permit beneficiaries to go directly to a specialized care provider, with the plan's approval, in return for payment of an extra charge. Others, such as private fee-for-service plans, have no requirement as to specific providers, although the providers must agree to accept the PFFS plan, and that factor may create a complication for the enrollee.

The methods for delivering and financing health care are in flux for all Americans. Medicare Advantage plans sometimes change their benefit packages due to certain circumstances, usually financial.

However, the growth of Medicare Advantage plans over the years of the program's revival has been overwhelming. From its inception in 1999 through 2017, the enrollment in Medicare Advantage had grown to over 21 million Americans. This is a significant trend, considering the head-start Medicare supplement had on additional Medicare coverage.

Medicare Advantage Options

Under Medicare Advantage, a Medicare beneficiary can choose to remain in his or her current managed care plan, or choose to receive Medicare covered services through any of the additional following types of health insurance plans. However, no matter which plan or type of plan the beneficiary chooses, he or she must be eligible for and maintain both Medicare Part A and Medicare Part B (i.e., pay the monthly Part B premiums to Medicare).

Producers should understand that a Medicare Advantage product or plan they represent may include a number of options with regard to three specific elements: the deductible, co-payments, and coinsurance. A plan's deductible is typically a fixed amount, though some plans may not require a deductible. A plan's co-payment, or "co-pay," is a set dollar amount that a plan participant pays to the provider of a covered service. A coinsurance amount is a percentage of the cost of the service provided that the insured is responsible for paying. Coinsurance amounts are typically 20 percent: the insured pays 20 percent of the cost and the plan pays 80 percent of the cost.

Coordinated Care Plans (CCPs)

Coordinated care plans (CCPs) are managed care plans that include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and regional PPOs. They provide coverage for health care services with or without a point-of-service option (the ability to use the plan or out-of-plan health care providers). Some plans limit the enrollee's choice of providers. Others may offer benefits, such as prescription drug coverage, in addition to those in the traditional Medicare program. Other plans limit the choice of providers and supplemental benefits. It is very important for the Medicare enrollee to analyze the coverage details, advantages, and disadvantages of each plan.

The enrollee should also be aware that there are basically two types of Medicare Advantage plans:

-Network
-Non-network

Network plans offer care to enrollees through their network of physicians and hospitals and are identified as HMOs and PPOs. The non-network MA plan is a personal fee-for-service (PFFS) plan that (until 2011) did not require the enrollee to see a certain doctor or hospital, though the doctor or hospital they did choose had to be willing to accept the PFFS plan's payment structure. However, due to a later compliance ruling, non-network PFFS plans have largely disappeared from the Medicare Advantage scene.

In 2006, Medicare Advantage plan choices were expanded to include regional preferred provider organization plans (RPPOs). Regional PPOs help ensure that beneficiaries in rural and urban areas have multiple choices of Medicare Advantage health coverage. The PPO is a Medicare Advantage plan in which recipients use doctors, hospitals, and providers that belong to the network. The recipient can use doctors, hospitals, and providers outside of the network for an additional cost—a larger co-pay or coinsurance.

Before 2005, HMOs accounted for 80 percent of CCP contracts and 98 percent of CCP enrollments.

CCPs continue to be highly utilized for delivering Medicare Advantage plans.

Following are the various Medicare Advantage plans in order of preference by utilization.

Health Maintenance Organizations (HMOs) With or Without Point-of-Service (POS)
A Medicare Advantage HMO plan is composed of its own network of doctors and hospitals that enrollees must use for most services. The enrollee must see the network primary care doctor and get a referral to see any other health care provider, except in an emergency. If the plan has a point-of-service (POS) option, the enrollee can go out-of-network but will have to pay more for services, possibly even full costs. If the enrollee's doctor leaves the plan, the plan will notify the enrollee, and the enrollee can choose another plan doctor. The cost of Part D is included in the premium paid for the plan. Some HMOs offer extra benefits in their programs. Funding for HMOs comes directly from CMS, per enrollee, per month, and is based on a benchmark allotment formula developed by CMS. HMOs are highly utilized for delivering MA plans.

Preferred Provider Organizations (PPOs)
A Medicare Advantage PPO plan is available in local or regional areas and is offered by a private insurance company. PPOs operate similarly and provide services similar to HMOs in that the enrollee can go outside of the network to receive care, usually at a higher co-pay or coinsurance cost. Regional PPOs were developed in MMA 2003 to enable people in rural areas to access care delivery similar to urban areas. Extra benefits, including Part D, can be offered for an additional premium; however, most Part D benefits are built into plan costs—not charged separately. Funding for PPOs from CMS is similar to that of HMOs.

Provider Sponsored Organizations (PSOs)
PSO plans, like HMOs, are owned and operated by hospitals and doctors that provide most of the services to the beneficiary; however, they're supposedly more user friendly than HMOs.

Private Fee-for-Service (PFFS) Plans
A private fee-for-service (PFFS) plan offers another alternative to Medicare Advantage enrollees. A PFFS plan is one that:

-Reimburses providers, on a fee-for-service basis, at a rate determined by the plan
-Does not vary rates for the providers based upon their particular utilization
-Providers agree to accept the terms and conditions of payment established by the plan and can do so on a case-by-case basis
-Can be utilized by network or non-network providers depending on the locality of the plan

The Medicare program makes capitated payments (fixed amounts per enrollee) to private fee-for-service plans, just as it does to HMOs and PPOs, based upon geographical, regional, and county benchmark payment criteria. These plans do not have to follow the usual Medicare fee limitations. They establish their own rates, without reference to the Medicare Part B reasonable charge or limiting charge restrictions. The rates set by these plans may be higher or lower than those in the traditional Medicare program. Providers under contract with a private fee-for-service plan will be required to accept an amount not to exceed 115 percent of its contracted rate as payment in full for covered services (including any permitted deductibles, coinsurance, co-payments, or balance billing).

However, the provisions of MIPPA 2008 called for changes to private fee-for-service plans in some areas by requiring them to organize networks of providers and to have the same quality improvement programs as local PPOs. Also, the same law required them to demonstrate coordinated care with Medicare and Medicaid in relation to special needs plans (SNPs) for three classes of enrollees: institutional level recipients, dual eligible contracted individuals, and disabling chronic condition individuals. These requirements virtually eliminated PFFS plan flexibility, forcing them to operate in a manner similar to PPO plans; consequently, a number of Medicare Advantage

companies were compelled to discontinue their PFFS plans in certain locations. This, in turn, resulted in nearly 1.6 million enrollees having to switch to PPO or HMO plans or return to Original Medicare and purchase a Medicare supplement policy. The final result is that enrollees must inform providers who are not in a network that they are PFFS plan members before receiving services so that the providers can decide whether to accept the plans terms and conditions to treat a patient on a patient-by-patient and visit-by-visit basis.

Special Needs Plans (SNPs)
SNPs must limit new enrollments to certain sub-populations of beneficiaries. Types of SNPs include:

-Dual eligible SNPs that service beneficiaries eligible for both Medicare and Medicaid (dual eligible)
-Chronic care SNPs that service beneficiaries with certain severe or disabling chronic conditions, such as diabetes
-Institutional SNPs that serve beneficiaries in long-term care facilities within the plan's network as well as beneficiaries living in the community who require an institutional level of care

All SNPs provide Part D Prescription Drug coverage. SNPs were, at one time, somewhat curtailed because abuses occurred where patients were put into SNP plans without developing a plan of care for that patient. Currently, SNP enrollments must abide by the plan-of-care rules.

Cost Plans (1876 Cost Plans)
Cost plans are HMOs that are reimbursed on a cost basis rather than on a capitated (per head) amount like other private health plans. Cost enrollees are allowed to receive care outside of their HMO and have those costs be reimbursed through the traditional fee-for-service system.

Preferred Provider Organization Demonstration Plans (PPO Demo), Private Contracts, and Other Demonstration Plans
These various plans are all technically a part of Medicare Advantage, but due to their limited singularity of purpose, they are not mainstream plans. They are primarily included as MA plans because their beneficiaries have needs outside the scope of Original Medicare.

Medicare Medical Savings Account Plans (MSAs)
Medicare medical savings account plans combine high-deductible MA policies with a medical savings account for medical expenses. Accordingly, MSAs consist of two components:

-A private MA insurance policy with high annual deductibles (as high as $12,000)
-A medical savings account

The MA health insurance policy does not pay covered costs until the deductible (which varies by plan) has been met. The second component of the plan, the medical savings account, comes into play when Medicare deposits money into an account for the enrollee (deposited into the tax-free MMSA account), which can then be used for any health care expenses, including the plan's deductible. Beneficiaries pay for medical bills out-of-pocket for the amounts under the deductible. Tax penalties are imposed for withdrawing money for any reason other than medical.

Religious and Fraternal Benefit Society Plans
Medicare Advantage plans may be offered by religious and fraternal organizations. These organizations are able to restrict enrollment in their plans to their members.

Scope of Coverage

Medicare Advantage plans, except for private contracts, must provide coverage for all services currently available under Medicare Parts A and B. Plans must inform their enrollees about the

availability of hospice care, including whether a Medicare-participating hospice program is located within their service area or whether it is common to refer outside the area.

Plans must pass on to beneficiaries any cost-savings achieved through efficient plan administration in the form of additional benefits. Medicare Advantage plans may offer supplemental benefits, for which a separate premium may or may not be charged, but the separate premium cannot vary among individuals within the plan and must not exceed certain actuarial and community rating requirements. Part D Prescription Drug benefits may or may not be included in the benefits. At least one plan from any MA company must include Part D, except for PFFS plans, whose enrollees can utilize Part D stand-alone products, as well as service in the plan.

Included in the Patient Protection and Affordable Care Act is a provision that prohibits Medicare Advantage plans from charging higher cost sharing than Original Medicare charges for certain covered services such as chemotherapy, dialysis, and skilled nursing care. In addition MA companies are also subject to medical loss ratio scrutiny, which means that 85 percent of all premium monies received by the plan must be distributed to enrollees in the form of plan benefits. This determination will be performed by Medicare's recovery audit contractors (RACs) in the same way Medicare currently tracks payments to hospitals and doctors in Original Medicare fee-for-service.

Recent Changes
For their 2019 (and later) plans, MA companies are now allowed to expand the scope of their coverage and provide several types of non-health related items in their benefit plans. In a "first-ever" decision by Medicare, MA plans can now offer additional benefits that have traditionally been associated with long-term care and long-term care insurance. These benefits can include:

-In-home support services—services performed by a personal care attendant to assist disabled or medically needy individuals with activities of daily living or instrumental activities of daily living. Services must be performed by individuals licensed to provide personal care services, or in a manner that is otherwise consistent with state requirements.

-Home-based palliative care—services not covered by Medicare in the home for palliative care (comfort care) to diminish symptoms of a terminally ill enrollee with a life expectancy of more than six months.

-Transportation for (non-emergency) medical services—transportation to obtain Part A, Part B, Part D, and supplemental benefit items and services. The transportation must be used to accommodate the enrollee's health care needs; it cannot be used for non-medical services, such as buying groceries or running errands.

-Home safety devices and modifications—safety devices to prevent injuries in the home and/or bathroom. The modifications must be non-structural and non-Medicare covered. This benefit can include a home and/or bathroom safety inspection to identify any need for safety devices or modifications.

In order to be covered by the plan, these supplemental benefits must be recommended by a physician or licensed medical professional.

This expansion of allowable benefits and coverages was not announced until mid-2018—too late for most MA companies to make changes to their 2019 plan offerings. It is expected that the inclusion of some of these new benefits in MA plans will be more pronounced in 2020 and later.

The Basics of Medicare Advantage Plans

Eligibility
Generally, a Medicare beneficiary is eligible to enroll in a Medicare Advantage plan if the following two conditions are satisfied:

1.The beneficiary is entitled to Medicare Part A and is enrolled in Medicare Part B as of the effective date of enrollment in the Medicare Advantage plan.
2.The beneficiary lives in the service area covered by the Medicare Advantage plan.

There are some exceptions to the general rule, though, and some other eligibility rules. For example, a Medicare beneficiary is not normally eligible to enroll in the Medicare Advantage plan if he or she has end-stage renal disease (ESRD)—that is, permanent kidney failure that requires regular kidney dialysis or a transplant to maintain life. However, if an individual is already enrolled with the Medicare Advantage organization when he or she develops ESRD, and this individual is still enrolled with the Medicare Advantage organization at the time, he or she can stay in the existing plan or join another plan offered by the same company.

Enrollment Periods
An eligible individual can enroll in the Medicare Advantage plan at the following times:

-Initial election period (IEP)—The IEP is also known as initial coverage enrollment period. The key word is "initial." A person can elect to enroll in a Medicare Advantage plan when he or she first becomes entitled to both Part A and Part B of Medicare. The initial election period begins on the first day of the third month before the date on which he or she is entitled to both Part A and Part B and ends on the last day of the third month after the date that the person became eligible for both parts of Medicare. Three months before, the month of, and three months after, creates a seven-month initial election period. This is the same election period as Medicare itself. Prospects within this initial period do not need to wait for any other enrollment period. Coverage begins on the first day of the enrollee's birth month. For disability enrollees, there is also a seven-month enrollment window from the time the individual starts receiving Medicare disability benefits. annual coordinated election period (ACEP or AEP)—The ACEP or AEP is when Medicare beneficiaries can elect to enroll, drop, or change their enrollment in a Medicare Advantage and/or Part D plan. This period runs from October 15 through December 7 every year. Coverage begins on January 1 of the following year.

-Open enrollment period—The open enrollment period is another period when current Medicare Advantage members can make changes to their enrollments. Prior to 2019, there was an annual Medicare Dis-enrollment Period, which ran from January 1 to February 14 every year. This has been replaced with a different arrangement: Medicare Advantage Open Enrollment. This new period runs from January 1 to March 31 every year, during which time current MA or MAPD enrollees can:

-Enroll in a different MA plan, with or without drug coverage
-Drop their MA plan and return to Original Medicare, Parts A and B
-Sign up for a stand-alone prescription drug plan if they return to Original Medicare

The advantage to the open enrollment period is that those who joined an MA or MAPD plan during the annual election period and find that they don't want that plan now have a 90-day window to drop or switch an MA or MAPD plan, as opposed to 45 days as was the case under the prior dis-enrollment period. Any changes become effective the first month after the plan receives the request.

This new open enrollment period does not apply to those who are enrolled in Original Medicare—that is, Original Medicare enrollees cannot use this period to switch to a Medicare Advantage plan,

nor can they make any changes to their enrollment in an existing prescription drug plan. Insurance companies and producers cannot actively market during this open enrollment period to encourage beneficiaries to switch plans.

-Special election period (SEP)—SEPs are special periods during which a person is permitted to enter into or to discontinue enrollment in a Medicare Advantage plan and change his or her enrollment to another Medicare Advantage plan or return to Original Medicare. The person can enroll in an MA plan if he or she is recently disabled or can begin receiving assistance from Medicaid, and he or she does not have to wait until the October 15 ACEP enrollment period. These circumstances are commonly referred to as "life events." In the event of the following circumstances, a special election period is warranted:

-The MA plan that the member is enrolled in is terminated. This is termed involuntary dis-enrollment, which results in involuntary loss of creditable coverage for the member.

-The enrollee permanently moves out of the service area or continuation area of the MA plan, recently moved into the service area, or recently returned to the United States after having lived permanently outside of the United States.

-The Medicare Advantage company offering the plan violated a material provision of its contract with the enrollee.

-The enrollee meets such other material conditions as CMS may provide, such as an involuntary loss of creditable group coverage, or a delayed enrollment due to an employer's or union's coverage or spouse's employer group health insurance coverage being terminated.

-The individual experienced a recent disability.

-The individual is receiving any assistance from Medicaid. This includes the following:

-Full dual eligible
-Partial dual eligible (Medicare Savings Program enrollees)
-Beneficiaries residing in long-term care facilities

-The individual meets other qualifications relating to long-term facilities, creditable coverage, LIS (low-income subsidy) eligibility or loss of such; loss of Part D coverage; and other circumstances that give CMS discretion to create an SEP.

Dis-enrollments Under the 5-Star Rating System

There is another option for MA dis-enrollment or switching. Medicare uses a "star" rating system for Medicare Advantage and Medicare prescription drug plans to indicate the quality of a plan's performance. All plans are rated on a one- to five-star scale, with one star representing poor performance and five stars representing excellent performance. An enrollee may switch from an existing plan to a five-star plan at any time during the year. However, it's possible that enrollees may not be able to find a five-star plan in their area. Even though the enrollee may make this switch at any time of the year, he or she can only make the selection one time during the year. The new rule applies to Medicare Advantage plans, Medicare Advantage prescription drug plans, and stand-alone prescription drug plans. In addition, a producer who represents a five-star plan is allowed to market that plan any time during the year that the company achieves and continues to maintain the plan's five-star rating.

Voluntary Dis-enrollment

Medicare Advantage plan members can end their membership for any reason. If they want to disenroll, they should write a letter or complete a dis-enrollment form and send it to their plan's Customer Service department. The date of their dis-enrollment will depend on when the plan

receives the written request to disenroll. In general, written requests to disenroll must be received by the Medicare Advantage plan no later than the tenth of the month to be effective the first of the next month. Written requests to disenroll that are received after the tenth of the month will be effective the second month after the request is received.

An exception to this general rule is that dis-enrollment requests received between November 1 and November 10 are usually effective December 1. However, because the month of November is also the annual election period, enrollees can ask for a January 1 effective date.

Even though a person has requested dis-enrollment, he or she must continue to receive all covered services from the contracting medical providers until the date his or her dis-enrollment is effective. The person will be covered by Original Medicare after this unless he or she has joined another Medicare Advantage plan.

Other Voluntary Dis-enrollment Factors
In addition, other factors are involved in voluntary dis-enrollment For instance, suppose a Medicare beneficiary's first Medicare enrollment was in a Medicare Advantage program. Then he or she decides to disenroll from the program and enroll in Original Medicare. Within the first 12 months of coverage, the beneficiary has a 63-day opportunity to purchase any Medicare supplement plan within the scope of the plans that the carrier offers, on a guaranteed basis.

Or, suppose a person originally enrolled in Original Medicare and a Medicare supplement program, and then he or she decided to switch to Medicare Advantage. Then the person decides to switch back to Original Medicare. In this case, the individual may, within 12 months after that decision, go back to Original Medicare and the same Medicare supplement offered by the same MS carrier as before, if the person had been in the Medicare Advantage plan for less than a year.

A problem that may arise involves Part D coverage. If a person decides to use the one-year guarantee to switch out of Medicare Advantage, then CMS rules do not permit him or her to disenroll from the Prescription Drug program. In that case, the person must complete a stand-alone Part D application and mark the "Special Election Period (SEP)" oval that is in the "Office Use Only" portion of the application. CMS will then use the SEP on the Part D application to begin the process for the MA dis-enrollment and return the person to Original Medicare. (This SEP procedure is also available when enrolling in an MA plan when receiving Medicaid assistance or when receiving Medicare disability at any time during the year.)

If individuals want to voluntarily disenroll during the new Medicare Advantage open enrollment period (January 1 to March 31), they may do so by writing or calling their plan or by calling 800-Medicare; however, a written request for dis-enrollment may be required. The MA company must provide a dis-enrollment notice within seven days of receiving the request. If the person wants to return to Original Medicare and obtain a Medicare supplement policy, the Medicare supplement company will require that he or she complete the MA questions on the Medicare supplement application. The company will then require one of the following:

-A copy of the person's MA plan dis-enrollment notice
-A copy of the letter that the person sent to his or her MA plan requesting dis-enrollment, or
-A signed statement verifying that the person has requested to be dis-enrolled from his or her MA plan

If a person dis-enrolls later than the March 31 cutoff date, a copy of his or her MA plan dis-enrollment notice will be necessary.

Moves or Extended Absences
If individuals are permanently moving out of the Medicare Advantage service area or plan an

extended absence, it is important that they notify the provider of the move or extended absence before they leave the service area for a period of more than six months They may be eligible to continue to receive benefits if they are in the plan's continuation or network area.

Failure to notify the Medicare Advantage organization of a permanent move or an extended absence may result in a person's involuntary dis-enrollment from the plan. The plan is required to disenroll a person if he or she permanently moves outside the service area. An absence from the service area of more than 12 months is considered a permanent move. If individuals remain enrolled after a move or extended absence and have not been involuntarily dis-enrolled as described, then they should be aware that services will not be covered unless they are received from a Medicare Advantage plan provider in the Medicare Advantage plan service area (except for emergency services, urgently needed services, out-of-area dialysis, and prior authorized referrals).

Involuntary Dis-enrollment
The Medicare Advantage organization may disenroll an insured from a plan only under the conditions listed below:

-The insured moves permanently out of the service area and does not voluntarily disenroll.

-The insured temporarily moves out of the service area for an uninterrupted absence of more than six months. In cases such as "snow bunnies" who move to a warmer climate in the winter months, enrollees can inform their MA ahead of time that they will temporarily be out of the service area and the MA company will likely accept that information as a reason not to terminate the enrollee.

-The insured's continuation of coverage of Part A is terminated.

-The insured's entitlement to Medicare Part A or enrollment in the Part B benefits ends.

-The insured supplies fraudulent information or makes misrepresentations on his or her individual election form that materially affects the person's eligibility to enroll in a Medicare Advantage plan or Medicare Parts A, B, and D.

-The insured is disruptive, unruly, abusive, or uncooperative with regard to his or her membership in the Medicare Advantage plan, and the behavior seriously impairs the provider's ability to arrange covered services for the person or other individuals enrolled in the plan. Involuntary dis-enrollment on this basis is subject to prior approval by CMS.

-The insured allows another person to use his or her membership card to obtain covered service under Parts A and B.

-The insured fails to pay the plan premiums on a timely basis.

-The insured joins a stand-alone Medicare Prescription Drug plan, unless he or she is in a PFFS plan that does not include Part D coverage, or he or she is in a MSA plan.

-The MA company decides to terminate its plan, which renders the insured involuntarily dis-enrolled

Note that an insured will not be dis-enrolled due to health status. Dis-enrollment on the aforementioned grounds can only occur after the insured has been provided notice with an explanation of the reasons for the dis-enrollment and information on applicable grievance rights. No insured shall be dis-enrolled because of his or her health status or requirements for health care services. Any insured who believes he or she was dis-enrolled by the Medicare Advantage organization because of the insured's health status or requirements for health care services should

bring the matter to the attention of the local CMS regional office.

Premiums and Payments
Enrollment in an MA plan is predicated on the enrollee's payment into the Medicare system. Consequently, enrollees must pay their monthly Medicare Part B premium (as well as Part A if they're not receiving Part A free of charge). Part B premiums are billed through Medicare and typically subtracted from enrollees' monthly Social Security or Railroad Retirement benefits. In addition, enrollees may be charged an additional monthly premium by the MA plan. This is typical if the plan provides benefits outside the scope of Original Medicare, such as prescription drug coverage or dental and vision care.

However, not all MA plans charge an additional premium. Many offer "zero premium plans," through which the plan is able to arrange for lower contracted payments to its providers (hospitals, physicians, etc.) with the savings passed on to the plan's enrollees.

In addition to their premiums, MA enrollees are usually obligated to pay their co-payments and co-insurance charges at the time service is rendered.

Annual Contract
The Medicare Advantage company's contract with CMS is reviewed and renewed annually. At the end of each contract year, the contract can be terminated by either the Medicare Advantage organization or CMS. If the Medicare Advantage organization ends the contract, insureds must receive a minimum 90-day notification before the end of the contract. If CMS ends the contract, insureds must receive a minimum 30-day notification, with an explanation of what their options are at that time. For example, there may be other Medicare Advantage plans in the area for them to join if they wish. Or, they may want to return to Original Medicare and possibly obtain supplemental health insurance. Whether an insured enrolls in another Medicare Advantage plan or not, there would be no gap in Medicare coverage. Until returning to Original Medicare coverage, the insured would still be a member of the Medicare Advantage plan. Important provisions are in place to protect insureds in cases that relate to guaranteed issue of a Medicare supplement policy after returning to Original Medicare.

The implication of annual plan contracting is important for producers to understand and explain to their clients. Because all MA and MAPD and stand-alone Part D plans are on a one-year contract between CMS and the MA-MAPD-PDP company, the provisions of the coverage, the coverage amounts, and plan's drug tiers (as well as the covered drugs themselves) will change from year to year. This is why Medicare advertises notices to remind people to examine their coverage each year and check to see if their plan renewal letters include any changes. Producers must be aware of any changes the companies they represent have made, to ensure their clients will be enrolled in the plan best suited for their needs.

MA Plan Appeals or Grievances
Members of a Medicare Advantage plan are encouraged to notify CMS if they have concerns or experience any problems with their Medicare Advantage plan. They can submit an appeal or grievance to the Medicare Advantage company for review and resolution, but certain procedures must be followed. The insured should begin these appeals and grievances with the Medicare Advantage plan customer relations department. Specific procedures include the following:

-General information on Medicare appeals procedures
-Medicare standard organization determinations and appeals procedures

-Medicare drug plan 72-hour determinations and appeals procedure

-The Medicare Advantage organization grievance procedure

-Quality improvement organization (QIO) immediate review of hospital discharges

-QIO quality of care complaint procedure

After MIPPA 2008, low-income subsidy beneficiaries are now allowed to have the same judicial review rights as other beneficiaries.

Moreover, a member of a Medicare Advantage plan has the right to appeal any decision about payment for or failing to arrange or continue to arrange for what he or she believes are covered services (including non-Medicare covered benefits) under a Medicare Advantage plan. Coverage decisions that are commonly appealed include the following:

-Payment for emergency services, post-stabilization care, or urgently needed services

-Payment for any other health services furnished by a non-contracting medical provider a facility that a person believes should have been arranged for, furnished by, or reimbursed by the Medicare Advantage organization

-Services that a person has not received but that he or she feels the Medicare Advantage organization is responsible for paying or arranging

-Discontinuation of services that he or she believes are medically necessary covered services

-Disagreement with the MA plan's decision regarding pre-authorization for some procedures

Medicare Part D-Prescription Drug Program

With the enactment of MMA 2003, Congress added a completely new coverage option—Medicare Part D—which provides coverage for prescription drugs. In addition to Medicare taking the prescription drug responsibility for low-income beneficiaries from the Medicaid program and transferring it to the Medicare program, Medicare offers prescription drug insurance coverage for Medicare beneficiaries. Plan D is available through "stand-alone" Part D plans or through some Medicare Advantage plans, known as MAPD plans.

Historically, Medicare had not covered outpatient prescription drug costs (except for one year—1989). Then, in 2003, Congress passed and the president signed the Medicare Prescription Drug Improvement and Modernization Act (MMA 2003), which expanded Medicare to include a prescription drug benefit. The prescription drug benefit began in 2006. Medicare (through laws established by Congress) reserves the right to define the care that it will cover, including that which is offered under Part D. In addition, all medical procedures and treatments are subject to Medicare's approval, which is why it is imperative to fully understand the program.

In a 12-page bulletin issued January 21, 2005, CMS released its "Final Rules Implementing the New Medicare Law: A New Prescription Drug Benefit for All Medicare Beneficiaries, Improvements to Medicare Health Plans and Establishing Options for Retirees." The first paragraph of the report summarized the intent of the law, and its content can be used as a starting point for our discussion of the Part D program:

"The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) today issued the final regulations implementing the new prescription drug benefit that will help people with Medicare pay for the drugs they need. This benefit begins in January 2006 and allows all Medicare beneficiaries to sign up for drug coverage through a prescription drug plan or Medicare health plan. The final regulations also provide new protections for retirees who currently receive drug coverage through their employers or unions, and they strengthen the Medicare

Advantage program."

Two significant points contained in this paragraph serve as the focus of our discussion. The first point is ". . . drug coverage through a prescription drug plan or Medicare health plan." This refers to utilization of the "stand-alone" Medicare Part D plan or utilization of a Medicare Advantage plan (to gain prescription drug coverage)—MAPD. The second point, ". . . new protections for retirees who currently receive drug coverage through their employers or unions," refers to the concern that employers would drop retirees from their existing group health insurance because of escalating prescription drug costs. We will address both of these statements separately in a moment.

A second paragraph in the "Final Rules" document summarized the outlook for the new program by stating the following:

"With the enactment of the MMA, and the final rules issued today, Medicare looks more like the rest of the American health care delivery system by giving beneficiaries the option of new, subsidized drug coverage, as well as new support to keep their current retiree coverage secure."

A final paragraph describing the implementation of the Part D plan has significance to both Medicare Advantage plan representatives and Medicare supplement producers:

"The Medicare Prescription Drug benefit: The final rules describe the plan options that beneficiaries will have to obtain their outpatient drug coverage. Prescription drug plans and Medicare Advantage plans will be required to provide basic coverage, but may also offer additional plans with supplemental coverage."

Medicare supplement producers should not confuse this paragraph with Medicare supplement plans—the paragraph addresses prescription drug plans. In this case, that means the prescription drug plans (Part D) that health insurance providers began offering to Medicare recipients beginning January 1, 2006. In other words, private companies (prescription drug providers, or PDPs) offer the Part D plans, and a Part D premium will pay for them; the paragraph does not refer to Medicare supplement companies. At least one Medicare Advantage plan per company was required to have the Part D benefit built into its offerings.

Part D Plan Enrollment
The initial enrollment period for Part D is the same as the initial enrollment period for Medicare: it is the seven-month period that begins three months before the month the individual turns 65, includes the birthday month, and ends three months after the month the individual turns 65.

Late Enrollment Penalty
It is important to note that those who do not take advantage of the initial Part D enrollment period at the time they first become eligible will pay a penalty premium if and when they do later enroll. The penalty is an increase in the premium equal to an additional 1 percent per month (cumulatively) for each month they delay enrollment, unless they could prove creditable coverage from an existing plan, such as an employer-sponsored group health insurance program. The 1 percent is based on the national base benchmark premium for each year ($32.74 for 2020). As an example, currently and in the future, anyone who delays enrollment for three years (36 months) will see a 36 percent additional charge in their monthly premiums. In short, the Part D premiums are surcharged for late enrollees, and the amount charged at the time of enrollment is cumulative. In other words, the additional charge is added in perpetuity.

Why would someone delay enrollment? Suppose an enrollee believes she does not need Part D at age 65, because she feels completely healthy and does not use prescription drugs. Then, at age 78, conditions arise that indicate a need for Part D coverage. The result is a 156 percent premium surcharge for the 156 months of delayed enrollment. The premiums for the Part D coverage alone

can become a financial hardship when the surcharge is added, as can the inflationary increases in the price of the prescription drugs.

The 1 percent per month premium surcharge penalty for late enrollment in a Part D plan is waived if the enrollee had prior "creditable coverage," as might be available under an employer plan, and did not go for more than 63 days without such creditable coverage before enrolling in Part D. For employer-provided or union-provided drug coverage to be considered "creditable," its actuarial value must at least equal the actuarial value of basic Part D coverage. The determination of whether or not the group plan is "creditable" is made by Medicare.

A problem can arise if a person continues his or her group health plan under COBRA because the prescription drug benefits of the group plan may not be considered as creditable—which then could result in the 1 percent per month penalty for late Part D enrollment.

Basic Foundations of Medicare Part D

Title I of MMA 2003 describes the parameters of the act:

-MMA 2003 established a voluntary prescription drug benefit.

-The benefit is for outpatient drug purchases.

-The beneficiary must be enrolled in Part A and/or Part B of Medicare.

-Coverage is available through two options:

1. Stand-alone private prescription drug plans (known as PDPs), which offer drug-only coverage, and the beneficiaries remain in traditional Medicare for their Part A and Part B services

2. Medicare Advantage plans, which offer both prescription drug and health care coverage (known as MAPD plans) and combine or integrate the Part D prescription drug coverages with the coverage for Part A and Part B services

-Another type of Medicare Advantage plan can be offered: a Regional Preferred Provider Organization (Regional PPO) plan. Regional PPOs must follow special rules: (1) they must offer Medicare Part D prescription drug benefits; and (2) they must place a cap on annual beneficiary out-of-pocket expenditures on Medicare cost sharing.

-Every Medicare beneficiary must have access to a prescription drug plan, either through an MAPD plan in his or her region or through a stand-alone PDP.

-Both types of plans (PDP and MAPD) must offer a standard drug benefit but must have the flexibility to vary the drug benefit within actuarial equivalency parameters.

-Assistance with premiums and cost sharing are provided to eligible low-income beneficiaries (this is low-income subsidy, or LIS, also known to Medicare as Extra Help).

-Covered Part D drugs are essentially the same drugs and biologicals that are approved for the Medicaid program. Drugs and biological products that are already paid by Medicare Part A or Part B are not included.

-Covered Part D drugs must be dispensed by a prescription and on an outpatient basis.

Medicare Part D Drug Benefit

Medicare has allowed four modifications to the basic standard plan of Medicare Part D, but these

modifications must follow certain rules regarding construction of benefit packages and cost sharing. These modifications are known as:

-Alternative basic standard plan
-Alternative enhanced plans
-Alternative enhanced plans that offer supplemental prescription drug coverages
-Alternative enhanced plans that offer optional prescription drug coverage

One additional plan, called the fallback plan, can be offered in any region or in a local area of any region where a choice of at least two qualifying plans, one of which is a stand-alone PDP, does not exist. These plans can be offered by Medicare Advantage plans.

The four modification plans have a wide variety of complexities and differences. Only the basic standard plan is discussed here, because it is the basis on which the other variations are built. The basic standard plan is the most commonly described plan and is the foundation of the Part D program. Consider the following facts of the Part D basic plan:

-Part D premiums were originally set at an anticipated benchmark of $37 per month for the basic standard plan, but in actuality, the prescription drug providers obtained lower premiums through bidding for the first year. (Premiums, however, are expected to rise in the future as the costs of certain prescription drugs skyrocket.)

-CMS set the national benchmark premium at $32.74 a month for 2020. The annual deductible in 2020 was set at $435.

Not all MAPD and PDP plans are alike, especially with respect to the formulary (covered drugs and their tier assignments) used by companies. Additional differences will be found in "no deductible" plans and plans that are more expensive but pay through the coverage gap (i.e., the donut hole).

Example: Basic Standard Part D Plan
The following is a simplified outline of the basic standard Part D plan for 2020:

-The enrollee pays the first $435 as a deductible.

-After the enrollee pays the deductible, he or she is in the initial coverage period. During this period, the enrollee pays 25 percent of drug costs, and the plan pays 75 percent, up to a combined amount of $4,020, including the deductible.

-After the initial coverage period, the enrollee then enters the coverage gap. Prior to 2011, 100 percent of prescription drug costs were paid by the insured while he or she was in the coverage gap. Then in 2011, drug manufacturers and Part D insurers began to share a portion of the insured's coverage gap costs in the form of discounts. As of 2020, 75 percent of the cost of generic drugs will be paid by the Part D plan and the brand-name drug manufacturer will assume 75 percent of the costs of brand-name drugs while the insured is in the coverage gap. The insured pays 25 percent. The amount the enrollee and the plan both pay counts as out-of-pocket spending until spending reaches a total of $6,350 at which point the coverage gap ends, and the enrollee is now into catastrophic coverage. (Note that in 2020, the coverage gap still exists but drug companies are required to pick up more of the cost.)

-At the catastrophic coverage point, the enrollee pays either 5 percent or $3.60—whichever is greater—for generic drugs and $8.95 for all other drugs through the end of the year.
Most MAPD or stand-alone PDPs are likely to be very different from the standard basic plan as they are allowed to vary their offerings and provisions from the basic plan. In reality, a producer will probably never see a "standard" plan, because most companies' offerings differ in many ways.

The above only describes the Part D basic standard plan for 2020. But, for most Part D plans, the producer will see several variables, such as no deductible plans (or plans that require a deductible for only higher tiered drug levels). For example, a plan might impose a deductible only for Tiers 4 and 5, and no deductible for Tiers 1, 2, and 3.

Tier 1 – Preferred generic drugs
Tier 2 – Generic drugs
Tier 3 – Preferred brand drugs
Tier 4 – Non-preferred brand drugs
Tier 5 – Specialty drugs

The producer may also see differences in copay amounts between "Preferred Pharmacies" and "Standard Pharmacies," and variations in payments (lesser) for mail-order drugs.

Some Important Considerations for Producers
Producers must remember that not all drugs are included in a plan's formulary, and for plan year 2020, some high-priced drugs have been removed from plan formularies. This situation is particularly evident with respect to high-cost cancer drugs; even the cost of some generic drugs that have been used for years has increased by as much as 1,000 to 5,000 percent. So, a genuine and diligent search of a plan formulary for clients is more important than ever.

Producers must also be aware of changes in the tier structures of a particular drug. In recent years, for example, many of the generic tier 1 and tier 2 drugs were moved into more expensive tier 3 and tier 4 categories.

As with Medicare Advantage plans, CMS's contracts with Part D plans are written on an annual basis. Consequently, premiums, deductibles, co-pays, coinsurance amounts, and donut hole costs paid by the insured may, and probably will, change from year to year.

A Note of Caution Regarding Switching People Out of Group Health Plans
A Medicare Advantage producer must remember, at all costs, not to switch retirees from their group health plan, a spouse's group health plan, or a union health plan to a Medicare Advantage plan without the approval of the human resources department or the group health plan's knowledge. This action may trigger (and has triggered) a loss of the entire package of group health benefits available to the retiree and eliminates any chance of the retiree returning to his or her original group health plan. The same is true for a stand-alone Part D plan. There is a requirement in the MA/MAPD/PDP enrollment process that the producer read the section to the enrollee regarding group employer or union coverage. The producer cannot afford to overlook this requirement because of the damage it may cause the enrollee.

It is important to note that producers should let Medicare Advantage or Part D plan enrollees know that they can receive help paying for their drug costs by contacting the Social Security office or their state or county office on aging or Medicaid to see if they would qualify for "Extra Help."

Medicare's Premiums and Benefits

Premiums
The Medicare Part B premium that enrollees pay is just one part of Medicare—the physician services part of the program. Over time, beneficiaries are going to be asked to pay a larger share of the costs of the program. One reason is that some of the benefits that were covered formerly in Part A were shifted to Part B, such as HHC services. These benefit shifts caused an increase in Part B premiums.

Part B premiums rose because Medicare expanded the Part B program, largely through significant preventive benefit increases and medical care cost inflation. In comparison to Part B premiums of

the late ’90s and early 2000s, significant increases had been the trend. But beginning in 2012, expense factors began to slow down for Medicare, and decreases or premium holding patterns had been the norm from 2012 to 2015. That pattern ceased to exist for 2016, when MedPAC ruled that Part B premiums needed be increased. The lower Part B premium will probably not hold for long as more members of the boomer generation become Medicare recipients.

For many receiving a Social Security monthly check in the $700 to $800 range, the increases in Part B premiums can outstrip the relatively small COLA (cost-of-living adjustment) increases in their Social Security income. Even though the “take-home” amount of the Social Security check is protected by a “floor of protection” (a “hold harmless” provision) that does not allow the benefit amount to decline because of Part B increases, the result is one of no inflation protection for the Social Security recipient in other areas. This is not an insignificant trend for the average retiree.

In 2018, CMS ceased creating anomalies (which had been created by different COLA increases prior to 2018) with different tier levels and settled at a $134 premium for everybody. Then, for 2020, the premium was increased to $144.60. Even though people who are “held harmless” will not see their premium go up to $144.60, all other payers will—including those who are categorized as “High Earners,” who will see far greater increases in their Part B premiums.

Most beneficiaries pay no premiums for Part A, having qualified automatically by Social Security or Railroad Retirement FICA (tax) payments (or “contributions” as the government calls them) during the course of a working lifetime. Only about 1 percent of beneficiaries buy into the system with Part A premium payments, with the amount depending on how many quarters of Social Security or Railroad Retirement coverage they were short. It is important to note that many ideas have been developed to address the fiscal problems of Medicare. Among those ideas is a concept to introduce a Medicare Part A premium, which would be a first for the Medicare program. Also, some thoughts have surfaced to combine Part A and Part B. This is unlikely, because it would require a restructuring of the entire Medicare program.

Benefits and Costs

In the last few years, several cancer screening and other preventive benefits have been added to Medicare. Benefits now include annual mammograms. In years past, Medicare paid for these types of benefits every two years, including cervical cancer screenings and prostate cancer screenings. Benefits now include a diabetes self-management program, which includes education and supplies for diabetics to help them better cope with their disease. With the addition of the annual wellness “prevention” benefits at no cost to the Medicare recipient, the preliminary costs are expected to be greater for Medicare early on but less in the long run, because prevention measures will hopefully minimize the need for greater care later.

Medicare used to be called the “sickness model”: it paid for individuals when they got sick. However, the health care system, in general, is changing, with more emphasis on prevention. Congress has made an effort to create a more comprehensive preventive benefit package for Medicare. MMA 2003 and PPACA 2010, added several further preventive benefits, which were previously discussed.

Expenditures created by taking on the prescription drug obligations of Part D and transferring some 6 million people from Medicaid to Medicare for prescription drug expenditures contributed to a jump in Medicare expenditures starting in 2006. However, in reality, these figures are only a fraction of the problem. The first of the nation’s baby boomers started to collect Medicare benefits in 2011, and by 2030, an additional 78 million will be added to this program.

Expectations were that Medicare expenditures would total around $591 billion for 2013, even though the number of enrollees “only” grew by about 4 million, due to the baby boomers starting to enter the system. By 2018, Medicare recipients totaled over 59 million, and Medicare spending grew to approximately $731 billion according to the Henry J. Kaiser Foundation.2 Four factors

have contributed to this expenditure growth:

-First, the growth of the Medicare population itself created more costs.

-Second, overpayments, fraud, improper payments, and waste had become rampant during the last half of the decade, which were estimated to run as high as $50 billion to $60 billion by 2018.

-A third factor was the large amount of money available to Medicare Advantage and Part D Prescription programs.

-Fourth, the ACA created several layers of "preventive" benefits, covered fully by Medicare with no deductible or co-pay responsibility to the patient.

Medicare's Costs and Payments

Efforts to rein in costs have proved politically difficult. Congress has enacted measures over the past two decades to combat the ever-increasing costs of Medicare by:

-Restructuring hospital payments in 1983 (prospective payment system, DRGs)
-Restructuring physician payments in 1989 (Physicians Reform Act)
-Restructuring payments for home health care, nursing home care, and hospital outpatient care, which are getting to be a larger and larger portion of the Medicare program (OBRA 96, BBA 97, HIPAA 97, MMA 2003, PPACA 2010)
-Restructuring home health care payments (prospective payment system)
creating effective fraud and recovery legislation, which gives CMS and its legal units the ability to pursue overpayments and fraud through several new programs
cutting $117 billion from Medicare Advantage payments as called for in PPACA 2010 (Actually, Medicare Advantage payments increased by a great amount starting in 2016.)
-Introducing "value based care" in 2015, implementing changes in doctor payments for such items as "bundled care," which capitated some costs as opposed to fee-for-service payments

During 2016, Congress passed MACRA (Medicare Access and CHIP Reauthorization Act) that eliminated SGR (Sustainable Growth Rate) rules, which had for 13 years dictated how much doctors were going to be paid, and instituted two new ways that doctors could choose to be paid.

In the past, all health care providers had been paid based on what they charged, and it was found that if they were given the money based on what they charged, they kept increasing their charges. With the aforementioned legislation, Congress voted to no longer do that for hospitals, doctors, home health care agencies, or for nursing homes and hospital outpatient costs. Currently, Medicare pays all providers a certain rate based on a fee-for-service formula for each U.S. zip code. Structured payments, such as those made to Accountable Care Organizations (where groups of health care professionals collaborate to tend to all of a patient's needs), are becoming the modern way of addressing costs. Under such an arrangement, Medicare pays an agreed-upon, per-patient amount, and the ACO providers sort out the distribution of the payment. This structure does not relate to Medicare Advantage plans except for those that utilize ACOs.

In 2015, CMS announced a new system of "value based care," which was to be implemented over the next three years. This will replace the fee-for-service method that has been prevalent since Medicare's inception. Value based care includes Accountable Care Organizations and several other techniques such as "bundled payments." The intent was for 30 percent of Medicare payments to be achieved by the value based technique in 2016, 50 percent in 2017, and 70 percent by 2018. This was an ambitious attempt to get some of Medicare's costs under control, and CMS has indicated that the technique is working to reduce Medicare costs.

The Outlook for Medicare
It is impossible to predict what will transpire with Medicare more than a few years into the future. Several factors, including the impending stampede of baby boomers into Medicare, which started in January 2011, will have more than a considerable impact on this important program. The impact will also be felt by all those under age 65—the majority of the nation's taxpayers:

-The number of Medicare enrollees in 2018 was about three times as many as in 1970.

-Over the same period—1970–2018—Medicare expenditures increased from $7.5 billion to over $700 billion. Whereas enrollments increased 3 times, expenditures increased 93 times. These statistics are eye-opening enough, but they only represent the past. Medicare has increased its own burden, starting about 15 years ago, and has dramatically expanded its promises in the first few years of the twenty-first century. The full impact of benefits brought on by the promises of MMA 2003—Medicare Advantage plans and Medicare Part D—began to show themselves starting in 2006. The full impact of the "no deductible, no co-payment" preventive benefits that were added by PPACA has begun to show itself. These promises will probably continue to manifest in greater costs. When Medicare spending increased by 5.7 percent in 2015, it represented the first time that Medicare expenditures equaled 20 percent of the nation's gross domestic product (GDP).

-The expenditures of Part D, additional income provided to Medicare Advantage plans, the transferring of prescription drug benefits of dual eligibles from Medicaid to Medicare, additional services included in Original Medicare, the subsidies to American companies, outlandish costs for prescription drugs, and general medical care inflation amounts, which are far in excess of corresponding inflationary factors in the general economy, are crippling and, if not corrected, will soon strangle the Medicare program. In fact, the skyrocketing costs of Medicare forced Congress to consider cuts to all Medicare programs during most of 2009, during which time a total health care reform agenda dominated the political scene, and resulted in PPACA 2010.
But, all of these factors are minor compared to what is coming. In addition to the well-advertised baby boomer age wave, Medicare has a myriad of other problems to address. The health ravages of increasing obesity, the unprecedented growth in the rate of diabetes, increases in heart, hypertension, opioid addiction, and cancer diagnoses, extended longevity, and the general health care needs of an increasingly growing elderly population will stretch Medicare expenditures (and expectations) to impossible proportions. Medicare health care demands will be far, far greater than ever before. In fact, the American demand for quality health care may be replaced by the word "triage," as has already happened in hospital emergency procedure wait times.

Congress now understands that it has been warned. Even as it continued to increase benefits, several significant departments of the federal government warned Congress to act to get these promises under control. But Social Security and Medicare are the "third rails" of politics, and a powerful senior block of voters deterred politicians from addressing an honest downsizing of already bloated care packages. Medicare will survive, but only after serious and significant changes are made, and assuming that the nation's younger taxpayers accept the mortgage their parents and grandparents have placed on their futures.

Chapter 5 Medicare Supplement Plans

Though Medicare covers many health care costs, recipients still have to pay Medicare's coinsurance and deductibles, and generally the Part B premiums. Medicare also does not cover certain medical services.

The first of the solutions to Medicare deficiencies is called a "supplement to the Original Medicare plan." Historically, a fully constituted Medicare plan had only two components:

1. Coverage provided by the Original Medicare program through Parts A and B
2. Medicare supplement insurance, also known as Medigap insurance

With the introduction in 1999 of Medicare Part C (Medicare Advantage), another program became available. In this chapter, we'll focus on Medicare supplements to the Original Medicare plan.

Background to Medicare Supplement Plans

While only the government calls a Medicare supplement policy "Medigap," they both mean the same thing. Medicare supplement policies are private insurance plans that help pay a person's Medicare cost-sharing amounts. The initial standardization of Medicare supplement plans in 1993 resulted in ten standard policies: Plans A through J. Each offered a different combination of benefits. MMA 2003 added two more plans, K and L, and eliminated the prescription drug benefits of plans H, I, and J. MMA 2003 also created Medicare Part D and "stand alone" Part D plans (PDPs) and Medicare Advantage plans that include Part D benefits (MAPDs), thereby transferring all prescription drug benefit references to the Part D program. As a result, no new Medicare supplement policies with drug coverage can be sold.

Then, in 2008, the Medicare Improvements for Patients and Providers Act directed CMS to use NAIC plan modeling to implement a revision to the series of Medicare supplement plans. The new modeling resulted in significant changes to the array of Medicare supplement plans. First, all companies selling Medicare supplement plans had to cease selling the "old" series of plans effective June 1, 2010. Plans that were sold before this date can remain in force, and insureds who are covered by these older plans will remain covered after this date. However, this has financial implications for these insureds. Because no new insureds can be added to the existing pool that these plans cover, the premiums for many covered under these policies have increased (or will increase). In Medicare and the Medicare supplement business, the older a book of business, the more expensive it becomes because of the utilization by an ever-aging demographic.

The 2008 MIPPA regulations also required and provided for a new set of Medicare supplement offerings, which eliminated some existing plans (E, H, I, and J); added new Plans M and N; and called for a change in the basic (core) benefits of all MS policies. We will cover this transformation in depth.

Basic Medicare Supplement Plans

A Medicare supplement plan is a private health insurance plan that fills the "gaps" in Original Medicare coverage. Each plan offers a different set of benefits. Any standardized plan can also be sold as a Medicare Select plan, if an issuing insurer chooses to make a Medicare Select plan available. Medicare Select plans usually cost less, because a person must use certain doctors and hospitals, except in an emergency.

A Medicare beneficiary has certain rights and protections related to Medicare supplement plans. Individuals need to be aware of what these rights and protections are as they shop for Medicare supplement plans. If individuals are in a Medicare Advantage plan, or if they are covered by Medicaid, they do not need a Medicare supplement plan. In fact, the "Medicare and You 2020" guidebook (the official U.S. government Medicare handbook distributed yearly to every Medicare recipient) contains language to the effect: "If you have a Medicare Advantage plan, it's illegal for anyone to sell you a Medigap policy unless you're switching back to Original Medicare."

Every company that markets and sells Medicare supplement plans must offer Plan A, which includes certain "basic" or "core" benefits. The basic benefits included in all plans are these:

-Hospitalization, Medicare Part A coinsurance, plus coverage for 365 additional days during the insured's lifetime after Medicare benefits end
-Medical expenses, Medicare Part B coinsurance—generally 20 percent of Medicare-approved expenses, or co-payments for hospital outpatient services
-Coverage for the first three pints of blood each year
-Coverage for hospice care

The standard plans have certain prerequisites. For example, Medicare supplement policies assume that a person has both Medicare Part A and Part B coverage. The applicant must be enrolled in both parts. Each policy provides coverage for gaps in both parts of Medicare, and a person cannot buy a policy that deals with only one part or the other. Nor can a person buy a Medicare supplement policy without getting Medicare Part B coverage. In other words, for a plan to "supplement" Medicare, Part B Medicare coverage must be in place before an insurance policy can supplement it. (Some states and some Medicare supplement companies may have variances on these Part B qualifying rules.)

Beneficiaries, prospects, and insurance producers alike must be careful not to confuse Part A, Part B, Part C, or Part D of Medicare with Plan A, Plan B, Plan C, or Plan D of Medicare supplements.

The Producer's Dilemma: Pre- and Post-June 2010 Plans
With the series of standardized ("modernized") Medicare supplement plans introduced in 2010, the producer is caught in a "pre" versus "post" situation. For many years to come, a producer will have to discern what benefits were sold before June 1, 2010, with respect to Plans A through L. This will require some thinking if a policy replacement is being considered. All producers, new and old, will need to familiarize and "re-familiarize" themselves with the "old" plans in order to be able to conduct a sensible and accurate discussion with individuals who already own an existing Medicare supplement plan and are thinking about purchasing a new plan. For instance, some pre-existing conditions may totally rule out issuance of a new policy or may result in a six-month waiting period before they are covered.

With premiums sure to raise on the pre-June 2010 plan series, agents will be called on by potential clients to replace older policies with newer, less expensive policies. These newer policies will include the post-June 2010 benefit changes. Thus, to determine what may be appropriate or suitable for clients and prospects, agents will have to evaluate the pre-2010 policies when comparing the provisions, features, and benefits of these older policies with the provisions, features, and benefits of the newer policies. In addition, agents will have to remind their prospects that the prospect may have to answer medical questions to determine if he or she qualifies for a new plan.

This chapter presents an explanation of both series of Medicare supplement policies: those that are available now and those that were available before June 2010.

2020 Medicare Supplement Plans

Currently, there are 11 standardized Medigap plans, each comprising a defined combination of benefits. Plan A represents the most basic plan available, providing certain "core" benefits. All Medigap policies must include these basic benefits. The 11 standardized Medigap plans now available are:

-Plan A
-Plan B
-Plan C (available only to those who turned 65 before January 1, 2020)
-Plan D
-Plan F (standard) (available only to those who turned 65 before January 1, 2020)
-Plan F (high deductible) (available only to those who turned 65 before January 1, 2020)
-Plan G
-Plan K
-Plan L
-Plan M
-Plan N

As noted, Plans H, I, and J were eliminated from the line-up of Medigap policies in 2010 (Plan E

had been eliminated earlier); however, those who had these plans when the new series was introduced were allowed to retain them. For this reason, they are included in the following explanation.

We will explain in detail the features of all Medicare supplement plans, past and previous, in the following section. We will also note which policies are no longer allowed to be sold after June 2010 (although they are allowed to remain in force since that time, those that covered any prescription drugs are now forbidden to so). This will allow a producer to understand what the older plans covered if he or she is asked to compare a new "modernized" plan.

Plan A—The Basic Policy
Plan A includes the following coverages:

-Coverage for the Part A coinsurance amount for days 60 through 90 of hospitalization in each Medicare benefit period
-Coverage for the Part A coinsurance amount for each of Medicare's 60 nonrenewable lifetime hospital reserve days
-After all Medicare hospital benefits are exhausted, coverage for 100 percent of the eligible Medicare Part A hospital expenses—coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid at the Medicare-approved rate
-Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood
-Full coverage for the coinsurance amount for Part B services (which is generally 20 percent of the approved amount, or 20 percent of approved charges for outpatient mental health services) after the annual deductible is met
-Coverage for hospice care. This benefit was added as a core benefit for post-June 2010 supplements and is subject to Medicare requirements, including a doctor's certification of terminal illness. Medicare covers all but a very limited co-payment/coinsurance amount; Medigap plans must pay these co-payment/coinsurance amounts as part of the basic benefits of the policy.

Plan B
Medigap Plan B includes all of the Plan A basic benefits, plus coverage for the Medicare Part A inpatient hospital deductible.

Plan C
Medigap Plan C includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for the Medicare Part B deductible
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000

Note: Plan C is not available for issue to newly Medicare eligibles—those who turn 65 after January 1, 2020—but will still be available to those who turned 65 before this date.

Plan D
Medigap Plan D includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country,

beginning during the first 60 days of each trip outside the U.S. after a $250 deductible, to a lifetime maximum benefit of $50,000

Medigap Plan D plans issued before June 2010 include coverage for at-home recovery care for short-term personal care assistance to help with recovery from an injury or sickness for which Medicare approved a home care treatment plan. Due to underutilization, this benefit was eliminated from Plan D plans sold after June 2010. Note: Plan D remains as it did prior to January 1, 2020.

Plan E
Medigap Plan E was eliminated from the Medicare supplement series prior to 2010. No new plans could be sold as of the date of elimination, but existing policies may remain in force.

Plan E includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the United States, after a $250 deductible, to a lifetime maximum benefit of $50,000
-Coverage for preventive medical care not covered by Medicare (The preventive medical care benefit pays up to $120 per year for such items as a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test, administered or ordered by a doctor when not covered by Medicare.)

Plan F
Medigap Plan F includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for the Medicare Part B deductible
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000
-Coverage for 100 percent of Medicare Part B excess charges—Plan F pays a specified percentage of the difference between Medicare's approved amount for Part B services and t he actual charges up to the amount of charge limitations set by either Medicare or state law.

Plan F is also available with a high-deductible option. The high-deductible Plan F pays the same amounts and offers the same benefits as the standard Plan F, after the insured has paid a calendar year deductible ($2,340 as of 2020). Benefits from a high-deductible Plan F will not begin until out-of-pocket expenses have reached this deductible amount.

Note: Plan F will not be available to newly Medicare eligibles—those who turn 65 after January 1, 2020, but will still be available to those who turned 65 before this date.

Plan G
Medigap Plan G includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for 100 percent of Medicare Part B excess charges—Plan G pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges up to the amount of charge limitations set by either Medicare or state

law.
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000

Plan G plans issued before June 2010 include coverage for at-home recovery care for short-term personal care assistance to help with recovery from an injury or sickness for which Medicare approved a home care treatment plan. Due to underutilization, this benefit was eliminated from Plan G plans sold after June 2010. Note that Plan G does not cover the Part B deductible—that is the only difference between Plan G and Plan F. Also, Plan G provisions remain the same as before January 1, 2020.

Plan H
Medigap Plan H was eliminated from the Medicare supplement series in 2010. As of June 1, 2010, no new Plan H policies can be sold, but existing policies may remain in force.

Plan H includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000

Plan I
Medigap Plan I was eliminated from the Medicare supplement series in 2010. As of June 1, 2010, no new Plan I policies can be sold, but existing policies may remain in force.

Plan I includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for 100 percent of Medicare Part B excess charges—Plan I pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges up to the amount of charge limitations set by either Medicare or state law.
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000
Coverage for at-home recovery—The at-home recovery benefit pays up to $1,600 per year for short-term personal care assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an injury or sickness, for which Medicare approved a home care treatment plan. There are various benefit requirements and limitations.

Plan J
Medigap Plan J was eliminated from the Medicare supplement series in 2010. As of June 1, 2010, no new Plan J policies can be sold, but existing policies may remain in force.

Plan J includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for the Medicare Part B deductible
-Coverage for 100 percent of Medicare Part B excess charges—Plan J pays a specified percentage of the difference between Medicare's approved amount for Part B services and

the actual charges up to the amount of charge limitations set by either Medicare or state law.
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000
-Coverage for at-home recovery—Provides for (limited) at-home recovery care for short-term personal care assistance to help with recovery from an injury or sickness for which
-Medicare approved a home care treatment plan.
-Coverage for preventive medical care not covered by Medicare—The preventive medical care benefit pays up to $120 per year for such items as a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test, administered or ordered by a doctor when not covered by Medicare. (This benefit has been undermined given Medicare's expanded coverage of preventive care treatment.)

Plan J was also available with a high-deductible option. The high-deductible Plan J pays the same amounts and offers the same benefits as the standard Plan J, after the insured has paid a calendar year deductible. Benefits from a high-deductible Plan J will not begin until out-of-pocket expenses have reached this deductible.

Plan K
Basic benefits for Plan K include similar services as Plans A through G, but cost sharing for the basic benefits is at different levels:

-100 percent of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end
-50 percent hospice cost sharing
-50 percent of Medicare-eligible expenses for the first three pints of blood
-50 percent Part B coinsurance, except for the 100 percent coinsurance for the Part B preventive services
-50 percent skilled nursing facility coinsurance
-50 percent Part A deductible
-A $5,880 out-of-pocket annual limit (as of 2020). Once the insured's out-of-pocket expenses reach the limit, any remaining benefits paid during the year are paid at 100 percent. (Note that this is considered a "partly self-insured" plan.)

Plan L
Basic benefits for Plan L include similar services as Plans A through G, but as with Plan K, cost sharing for the basic benefits is at different levels:

-100 percent of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end
-75 percent hospice cost sharing
-75 percent of Medicare-eligible expenses for the first three pints of blood
-75 percent Part B coinsurance, except for the 100 percent coinsurance for the Part B preventive services
-75 percent skilled nursing facility coinsurance
-75 percent Part A deductible
a $2,040 out-of-pocket annual limit (as of 2020). Once the insured's out-of-pocket expenses reach the limit, any remaining benefits paid during the year are paid at 100 percent. (Note that this is considered a "partly self-insured" plan.)

Plan M
Plan M was introduced with the post-June 2010 Medigap series to provide a lower premium policy option through higher cost sharing on the part of the insured. Plan M includes all the Plan A basic benefits, plus:

-50 percent coverage of the Part A deductible
-Full coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside the U.S., after a $250 deductible, to a lifetime maximum benefit of $50,000 (This, too, is considered a "partly self-insured" plan.)

Plan N
Plan N was also introduced with the post-June 2010 Medigap series as another cost sharing, lower premium policy. Plan N includes the basic benefits of Plan A, but with the following change:

100 percent coverage of the Part B coinsurance, except $20 co-payments for office visits and up to a $50 co-payment for emergency room care (which is waived if the patient is admitted to the hospital)

In addition, Plan N provides for:

-Full coverage of the Part A deductible
-Full coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside the U.S., after a $250 deductible, to a lifetime maximum benefit of $50,000 (Plan N is also considered a "partly self-insured" plan.)

The federal Medicare and CHIP Reauthorization Act (MACRA), signed into law in April 2015, has had a significant effect on Medicare supplement policies. MACRA prohibits the sale of supplement policies that cover Part B deductibles to new Medicare enrollees who:

-Reach age 65 on or after January 1, 2020, or
-First become eligible for Medicare due to age, disability, or end-stage renal disease on or after January 1, 2020

Consequently, after January 1, 2020, Medicare supplement Plans C and F will not be available to these "newly eligible" Medicare enrollees; however, those who were already on Medicare as of January 1, 2020, can still elect to enroll (or re-enroll) in these plans (though they will have different alphabetical designations). Industry experts predict that the Medicare supplement market will be "split" into two groups: those who enrolled in Medicare prior to January 1, 2020, and those who enroll in Medicare on or after January 1, 2020.

About Replacement
With the options that the 2010 plans provide consumers (and with premiums likely increasing for many of the pre-2010 policies), many policyowners will want to know whether they should replace their existing Medicare supplement policies with one of the newer options. While replacement is legal and often beneficial, the producer will have to be aware of the requirements that must be followed for Medigap replacements. One of these requirements is a "replacement" form, which serves to explain the reason for the replacement.

Medicare Select
Medicare Select is another type of Medicare supplemental health insurance sold by insurance companies throughout most of the country. Medicare Select is the same as standard Medicare supplement insurance but was only available with Plans A through J. The only difference between Medicare Select and standard Medicare supplement insurance is that each insurer has specific hospitals, and in some cases, specific doctors, that the insured must use, except in an emergency, to be eligible for full benefits. Medicare Select policies generally have lower premiums (10 to 15

percent) than other Medicare supplement policies because of this provider hospitalization requirement.

Medicare Select is a type of standardized Medicare supplement plan. If a person buys a Medicare Select plan, he or she is buying one of the basic standardized plans. What makes Medicare Select different from regular Medicare supplement insurance is that the insurance company and the hospital have an agreement that says that the hospital will "forgive," or waive, the Part A deductible for the patient enrolled in the Medicare Select plan. The idea is that the hospital will attract more customers through the efforts of the agents of the Medicare supplement company. This theory would be effective in a county or area of competing hospitals.

When a person goes to the Medicare Select preferred providers, Medicare pays its share of the approved charges, and the insurance company is responsible for all supplemental benefits in the Medicare Select plan. In general, Medicare Select plans are not required to pay for any benefits if the insured does not use a preferred provider for non-emergency services. Medicare, however, will still pay its share of approved charges with any Medicare certified provider the insured chooses.

Few companies offer Medicare Select Plans these days, though some do. Producers should check with the companies they represent to determine of the companies still sell Medicare Select plans.

Medicare Supplement Enrollment

The best time to buy a policy is during a person's Medicare supplement initial open enrollment period. The initial open enrollment period is the six-month period from the date a person is first enrolled in Medicare Part B and is age 65 or older. During this period, a person has a right to buy a Medicare supplement policy of his or her choice without denial by the insurance company based on pre-existing conditions.

Medicare Supplement Issue Guaranteed During Open Enrollment

The person cannot be turned down or charged higher premiums because of poor health if he or she buys a policy during this period. Once the person's Medicare supplement open enrollment period ends, he or she may not be able to buy the policy of choice because of pre-existing conditions or may encounter a six-month pre-existing condition exclusion if a policy is issued. As a result, the person may have to accept whatever Medicare supplement policy an insurance company is willing to sell him or her. Applicants may even be denied coverage because of their health if application for coverage is made after their open enrollment period has ended.

Unlike Medicare Advantage or Medicare Part D plans which have open enrollment periods every year, the only open enrollment period for a Medicare supplement plan is the six-month period following the date a person turns 65 and first enrolls in Medicare Part B. This is not to say that a person has to buy a supplement policy during this period or that he or she cannot switch to another policy in the future. However, after an individual's open enrollment period passes, any purchase of a new or replacement supplement plan will be subject to medical underwriting and policy issue is not guaranteed.

When inquiring about a Medicare supplement plan, a person should find out whether it limits or excludes coverage for pre-existing conditions after the open enrollment period. If a person has a health problem, and the company limits or excludes coverage for pre-existing health conditions (for up to six months), the insurance company may not cover the costs for any care related to that health problem. During this period, the insured would still receive benefits from Medicare Parts A and B; it's the deductibles and coverage gaps that might not be covered during the six-month period.

Medicare Supplement Replacements

Medicare supplement plans are designed so that people do not need other similar coverage. In fact, it is illegal for an insurance company to knowingly sell anyone a second Medicare supplement

plan, even if the coverage is to "overlap" for as little as one day. For that reason, the Medicare supplement replacement form was developed to be used if a person chooses to replace an existing Medicare supplement plan with another. Replacement is not illegal if the benefits of the new policy will be greater, or if the new premium will be equal or less, or the new policy will contain fewer benefits and lesser premium; however, applicants must sign a notice that indicates they are aware of the differences of the transaction. It is also illegal to sell someone a Medicare supplement plan if he or she is in a Medicare Advantage plan (unless that person disenrolls from the MA plan and returns to Original Medicare).

Producers should ensure that their prospects and clients have good reasons for switching from one Medicare supplement plan to another—they should only switch for different or better benefits, better service, or a more affordable price. On the other hand, no one should keep an inadequate plan or even an adequate plan without reviewing it simply because he or she has had it for a long time.

Policy Delivery
The insurance company should, and more than likely will, deliver a plan within 30 days. If it does not, individuals can call and ask the company to put the reason for the delay in writing. If 20 days go by without an answer, individuals should call their state insurance department. It is unlawful for an insurance company or agent to use high-pressure tactics to force or frighten a client into buying a Medicare supplement plan, or to make false or misleading comparisons to get a person to switch from one company or plan to another. The same holds true for a Medicare Advantage producer.

Medicare supplement plans are neither sold nor serviced by the state or federal government. State insurance departments approve the standardized Medicare supplement plans sold by private insurance companies, but approval only means that the company and the Medicare supplement plan meet the requirements of state law.

Age Rating
Medicare supplement companies use different methods of calculating and presenting premium rates. With attained age rating, an insured's premium will increase as he or she gets older. If individuals buy the plan at age 65, they will pay what the company charges 65-year-old customers. Then at age 66, they will pay whatever the company is charging 66-year-old customers.

With issue age rating, if individuals first buy the plan at age 65, they will always pay the premium that the company charges 65-year-old customers, no matter what their age. If they first buy the plan at age 70, they will always pay the premium that the company charges 70-year-old customers.

Producers should be careful not to lead prospects and policyholders to believe that the age-65 premium or any other "issue age" premium will never increase. They may increase, and often do, depending on the company's future price increase structures.

For many years, some companies used community rating, wherein all policyholders were charged the same rate. As Medicare costs began to soar, the companies that used community rating realized that older policyholders created a greater expense than younger policyholders, which made the rating system unfair to younger policyholders. As a result, these companies dropped this rating method.

The issue of whether to buy an attained age plan or an issue age plan becomes somewhat irrelevant when we see a disparity of as much as $1,000 annually between companies on their "street rate" (the rate charged at the original purchase date). One company may argue that its issue age policy is superior to attained age-rated policies, but the whole issue becomes

insignificant when most companies raise rates for all people in all classifications each year anyway.

The attained age-rated company may raise rates on an "across-the-board" basis, and the issue age-rated company will raise rates for each band simultaneously. Most rate increases are related to the rise in the cost of deductibles and coinsurance due to high inflation in health care nationwide, as has been the case for over two decades.

Other factors that may affect a person's premium are:

-Discounts for nonsmokers
-Discounts for couples
-All Medicare supplement premiums generally go up each year because of inflation.

When to Buy
For the reasons discussed, most individuals should purchase a Medicare supplement plan during their initial open enrollment period, which ensures that they will be enrolled in the plan of their choice. There are certain situations, however, when individuals may have the right to purchase a Medicare supplement plan after their open enrollment period. In these cases, the insurance company cannot deny someone coverage or change the price of a plan because of past or present health problems. Some examples include:

-Insureds lose their health coverage through no fault of their own under a Medicare Advantage plan, Medicare supplement plan, Medicare Select plan, or employer coverage. (The company goes broke or their Medicare Advantage plan is terminated.) After losing Medicare Advantage through an involuntary reason, there is a 63-day "open window" during which insureds must apply to the Medicare supplement company and provide the insurer with a letter of plan termination or involuntary termination. This letter must accompany a Medicare supplement application. If a person applies for a Medicare supplement policy within that 63-day window and provides confirmation of the involuntary disenrollment, the Medicare supplement company cannot:

-Refuse to sell the person any Medicare supplement policy designated A, B, C, or F that the insurer sells in the state (although after January 1, 2020, Plans C and F cannot be sold to newly eligible Medicare enrollees)
-Discriminate in the pricing of such a policy because of health status, claims experience, receipt of health care, or medical condition
-Impose a pre-existing condition exclusion

-Insureds join a Medicare Advantage plan for the first time and within one year of joining, they decide they want to leave Medicare Advantage.

-Many people are eligible for Medicare based on age but choose to continue to work and to receive coverage through their employer group health plans. When terminating employment or the group's health coverage, people have the right, within eight months, to apply for a Medicare supplement policy and not be subject to pre-existing condition clauses if the group health plan is considered "creditable coverage," which Medicare supplement companies must honor, and for which they cannot apply a pre-existing clause to the applicant's policy. COBRA benefits, on the other hand, are not considered "creditable coverage," so even though COBRA benefits can last for a period of 18 months, the application would have to be made within the eight-month creditable coverage timeline.

"Doc Fix" Bill
Of importance to all Medicare supplement producers is the recent repeal of the Medicare Sustainable Growth Rate (SGR) method of controlling fees paid to physicians. The SGR had provided annual targets for physician services under Medicare and was intended to control the growth of Medicare expenditures for physician services. For nearly two decades, physicians

operated under SGR, whose formula typically produced annual reductions in the amount of payment doctors would receive from Medicare, and each year, Congress had to change the formula to one that would generate slight increases in payments, rather than lowered payments as called for in SGR. Congress and physicians obviously grew weary of the uncertainty of payments. Thus, in 2015, through the Medicare Access and CHIP Reauthorization Act (MACRA), SGR was repealed and replaced with formulas for doctors to receive fees in accordance with better managed care programs rather than a simple fee-for-service formula. So, that part of the problem was solved. (MACRA became known as the "Doc Fix" act.)

Effect on Medicare Supplements Plans
As noted earlier, MACRA includes a provision that bars those who enroll in Medicare after January 1, 2020, from enrolling in Medicare Supplement Plans C and F. The reason given was that Plans C and F, which provide for first-dollar coverage of the Part B deductible, were being overutilized by policyholders of those plans, and eliminating these plans would save Medicare money. This matter was disputed by many associations and companies, but nevertheless, the "Doc Fix" bill calls for an end to newly eligible enrollments in Plans C and F.

Medicare Supplement Replacement—Ethics and Legality

With the options that the 2010 Medicare supplement "modernized" plans provide consumers (and with premiums likely to increase for many of the pre-2010 policies), many policyowners will want to know whether they should replace their existing Medicare supplement policies with one of the newer options. While replacement is legal and many times beneficial, the producer must be aware of the requirements that must be followed for Medigap replacements.

Features of Current vs. Replacing Plan
Even though they are now quite dated, some Medicare supplement policies sold before July 1, 1993, were better than the current standardized policy series. Some policies contained provisions that paid the client an automatic 80 (or more) days of nursing home care at any level of care—skilled, intermediate, or custodial. In today's environment, that amounts to about a $16,000 to $24,000 benefit, which was included automatically as a built-in feature. Replacement of that, or similar products, would result in a loss of benefits to the insured, a practice that is unethical because the policyholder may not be aware that the feature is not available in any standardized plan sold after July 1, 1993.

Rolling
Also unethical is replacing an existing policy to obtain a new first-year commission. Most states have enacted legislation that allows only level commission on policy renewal. This is meant to discourage, and even outlaw, the practice of rolling, in which agents switch people each year to obtain higher first-year commissions. The legislation has been highly successful.

Stacking
The practice of stacking—selling more than one policy to a client—is illegal under federal Medicare law, but some unethical agents still ignore or overlook the law and continue to take advantage of the client in their desperation to seek new sales. Another illegal practice is duplicating Medicare supplement policies.

Factors to Consider
Replacing Medicare supplement policies is legal, and in some cases, can be beneficial to the client. Because all Medicare supplement policies currently sold are identical by plan (Plan A, Plan B, etc.), the benefits of any single plan cannot vary. However, the agent must compare "apples with apples." Comparing a Plan B, which is normally less expensive, with a Plan F, which offers more benefits, means that the client must be made aware of a loss of benefits if he or she chooses to replace the F plan with a B plan, even in consideration of premium.

Clients must evaluate what is in their own best interest, or at least what is in their pocketbook,

when considering loss of benefits. In all instances, a replacement form ("Notice To Applicant Regarding Replacement of Medicare Supplement Insurance"), which discloses the reason for the replacement (lower premiums, change of plan, etc.), must be signed by the applicant and the agent at the time of the replacement and forwarded to the replacing company for it to determine if the replacement procedure is, in fact, suitable to the client. Depending on the premiums involved and coverages replaced, replacement is legal and, if done correctly, ethical. Duplicating coverage, even for one day, is illegal. In addition, not indicating that the new application is a replacement is illegal.

Variations in annual premiums between two companies may be as high as $500 for a Plan C product and as high as $1,000 for a Plan F product, depending on the age of the client. Replacing a Plan C product with another Plan C product that costs $500 less or replacing a Plan F product with another Plan F product that costs $1,000 less are examples of ethical replacements of existing policies—"apples-to-apples" replacements. The client receives the same coverage and the same benefits for much less money.

Above all, no potential client should be made to feel pressured into switching Medicare supplement policies, or switching from Medicare supplement to Medicare Advantage, or vice versa. Some agents are still being found guilty of "high pressure" tactics and unethical marketing practices.

In addition, policyholders should not cancel their existing policies until a new policy is generated and in the hands of the policyholder to see that the new policy has the correct plan, correct effective dates, and correct payment methods.

Chapter 6 Medicaid Program

Medicaid is a federally aided, state-operated program of health care assistance for the poor, or those who are aged, blind, disabled, or have families with dependent children and are within certain poverty guidelines. Eligibility for Medicaid assistance is based primarily on financial need.

Established in 1965 by Title XIX of the Social Security Act, Medicaid is jointly funded by the federal and state governments but administered by the states. Federal regulations mandate minimum standards for eligibility and coverage of benefits but grant considerable discretion to states in a number of program areas, including:

-Expanding eligibility to groups above the minimum required by the federal government
-Expanding health care services above the minimum
-Establishing provisions for reimbursement to providers

Under current law, federal funds pay for at least 50 percent of allowable Medicaid costs in every state. However, the federal government assumes a larger share of the cost in states that have a low per capita income. Currently the federal share ranges from 50 percent to 80 percent of Medicaid expenditures in a state.

Medicaid spending covers a variety of mandated services, including:

-Inpatient and outpatient acute care services
-Long-term care for the elderly and mentally ill
-Medicare Part B premiums for elderly persons in poverty
-Disproportionate share hospital payments

Medicaid and Medicare should not be confused. Medicare is not a welfare program; it is an "entitlement" program in that recipients pay into the system via payroll taxes, and thus are "entitled" to take out of the program. The income and assets of a Medicare beneficiary are not a consideration in determining eligibility or benefit payments. Medicaid is different. A Medicaid

recipient must be able to prove eligibility for benefits due to limited assets or limited income. Unlike procedures for Medicare, which do not vary significantly from state to state, those associated with Medicaid are different from state to state.

The services and medical care provided under a state's Medicaid program can be delivered separately from Medicare or, in some instances, in conjunction with Medicare. In this case, the recipient of both Medicare and Medicaid programs becomes known as a "dual eligible." The largest portion of Medicaid funds is spent on the elderly, but Medicaid also covers numerous people, including children, who are not eligible for Medicare.

Medicaid programs are run by the states, with the benefits provided and the requirements for eligibility determined on a state-by-state basis. Each state gets a portion of the funding for its Medicaid program from the federal government, so the coverage provided is based on guidelines issued at the federal level. Each state works out its own program within the guidelines. With the continuing push in Washington to lower the cost of Medicaid, the states are being given ever more flexibility in deciding how to spend the money and in determining eligibility qualification standards for recipients.

PPACA

To some extent, the Patient Protection and Affordability Care Act of 2010 changed this picture. A provision of the law, as originally passed, set forth a minimum Medicaid income eligibility level for all states, and stipulated that each state was to expand its Medicaid programs to include those individuals whose incomes were at or below 133 percent of the federal poverty level; failure to do so would result in loss of federal funds for the state's Medicaid program. The requirement that all states had to expand their programs was eventually overturned by the U.S. Supreme Court; however, many states did, in fact, follow this provision. As of late 2019, 37 states (including Washington, D.C.) had opted to expand Medicaid. Much of the cost of the expanded programs was borne by the federal government for the first three years.

For many elderly Medicare recipients, Medicaid assistance becomes a necessity. This occurs because of the financial problems caused by payments for long-term nursing home care or for high medical bills from a catastrophic illness. Because Medicare does not cover custodial care, many elderly individuals exhaust their financial resources long before their need for care ends. The costs associated with an extended nursing home stay or the expenses associated with catastrophic illnesses can overwhelm personal savings very quickly.

Assistance for medical care under the Medicaid program can also be provided for people who receive supplementary security income benefits from Social Security.

Basic Medicaid Coverage

Most states provide certain types of coverage to Medicaid recipients, but each state is flexible in the services that are covered. For Medicare beneficiaries who are eligible for their state's Medicaid program, Medicaid functions as the secondary insurer, with Medicare as the primary insurer.

Medicaid covers a variety of services with benefits designed to meet the complex needs of the diverse population it serves. State Medicaid programs are required to cover the following:

-Doctor and surgeon fees, inpatient or outpatient
-Inpatient and outpatient hospital services
-Physician, midwife, and certified nurse practitioner services
-Prescription drugs—MMA 2003 states that people with Medicare who are also fully eligible for Medicaid will receive their prescriptions through Medicare Part D. Medicaid eligibility will automatically qualify individuals for:
    -full premium subsidy
    -full subsidy of deductible

-minimal co-pays
-Rural health clinics and federally qualified health center services
-Early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21
-Laboratory and X-ray services
-Family planning services and supplies
-Nursing home and home health care for individuals aged 21 and older

Basic Medicaid Eligibility

Eligibility for Medicaid is determined by state requirements in three classifications:

-Proof of disability or age
-Income limitations
-Asset limitations

A person has to show financial need based on his or her state's formula for calculating the maximum allowable income and assets. This calculation excludes certain asset items, and it varies depending on the need for living expenses of a spouse, if any. It does not allow a person to keep much in the way of a financial cushion.

To apply for Medicaid assistance, the applicant must disclose all assets and sources of income. The formulas used and the types of assets that are counted are complicated and vary by state. If a person is poor, Medicaid is the place he or she will most likely look for assistance with medical bills. It is important that applicants learn about their states' requirements before needing assistance. This is especially important for married couples.

Spending Down

If an applicant is over 65, has an income below the state limitation, and does not have qualifying assets that exceed the state's requirements, he or she can qualify for Medicaid assistance. If the applicant's assets are above the allowable limits, he or she will have to nearly exhaust them before becoming eligible. This process is referred to as spending down one's assets to pay for nursing home or home health care or to become "dually eligible" for Medicaid benefits in addition to Medicare benefits. The limits and the types of income and assets counted also vary depending on whether the applicant has a spouse who requires support.

MIPPA 2008 included a number of specific statutory changes that allow low-income Medicare recipients to have greater and easier access to the various Medicare and Medicaid programs available to them. This includes making it easier to qualify for the "low-income subsidy" (Extra Help program) in the Part D Prescription Drug benefit and ease the assets test for Medicare Savings Programs.

In addition to Extra Help, a program called The Limited Income Newly Eligible Transition Program became effective in January 2010. This program provides Part D coverage for all low-income subsidy (LIS) beneficiaries with an immediate need who are not already enrolled in a Part D plan, and for full-benefit dual eligibles (those eligible for both Medicare and Medicaid) with uncovered months in the past. The plan can be accessed by auto-enrolling through CMS; by filling a prescription at the point-of-sale; or by submitting a receipt for prescriptions already paid for out-of-pocket during eligible periods. The enrollment is for the current month and the next month and an automatic enrollment in a standard Part D plan two months into the future.

MIPPA 2008 included provisions relating to the low-income subsidy and the Medicare Savings Program. More specifically, the act allowed for lowering or eliminating barriers to enrollment in such programs, provided money for training government employees to educate possible LIS beneficiaries about where and how to apply for these programs, and made such information and applications available at local Social Security offices. It also instructed Social Security employees to help applicants complete their applications and provided money for state SHIP employees to

help with the education of those employees.

In keeping with the intent to make qualification for low-income subsidy easier, beginning on January 1, 2010, states were no longer allowed to recover the amount of Medicare cost sharing paid under a Medicare Saving Program from the estate of a deceased Medicaid recipient. Also beginning January 2010, income and eligibility determinations for low-income subsidy program benefits could not include non-financial support (i.e., help from family or friends), nor can cash surrender values of a life insurance policy be considered as a detriment to eligibility for LIS support.

A conscientious Medicare Advantage or Medicare Supplement producer who believes a client might qualify for Medicaid assistance should advise the client to call the state or county Department of Health and Human Services to see if he or she would be eligible for Medicaid benefits.

Supplemental Security Income
If a person is receiving supplemental security income (SSI) payments from Social Security, he or she may be eligible for Medicaid. SSI is a program run by Social Security. It pays monthly checks to the elderly, the blind, and people with disabilities who do not own many resources or have much income. If a person gets SSI, he or she usually qualifies for food stamps and Medicaid, too. For such individuals, Medicaid helps pay doctor and hospital bills.

It is possible to receive SSI and not be eligible for Medicaid.

To qualify for SSI, a person must be elderly or blind or have a disability. For this purpose, the following definitions apply:

-Elderly means a person is 65 or older.
-Blind means a person is either totally blind or has very poor eyesight. Children as well as adults can get benefits because of blindness.
-A disability means a person has a physical or mental problem that is expected to last at least a year or result in death. Children as well as adults can get benefits because of disability.

The basic federal monthly SSI benefit for 2020 is the same in all states—$783 for one person and $1,175 for a couple. Not everyone receives this exact amount, however. A person may get more if he or she lives in a state that adds to the SSI check. Or, the person may get less if he or she (or his or her family) has other money coming in each month. In October 2019, approximately 8 million people received SSI benefits.

Basic Medicare and Medicaid Coordination—Dual Eligibles
A person may be eligible for both Medicare and Medicaid coverage. In this situation, the person is considered a dual eligible, and his or her Medicare coverage will be the primary coverage, with all available benefits being used before Medicaid begins. Medicaid may also pay for items that Medicare does not cover, but coverage is based on financial need. States are rigorous in conducting their searches for assets and income.

Basic Assistance for Low-Income Beneficiaries—Medicare Savings Programs

If a person has a low income and limited resources, the state may pay his or her Medicare costs, including premiums, deductibles, and coinsurance. Each state has several programs that are part of the Medicaid program that will pay some of the costs of Medicare. Combined, the programs function under the common name of Medicare Savings Programs. The programs have similar names but offer different benefits. They also have slightly different qualifications. A person’s income and resources (if any) determine which program he or she can apply for.

The different plans that Medicare Savings Programs offer include the following:

-Qualified Medicare Beneficiary (QMB)
-Special Low-Income Medicare Beneficiary (SLMB)
-Qualifying Individual (QI)
-Qualified Disabled and Working Individual (QDWI)

Qualified Medicare Beneficiary Program
Individuals may be eligible for the Qualified Medicare Beneficiary (QMB) Program if:

-They are entitled to Medicare Part A. If they do not have Medicare Part A because they cannot afford it, then the QMB program may pay the Medicare Part A premium for them.
-They have an income of 100 percent of the federal poverty level or less and resources not exceeding twice the limit for SSI eligibility.

Expenses covered by the QMB program include:

-Medicare Part A deductible
-The Medicare Part A premium (in some cases)
-Medicare Part A coinsurance for extended hospital stays and skilled nursing
-Medicare Part B premium
-Medicare Part B deductible
-Medicare Part B coinsurance
-The cost of additional health services and prescriptions if the person also qualifies for full
-Medicaid services (QMB Plus)

Specified Low-Income Medicare Beneficiary Program
Individuals may be eligible for the Specified Low-Income Medicare Beneficiary (SLMB) Program if:

-They are entitled to Medicare Part A; and
-They have an income above 100 percent but less than 120 percent of the federal poverty level, and resources do not exceed twice the limit for SSI eligibility.

Expenses that the SLMB program covers include:

-The Medicare Part B premium
-The cost of additional health services and prescriptions if individuals qualify for full Medicaid services (SLMB Plus)

Qualifying Individual Program
Individuals may be eligible for the Qualifying Individual (QI) Program if:

-They are entitled to Medicare Part A.
-They have an income of at least 120 percent but less than 135 percent of the FPL and resources do not exceed twice the limit for SSI eligibility.
-They are not otherwise eligible for Medicaid benefits.

The QI program covers the Medicare Part B premium for those who qualify.

The QI Program differs from the SLMB Program in the following ways:

-Because the state has only a certain amount of money for this program each year, once the money runs out, no one else is enrolled.
-Eligible beneficiaries receive assistance on a first-come, first-served basis.

-Beneficiaries must re-apply for the program every year.

Qualified Disabled and Working Individual Program
The Qualified Disabled and Working Individual (QDWI) program covers:

-Individuals with disabilities who lost their Medicare Part A because they returned to work and are eligible to purchase Medicare Part A benefits
-Individuals whose incomes are 200 percent or less of the FPL and whose resources do not exceed twice the limit for SSI eligibility
-Medicare Part A premiums

These individuals must not otherwise be eligible for Medicaid benefits.

Medicare Part D and Low-Income Subsidy—"Extra Help"
Once an individual is dual eligible (eligible for both Medicare and Medicaid), prescription drug benefits are covered under the Medicare Part D program or a Medicare Advantage plan that includes prescription drug coverage. Medicare automatically enrolls dual eligible individuals in a Medicare Part D Plan.

Dual eligible individuals automatically qualify for the Medicare Part D low-income subsidy, also called Extra Help. The low-income subsidy pays all or part of the individual's monthly premium for the Medicare Part D Plan. Plans are available that the enrollee can join and pay no premium. Other plans are available where enrollees have to pay a portion of the premium. If individuals are enrolled in a Part D Plan with a monthly premium less than the regional benchmark set by Medicare, their monthly premium is paid in full by Extra Help. Medicare Advantage or Medicare Part D producers will find a question relating to Extra Help on their enrollment forms.

A dual eligible individual has no annual deductible, and he or she is covered for prescription drugs, even through the Medicare Part D coverage gap. In 2020, co-pays on prescription drugs were $3.60 for generic drugs and $8.95 for preferred drugs in the catastrophic phase, depending on the dual-eligible individual's income. If an individual has been in long-term care, such as a nursing home, for at least one month, no co-pay applies.

Medicaid Payments to Providers
The federal government pays for Medicare, so its rules are uniform nationally. But because individual states also pay a share of Medicaid bills, many rules vary from state to state. Generally, Medicare and private insurance are more generous than Medicaid when it comes to paying health care providers. That means many providers who are happy to treat Medicare and private insurance patients will not treat a Medicaid patient. It also means that Medicaid patients have trouble getting proper care even though the program pays for it. However, in the fall of 2012, CMS determined that it would pay primary care doctors who take Medicaid patients the same scale it pays general practitioners and primary care doctors for Medicare services.

Beginning in 1989 and continuing today, all state Medicaid programs were required to pay Medicare's Part B premiums and deductibles for Medicaid enrollees.

Medicaid and Nursing Homes

In 1995, the Department of Health and Human Services issued the toughest nursing home regulations in the history of the Medicare and Medicaid programs. Those reforms led to measurable improvements in quality of care for nursing home residents.

After implementing those reforms and monitoring their results, the government developed additional steps in July 1998 to further ensure that all nursing home residents receive quality care. As part of this ongoing commitment, the Centers for Medicare and Medicaid Services now require states to strictly regulate nursing homes that repeatedly violate health and safety

requirements. CMS also has given consumers ready access to comparative information about nursing home quality and is changing the inspection process to increase its focus on preventing bedsores, malnutrition, and resident abuse. CMS also conducts ongoing studies of nursing home staffing levels and supports the Administration on Aging's Long-Term Care Ombudsman programs.

About 1.6 million elderly and disabled Americans receive care in nearly 11,000 nursing homes across the United States. Under the Medicare and Medicaid programs, states have the primary responsibility for conducting on-site inspections and recommending sanctions against nursing homes that violate health and safety requirements. The federal government helps fund these activities.

Nursing homes now may face fines of up to $10,000 for each serious incident that threatens residents' health and safety. In the past, fines could only be linked to the number of days that nursing homes failed to comply with federal requirements. This option permits penalty amounts to be more quickly determined and imposed.

On the other hand, nursing homes that have become dependent on Medicaid for the majority of their residents and funding for payment of their care are in a tight spot. The truth is that Medicaid is obviously a "bare-bones" proposition. For their Medicaid patients, nursing homes receive approximately 75 to 80 percent of the "street rate" (that is, the rate the nursing home would charge for private pay or insurance-paid care).

How, then, can government regulators and inspectors expect nursing homes to adhere to strict standards, such as staffing, when the amount of revenue generated by the Medicaid patient is less than is needed to keep the establishment viable? This is a serious dilemma, and is only exacerbated by the budgetary problems facing both federal and state governments. What appear to be credible and sensible requirements for quality care become hardships for nursing homes that cannot receive adequate compensation to provide that care.

Protective Legislation
In March 1999, bipartisan legislation was enacted to protect residents who are on Medicaid from being evicted inappropriately by nursing homes. Additional legislation provided assurances that nursing-home residents will receive the quality care that they deserve and expect by:

-Requiring nursing homes to conduct criminal background checks of employees
-Establishing a National registry of workers who have been convicted of abusing residents
-Allowing more types of nursing home workers with proper training to help residents eat and drink during busy mealtimes

Deficit Reduction Act of 2005

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law. This sweeping legislation affects many aspects of domestic entitlement programs, including Medicare and Medicaid.

The DRA provided states with much of the flexibility they had been seeking over the years to make significant reforms to their Medicaid programs. Combined with other options in Medicaid, states are able to reconnect their healthy populations to the larger health insurance system, transform long-term care from an institutionally based, provider-driven system to a person-centered and consumer-controlled model. It included great opportunities for covering more people at a lower cost and with greater continuity of coverage.

Long-Term Care Partnership Programs
From an insurance producer's standpoint, DRA presents a great opportunity for those in the long-term care insurance arena. DRA expanded what are known as long-term care partnership programs from four states to all states that want to participate. A state LTC partnership program

coordinates private LTC insurance plans and policies with its Medicaid eligibility standards. An insurance company and its producers can sell a LTCI policy with a certain dollar amount, whose benefits would be the first applied to cover the insured's long-term care needs. If and when the benefits under the private insurance policy are exhausted, the insured would be able to retain an amount equal to the benefits paid by the policy and have those assets "disregarded" for purposes of determining his or her eligibility for Medicaid.

For example, if a qualified long-term care partnership policy paid its full benefit of $250,000 and the insured continued to need long-term care, he or she would be able to have $250,000 of his or her assets not counted as "eligible assets" if he or she were to apply for Medicaid nursing home assistance. This would eliminate the need to "spend down" assets to qualify for Medicaid, up to the dollar amount of the policy's payments.

Nursing Homes and DRA

The cost of long-term care continues to increase, making such services difficult to afford for most individuals, and inaccessible for many. The Medicaid program provides coverage for long-term care services for individuals who are unable to afford this care.

Some individuals, with assistance from financial planners and attorneys, had developed methods of arranging assets in such a way that they were preserved for the individual and/or family members but were not countable as eligible assets when Medicaid eligibility is determined. This had the effect of transferring the risk of the cost of long-term care from the individual to the taxpayers. Various techniques were used to artificially impoverish Medicaid applicants, including gifting assets to family members, investing assets in financial instruments that are inaccessible, and executing financial transactions for which fair market value was not actually received.

The DRA included several provisions designed to discourage the use of such "Medicaid planning" techniques and to impose penalties on transactions that are intended to protect wealth while enabling access to public benefits. In addition, the partnership policy availability, once approved by a state, reduces the temptations of "Medicaid planning," because an LTCI policy can be built to absorb initial dollar amounts of long-term care—say $200,000—and the patient/policyholder can then apply for a like amount of benefits from Medicaid without having to spend down, hide or transfer assets in a questionable manner.

The Patient Protection and Affordability Act of 2010

The Patient Protection and Affordability Act of 2010 (ACA) also had a significant impact on Medicaid. As noted, when the Act went into effect, it required all states to expand their Medicaid eligibility standards to include individuals under age 65 with incomes up to 138 percent of the federal poverty level, with the federal government covering the full cost of the expansion for the first three years. This provision of the ACA was challenged and in 2012, the U.S. Supreme Court ruled that this required Medicaid expansion was unconstitutionally coercive to the states, but with mitigating factors. As a result, Medicaid expansion remained intact, but the ruling left to the states the decision as to whether or not to implement it. As noted earlier in the course, 37 states (including Washington, D.C.) have expanded their Medicaid eligibility requirements to include low income earners younger than age 65.

Chapter 7 Insurance Claims

The total impact of an insurance claim can be either a most comforting or a most devastating event. As an agent, you have certainly come to realize that when your clients have problems, you have problems. Therefore, anything you can do to eliminate these problems "pre-loss," is a clear "win" for you and your insurer. In order to best serve your client and your own personal exposure to claim uncertainties requires taking your practice to a higher by gaining a better understanding of the Claims Process.

Agent Risk Management
Risk managing can be defined as any conscious action (or decision not to act) that identifies and reduces the frequency, severity, or unpredictability of loss claims. As you know, sometimes there is simply no coverage available for certain exposures or the clear definition of coverage is uncertain or ambiguous. These are times when your role and obligation is to identify the "gap in coverage" to your client so they understand, in no uncertain terms, that an exposure still exists. In other moments, you become their advisor on ways to mitigate potential claims. In either case, you are managing their claims through loss control.

Risk control strives to reduce the frequency or the severity of this loss of resources. Risk control can focus on actual harm, not on the money paid to restore, compensate for, or otherwise finance this harm, which is the concern of risk financing. For example, when a machine is destroyed or a person dies, an organization, a family, or society as a whole suffers a loss of resources. From a risk control perspective, the extent of such a loss of resources is not changed. Similarly, the severity of the loss is not reduced because the owner of the machine or the family of the deceased receives financial compensation for the loss.

A "risk control technique" is risk control only for one or more specified exposures. For example, fire-suppression sprinklers are risk control for fire damage, but not for loss by embezzlement. Similarly, a sprinkler system can be effective risk control for most fires. However, if the system uses water as an extinguishant, the water is a hazard rather than a safety measure for grease fires, which are spread or intensified by water. In short, specifying a risk control technique also requires specifying the exposure being controlled.

Perspective of a Given Entity
The effect of a given risk control technique can be measured only from perspective of a given entity. For example, pedestrians are exposed to bodily injury from being struck by automobiles, and drivers are exposed to the liability from such accidents. The pedestrians' exposure to injury and the drivers' exposure to liability are two different exposures growing out of the same circumstances. Any risk control technique that safeguards pedestrians from being struck by automobiles has different risk control effects for the pedestrians than for the automobile drivers. For the pedestrians, the effect is to safeguard against bodily injury; for the automobile drivers, the effect is to protect against liability. For one entity, an elevated walkway is risk control for a personnel loss; for the other, it is risk control for a liability loss.

Identifying Loss Exposure
To identify exposures, or possibilities of loss, the risk management professional must be able to do three things:

-Apply a logical classification scheme for identifying all possible exposures to loss.

-Employ proper methods for identifying those specific loss exposures that particular persons or organization faces at a particular time.

-Test the significance of these actual loss exposures by the degree to which they may occur and disclose to clients the possible results and remedies.

Loss exposures are typically categorized in terms of the nature of the value exposed to loss. All financial losses that are the concern of risk management can be categorized as property losses, net income loss, liability losses, or personnel losses. The only exception to this would be losses of purely sentimental value.

Elements of Insurance

Purpose of Insurance

The fundamental purpose of insurance is to provide protection against risks of loss that attend the ownership and use of real and personal property and the health and life of an individual. Conceptually, the ownership of any type of property or engaging in any activity involves some risk of loss, and, presumably, for the right price, insurance could be acquired that would protect against such loss.

In reality, most persons cannot afford to insure against losses on an individual basis. Therefore, insurance is feasible only when there is a sizable group of individuals willing to pay a sufficient amount into an insurance pool so that risks can be spread among the participants at a reasonable price.

Insurance as a Legal Contract

Insurance is a legal contractual arrangement creating corresponding rights and duties among the parties to a policy. An insurer has the privilege of specifying the conditions and rules which apply to those who wish to participate in the insurance pool, and a policyholder has a duty to obey such rules and conditions if he or she anticipates coverage for insured losses.

Notwithstanding the contractual nature of a policy, an insurer cannot compel a policyholder to pay premiums, but in such event it can deny claims or cancel the insurance policy.

Parties to an Insurance Policy

The central parties to an insurance policy involve the "issuer," the "owner," the "insured" and the "beneficiaries." The "issuer" is the company that extends insurance coverage over the subject matter by the sale of a contract known as an insurance policy. The issuer is commonly referred to as the "insurer," and less frequently as a "carrier." The "owner" of an insurance policy is the purchaser of the policy. The "insured" is the person who is protected against loss and may or may not be the owner of the policy. A "named insured" is a person or persons whose name is shown on the cover page or the front of a policy.

Even though he or she may not be included specifically on the front of a policy, a spouse who is a resident in the same household as a named insured would automatically assume the same status. An "additional insured" is a person designated under a policy by way of endorsement, because such person has either a legal liability or an insurable interest in respect of the property.

Significant Definitions

The concept of insurance is facilitated by an understanding of certain other terms that are customarily used in the industry and that have established legal meanings. A "loss" commonly means being without a tangible or intangible that previously had ownership assigned to it. In insurance parlance the term loss is more restricted and has come to mean "an unplanned, undesired reduction of value on an economic basis."

Losses are not to be confused with expenses. In an insurance sense, expenses relate to something that is predictable, such as depreciation.

Insurable losses are either "direct" or "indirect." If "direct," a loss is the immediate or first result of a peril. An "indirect" loss, the secondary result of an insured peril, is sometimes designated as a "consequential loss." There can be no indirect loss without a direct loss. Insurance policies distinguish between direct and indirect losses when specifying the types and amounts of coverage.

A "chance of loss" refers to a ratio or a fraction where the numerator is the actual or anticipated degree of loss, and the denominator is the total number of loss exposures. By way of illustration, if there are 1,000 vehicles in an insurance pool, and the underwriters expect three of these vehicles to be destroyed during a flood, the expected "chance of loss" is 0.003 or 3/1,000. The

"chance of loss" is determined in part by the number of claims filed for a given period, and it is a chance of loss that drives the necessity for insurance.

The causative agent of the loss is referred to as a "peril." Criminal acts, fires, tornadoes, hurricanes, floods, and slip-and-fall accidents are all examples of insurable perils. Losses caused by perils are at the very heart of an insurance policy.

However, coverage under every insurance policy is not predicated upon a specific peril. Except perhaps for suicide, an insurance policy does not specify the peril causing a death. "Hazards" are conditions that enhance the degree of severity or the frequency of a loss.

Another important concept, particularly in property insurance, is "proximate cause," the first peril in a chain of events without which a loss would not have been sustained. If the pilot of a small Cessna, lost in a fog, flew into a petroleum storage tank which exploded, causing several houses in the surrounding area to burn to the ground, the proximate cause of the destruction of the houses would be the plane crash.

Not all situations involving multiple perils are that clear, and when that is the case it may take litigation to determine the proximate cause of the underlying event specified in a claim. One of the basic rules of insurance coverage is that an insured cannot collect unless either the proximate cause or one of the other occurrences in the chain of events is an insured peril.

There are two specific definitions of the term "risk." In the first situation, "risk" is a "variation" in possible outcomes of an event predicated upon chance. The more frequent the number of outcomes, the more enhanced is the risk. The second interpretation of "risk" is "the uncertainty involving a possible loss." Those involved in the insurance business sometimes refer to a risk as an "exposure to loss." The "degree of risk" is an index of the specificity with which the outcome of an event founded on chance can be foreseen. The less accurate the forecast of an outcome, the greater the amount of risk. For an insurance company, a better record of predicting the outcome translates into economic benefits. One of the greatest uncertainties in predicting risk is the uncertain aspect of human behavior.

A "third-party loss" occurs when there is damage to the property or health of a person other than the insured. If the insured was sailing on a lake when the boom on her boat hit her friend on the head, a third-party loss would be involved. If the boom knocked the insured unconscious, a first-party loss would have occurred.

"Premiums" are periodic payments made during the term of an insurance policy by an owner to the issuer for insuring against a loss. Funds attributable to premiums are placed into various investment vehicles by an insurance company. The payment of losses is funded by an insurance company from premiums and income earned on the investment of premiums.

An insurer may be a third party, such as a private company or the government, or a self-insurer. Private insurers are usually involved in selling vehicle and life insurance. The government is an insurer to the extent it provides Medicare and Medicaid coverage, flood insurance, veteran's disability benefits, and FDIC coverage for savings and other types of bank accounts. As the cost of obtaining health insurance continues to increase, many businesses are covering health care plans for employees through self-insurance. In such case, employees contribute to a pool, usually through payroll deductions, and certain medical costs are then paid for by the employer, functioning in the capacity of an insurer.

Suitability of Loss for Insurance Coverage

Not every exposure to loss is suitable for insurance coverage. A number of factors determine whether an exposure to loss is appropriate, including the existence of a suitable class of similar items exposed to the same peril, accidental losses, specific losses that cause extreme economic

hardship, and a significant probability of a low incidence of catastrophic losses.

To be relatively successful, a carrier must accurately predict losses before they occur in order to reduce risks. Accuracy in prediction cannot be attained unless a large pool is involved. In order to establish a fair premium, the units in a pool must be substantially similar; otherwise, the pool cannot equitably transfer the expenses relative to the losses. Perils faced by each unit in an insurance pool should be identical. If half the roofs in a condominium complex were covered with wood shingles and the remaining half with composition shingles, the first half would pose a much greater fire hazard, and the risk of loss would be allocated inappropriately among all of the condominium owners.

Intentional losses are against public policy. If a policyholder could burn down his or her building and collect for the loss, the expenses would not be spread equitably among the insured pool. Thus, for a loss to be insurable in a practical sense, it must be accidental and beyond the control of a policyholder. It is that same principle that excludes normal wear and tear from the umbrella of property insurance coverage.

Notwithstanding this basic principle, it is interesting to note that many carriers consider a suicide by a policyholder that occurs within two years of acquiring a life insurance policy to be an intentional loss. A suicide that occurs two years and one day after the policy was issued, however, is treated as an accidental loss, and is typically considered the result of some type of mental illness.

In ascertaining the nature and extent of a casualty, a competent claims adjuster appreciates that a loss must be measurable, definite, and of a sufficient degree of severity to cause economic hardship. It must be beyond question that a loss has occurred. Insured losses must be quantifiable. The large-loss principle means that the purchase of insurance is only appropriate when a potential loss is large and uncertain.

Many catastrophic losses are not insurable because the occurrence of a few could possibly bankrupt an insurer. A "catastrophic loss" is one that is, relative to the amount of the property in an insurance pool, extraordinarily large. Generally, catastrophic losses have two characteristics: They cannot be predicted with any degree of accuracy and they are limited in geographical scope. In that sense, a catastrophic loss may also be thought of as a loss that is unpredictable and capable of producing damage that is extraordinarily large relative to the quantity of property in the insurance pool.

From the standpoint of a policyholder, an insurable risk is one that does not require the payment of prohibitive premiums. The financial status of the insured as well as his or her attitude toward and tolerance of risk determine what may be prohibitive to him or her. The potential loss must be of sufficient magnitude to create economic difficulties for a policyholder if not covered by insurance. There are situations which generally are uninsurable, such as losses attributable to changes in price or a competitive market environment. Then there are political risks, such as insurrections, war and devaluation of currency, which are usually not insurable hazards either, although some such perils may be insured by a government instrumentality.

Claims Made Coverage

The ability to predict risks has a direct bearing on the establishment of premiums. Reliance on long-term predictions presents an inherent difficulty in setting reasonable rates. There are two forms of insurance coverage, and each has a distinct impact on the process of pricing insurance.

"Occurrence coverage" policies extend coverage for liability for activities that occur over a policy year, notwithstanding the fact that a suit might be brought at a later date to determine liability on the part of a carrier. The duty of a carrier to provide indemnification for an insured for losses incurred during a policy year could theoretically extend to claims filed a substantial time after the

expiration of that term.

Thus, it becomes necessary for a carrier to fashion a premium that covers the eventual or probable results of any present activities. If both the severity and the number of claims is likely to increase over the immediate future, pricing of insurance can become extremely difficult. Because of the burdensome nature of establishing premiums with confidence under occurrence coverage policies, a trend has developed to issue "claims-made" policies.

"Claims-made" policies provide insurance coverage against liability for any claims that are presented to an insurance carrier during a policy year, regardless of when the underlying conduct giving rise to the liability occurred. The premiums for a claims-made policy can be set with more certainty because there is no necessity for a carrier to predict exposure to claims that are more long-term in nature. Because a policyholder under a claims-made insurance agreement is always under the threat of having his or her policy canceled because of unsafe operations, there is an inherent incentive in claims-made insurance to create safe conditions in the insured environment.

Current Events

The Hard Markets

The general downturn in business is forcing companies to look for ways to reduce costs in all areas, especially claims. Risk avoidance, loss control, fraud avoidance, electronic productivity, automating workflow, legacy system improvements are all encouraged to make the handling of claims more efficient.

Challenging the Claim

In response to certain state legislation aimed at reducing premiums, insurers are challenging accident claims far more aggressively than in the past. They have been less willing to settle claims.

Class Action Problems

A disturbing trend is the severity of individual claims and wholesale growth in class-action lawsuits. In essence, people today are not waiting for something to happen to sue, they're out looking for vulnerabilities.

Natural Disasters/Global Warming

In recent years there have been at least fifteen "billion-dollar" climate-related natural disasters that have put some reinsurers out of business and the outlook is not good.

Fraud

Insurers claim to be losing between $85 and $120 billion a year to fraud. The problem will get worse as long as insurers continue to handle claims by phone or mail instead of investigating and negotiating claims in person.

Fraud Detection

The industry knows that insurance fraud is growing at an alarming rate. New software advances using predictive, similarity search, and visual link resources are proving to be effective investigative tools.

Internet Fraud

As carriers expand their online presence and begin integrating claims services electronically, the forging of documents and falsifying accident reports will most likely be commonplace. Currently, misleading web ads are rampant and the source of many claim problems.

"All Claims" Database

Slowly, but surely, the insurance industry is moving toward a national "all-claims" database system to be used by insurers and law enforcement agencies to help identify questionable claims

and other insurance fraud.

September 11
The effects of 9/11 on America and property insurers are profound. Business interruption claims, for example, are being filed whether or not there was any direct physical loss of property. Coverage analysis of the many claims still being submitted will necessarily be dependent on the particular facts of each individual claim.

Network Problems
The recent experience of insurers with network repairs has been frustrating and expensive. Several state legislators have adopted anti-steering reform bills, and insurance executives are looking at shifting their business to independent call centers that operate in fields detached from suppliers, such as technology or software. Carriers and agents are better assured that their customers are professionally served and that work is done correctly, completely and cost-effectively.

E-Business Claims
Most traditional forms including Property, Business, Income, and CGL policies require that physical or tangible damage occur to be eligible. Look for new CGL language with exclusionary language related to computer losses as well as new, innovative policies/endorsements offering first party and third party coverage for technology related offenses, perils, and security.

American Disabilities Act
Insurance companies and their agents will see increased activity in the area of civil rights claims, particularly those dealing with the American Disabilities Act (ADA).

AIDs/HIV
Cases are surfacing that challenge the AIDs/HIV policy exclusions and limitations and emphasize that the limitation must be highlighted or set apart in some way.

Defining Occupation
In essence, insurers are attempting to narrow down the definition of client's occupations as a way to deny benefits with varying degrees of success. Look for more of these "narrow definition" conflicts which may involve agents.

Psychologically Induced Illness
Insurers are attempting to deny claims because they felt that some of their client's injuries were at least partially psychologically induced. The courts, however, seem likely to rule in favor of the client if his disability is "total" as defined by the policy, regardless of whether the illness was psychologically stimulated or entirely physical.

Experimental Treatment
There will undoubtedly be many cases defining what constitutes experimental treatment under health policies in the years ahead. Recent cases have "tested" policy meaning regarding alleged experimental breast cancer treatment, AIDs-related liver transplants, bone marrow transplants, etc. Insurance companies have lost their cases where an exclusion about experimental treatment was NOT highlighted in a conspicuous manner or where policy language was considered ambiguous.

Language Barriers
There are new cases developing in the area of language misunderstandings where clients have pursued claims on the basis they did not fully comprehend the matters at hand. The courts have determined that the insurance company could only deny coverage where an intent to deceive was found.

Defining Accidental
Policy language often limits coverage for "accidentally sustained" injuries, so when cases are built around attempted suicides have left clients permanently or severely injured insurance companies have generally refused to pay. The courts seem to focus on if "accidental" was highlighted in the policy, and if the insurance company is required to treat the self-inflicted injuries or the mental disorders that usually motivate such actions.

Tenants as Implied Beneficiaries
The courts are leaning more and more to the proposition that tenants are implied beneficiaries under a landlord's policy with occasionally bizarre results. Research Bannock vs Sahlberry (1994), American National Fire Insurance vs A. Secondino (1995), Cigna Fire vs Leonard (1994) for details.

EIL vs CGL
Within the last 20 years the insurance industry introduced environmental impairment liability insurance (EIL) in an effort to provide pollution coverage for events the industry deemed not to be covered by the more well-known comprehensive general liability policy (CGL). A very important distinction between these coverages is that EIL policies are claims-made policies, while CGL policies are occurrence-based. What is covered un EIL and CGL policies and where these policies overlap has been the subject of much debate and litigation.

Contamination
Despite the fact that policies have been written as "All Risk," insurers continue to deny contamination claims based on policy exclusions.

"Sick Building" Syndrome
People have an unusual ability to acquire the problems and illnesses of others. Most "sick building" illnesses are found to be psychologically based rather than rooted in fact. Courts have sided with the insurer in many of these cases.

Asbestos
The removal of asbestos continues to be a major source of conflict between clients and insurance companies. Client's all risk policies do not typically cover the removal of asbestos since it is not considered an unexpected event.

Lead
New standards introduced in September 1996 require property owners who are selling or renting real estate built prior to 1977 to disclose any known lead-based paint or lead hazards. Experts believe that the next wave of lawsuits will result from these disclosures and potential client illnesses, real or not.

Business Interruption
On the heels of major hurricanes and earthquake, claims are surfacing concerning business interruption where clients have been forced to close stores and businesses incurring major damages. A major issue that occurs in these cases is the determination of income. Most policies include a clause similar to this: "In calculating your lost income we will consider your situation before the loss and what your situation would probably have been if the loss had not occurred."

Miscellaneous Actions
In addition to the events mentioned above, experts anticipate actions in the areas of Y2K compliance, Fen-Phen and Redux diet drugs, latex gloves, construction product defects, intellectual property, tobacco and carbon monoxide.

Chapter 8 Insurance Company Structure

Types of Insurance Companies
There are two fundamental types of insurance companies – the mutual insurance company and the stock insurance company. A mutual insurance company is owned by its policyholders. Dividends, if any, are paid to the policyholders. The ability to pay dividends is nearly directly proportional to the profitability of a mutual insurance company. Favorable operating results are common in a mutual company. Premiums usually exceed the amount necessary to pay anticipated losses and expenses, resulting in "built-in" premiums to the policyholders.

Policyholders are vested with rights similar to those of shareholders in a for-profit corporation. They can elect directors and vote on extraordinary corporate transactions, such as a change in bylaws or an increase or decrease in the number of directors. Even though mutual insurance companies are designated as not-for-profit corporations, typically they are run efficiently and economically.

Mutual Insurance Companies
Perhaps the most significant type of mutual insurance company is the "advance premium mutual," in which premiums are paid by policyholders upon commencement of insurance coverage, and upon termination, policyholders become eligible for a dividend. Advance premium mutual companies ordinarily do a very high volume of business. In the "assessment mutual," policyholders may or may not pay premiums at the inception of coverage, but they are liable for their pro rata share of expenses and company losses upon termination of their policy. The "factory mutual" is a third type of mutual insurance company which provides significant loss protection such as frequent examination of the insured premises. Factories must satisfy rigid safety requirements, such as including fire alarms and sprinkler systems on the premises, before they can qualify for coverage. A deposit of the entire premium for years in advance may be required.

Stock Insurance Companies
The other type of insurance company is a stock insurance company, which is substantially like any other corporation. It is not a prerequisite that a policyholder must first be a stockholder in the insurance company. Another difference between a mutual insurance company and a stock insurance company is that in the latter, stockholders are not liable for their share of corporate expenses and losses.

The Reciprocal Exchange
A "reciprocal exchange" is similar to a mutual insurance company due to the fact that policyholders provide insurance for each other on a nonprofit basis, although a reciprocal exchange is an unincorporated vehicle. Reciprocal exchanges are popular in the western part of the United States, providing a substantial amount of vehicle insurance. A reciprocal exchange is managed by an attorney-in-fact who is responsible for the performance of all the management functions of the organization.

Divisions
The basic functions of most insurance companies are carried out among four corporate divisions – underwriting, marketing, finance, and claims. The underwriting department is responsible for the evaluation of risks, determining which risks will be underwritten and setting premium rates. Tailoring policies to individual needs, directing sales and advertising are the functions of the marketing department. The finance department is responsible for corporate and financial activities, tax preparation, investments, annual reports and the preparation and filing of necessary reports with state and federal regulatory agencies. The claims department, perhaps the least favored department because of its perception of contributing to the shrinkage of the bottom line, handles the investigation, evaluation and settlement of claims.

Claims Departments
Within the claims division of a sizable insurance carrier, there may be a corporate office claims department which establishes claims procedures and practices for the entire carrier, a regional claims office which supervises branch claims offices within its jurisdiction, and branch claims offices which supervise claims representatives or adjusters as well as the investigation, evaluation and disposition of all but the largest and most troublesome claims presented to a carrier.

The head of a corporate office claims division is responsible for all of the big picture decisions made by the company including the establishment and supervision of common procedures, ensuring conformity and fairness across policies and payouts, and monitoring significant litigation.

The branch claims facility is the office to which most claims are directed. Most branch offices are located in significant population centers. The personnel within a branch claims office handle and supervise claims and issue the settlements. Line supervisors are typically found at branch claims offices and are directly responsible for supervising adjusters. Line supervisors specialize in claims surrounding a line or specific type of insurance. Typically, a line supervisor has the final word on the disposition or settlement of a claim. A line supervisor usually reports directly to a claims manager who is in charge of a branch office and is rarely involved with a claim.

The Adjuster
An insurance adjuster, sometimes referred to by a number of different titles, is a professional, trained in the examination, evaluation, and dispensation of claims as well as the identification of fraudulent or frivolous claims.

Some insurance carriers use both field adjusters, who spend substantial amounts of time at the site of an accident or a loss, and office adjusters, who for the most part remain in their offices handling claims by telephone under the direct supervision of a claims manager. Originally, office adjusters handled only small claims in which there was little or no liability. Presently, most claims are processed by an office adjuster over the telephone. If a claim is within elementary guidelines, many carriers will allow an office adjuster to settle the claim over the telephone without the intervention of an outside adjuster, thus reducing administrative and overhead expenses considerably for an insurer. Quick resolution of small claims also enables a carrier to establish a reputation for the effective handling of claims. Claims of a larger magnitude or that appear to be complex or potentially fraudulent, may be assigned to a field adjuster who makes personal contacts with both the claimant and witnesses and is responsible for the direct investigation of the subject or site of a loss. Turnover rates among field adjusters is understandably high considering that they are usually the target of hate for claimants, are typically underpaid, and are perceived to be low on the corporate ladder.

Adjusters, whether in the office or the field, must keep written progress reports about their investigation and disposition of claim files under their supervision and control. All telephone calls, instructions from supervisors and activities taken on each claim are recorded. Also, both field and office adjusters are, for legal purposes, agents of an insurance carrier. As a result, an insurance company is responsible for the actions of agents that are carried out in the ordinary course of business. Inadvertent or negligent acts or omissions can result in a carrier having to pay a claim it might not otherwise have intended to pay.

The professional loss claims adjuster must possess a substantial degree of expertise and knowledge to avoid imposing a settlement of unwarranted claims on a carrier. To that end, there are two legal principles that an adjuster must be extremely familiar with—”waiver” and “estoppel.” The intentional abandonment of a known right is designated as a “waiver,” and “estoppel” is the result of behavior that is incompatible with asserting a known right. The successful assertion of either one of these legal defenses by a claimant could result in a carrier being saddled with liability it might have otherwise avoided.

Independent Adjusters
A smaller insurance company that does not have branch offices may employ the services of an independent adjuster to provide claims services relative to the investigation, evaluation, and settlement of claims. Independent appraisers are typically hired by carriers for several reasons. During certain times of the year, such as hurricane and tornado season, the needs of many carriers are increased such that a number of extra adjusters are required. In less densely populated areas, the number of claims is not typically large enough to justify staffing a full-time office, so carriers look to independent adjusters to take care of the infrequent number of claims that are filed in such places.

Independent adjusters are typically self-employed but can be associated with a larger group of professional independents. Either way, independent adjusters usually have to pass exhaustive examinations to receive their licenses. The fact that most independent adjusters are paid on a case-by-case or hourly basis, unaffected by any payout or settlement, encourages them investigate quickly and come to a fair decision.

Public Adjusters
Sometimes referred to as a "loss consultant," a public adjuster also works independently of a carrier, but, unlike an independent adjuster, he or she is typically hired by a claimant. Many public adjusters have scanners in the fire and police departments and are labeled ambulance chasers. Unlike an independent adjuster, a public adjuster works on a percentage of the amount recovered. In some states, a public adjuster must be licensed before he or she can offer his or her services to the public, but this is not universal. A competent public adjuster is thoroughly grounded in the subtle provisions of a policy and usually handles all the paperwork and negotiation involved with the claim and settlement on the claimant's behalf. On average, a public adjuster recovers at least 17 percent more than a claimant acting on their own.

Catastrophic Situation Adjusters
One of the most remarkable trends in the development of insurance over the past several decades has been the organization of a team of insurance experts to deal effectively and swiftly with losses in major catastrophes. The result is immediate loss adjustment in an area of a disaster. Insurance professionals, including claims adjusters, sometimes use superhuman efforts investigating, evaluating, and settling claims, and often working long hours under very stressful conditions. The mobile operation may involve the use of sound trucks to advise policyholders of the availability of loss claims adjustment services. Temporary living facilities may be located. Cleanup crews may be made available. Also, the insurance team may assist the victims in securing lumber and other building supplies to begin needed repairs and reconstruction of their homes.

The Claims Department and the Underwriters
One of the responsibilities of the claims department of an insurance company is to advise the underwriters about various obstacles they encounter, such as: unfavorable laws, areas with an excessive incidence of claims, various cost items, and other potentially burdensome items. These claims files assist an underwriter in determining what can go wrong through an evaluation of the costs of different kinds of losses and practices of maintaining reserves. In turn, the underwriters should advise the claims department about stressful situations developing between the company and any policyholders. Expenses involved in the negotiation of claims and the cost of litigation can drive the general and administrative overhead and related expenses of an insurance company through the roof if there is little or no cooperation between the claims department of an insurance carrier and that company's underwriters. Postmortem conferences between the underwriters and the claims departments can help minimize or prevent future problems.

The Marketing and Claims Departments
One commonalty that exists between the marketing and claims departments of an insurance carrier is that both represent the carrier to the public. Nothing tests the performance quality of an insurance product more than a claim. An unsatisfactory resolution of a claim indicates that the

insurance product has failed to perform its intended need and function. The claims department can measure the delivery end of a carrier for the marketing department. Many facts developed from experiences with claims can make for a better insurance product.

The Claims and Loss-Control Departments
A significant amount of information from a claims department can enhance a loss-control specialist's knowledge of what to guard against in an attempt to reduce losses. Safety improvements and other changes may be warranted. Pre-claim activity should have as its goal the mitigation of losses. Necessary evidence should not be lost or misplaced after a loss. Claims and loss control should work together to prepare and maintain records that are invaluable following a loss. Such a system enhances quality control of the insurance product. The combined input of both departments can be provided to an underwriter to help in the decision about whether an insured's potential loss is desirable. Accurate information about losses is important to help emphasize to the carrier the trends in – and resulting costs of – accidents and their effects on premiums and rates and the need for a reliable safety programs.

The Insurance Policy
An insurance policy is a legally-binding contract between an insurance carrier and a policyholder that sets forth certain obligations, such as a requirement on the part of a policyholder to pay premiums in a timely manner, in return for a duty on the part of an insurer to cover losses relating to an insurable event included in the policy upon presentation of a valid claim by an insured.

The property & casualty insurance product differs from other insurance company products, such as an annuity, in that tangible payments or benefits are paid only after the occasion of a loss. A contemporary insurance package may contain a broad range of liability and property insurance at rates considerably less than if each type of insurance was purchased separately.

An insurance policy issued by a property and casualty carrier typically has a number of characteristics in common, including:

The Declaration Page – Sets forth the name and address of the policyholder, the maximum dollar limit of coverage, a description of the property or liaFbility to be insured, the amount of the premiums, the date upon which payment is due, and the types of coverage.

The Insurance Agreement – The relative obligations and responsibilities of both the carrier and the policyholder.

Terms and Conditions – Specifies aspects of the coverage as well as what is required of both parties in the event of an insured loss.

Exclusions – Describes any property and liability that are excluded from the coverage

Fraud and Concealment – Allows a carrier to either deny coverage or declare a policy to be void in the event a policyholder is caught committing fraud or concealing facts.

Exclusions of Peril – Any perilous losses that are excluded from coverage, as well as requirements involving the preservation of property following a loss.

Waivers – Declares that the only modifications to the policy that are acceptable to a carrier are those that are in writing and attached to the policy as an endorsement.

Cancellation – The conditions under which a policy may be canceled are included in this section as well as how premiums would be returned.

Interests of a Mortgagee – The provisions that if property covered by a policy is mortgaged, a

lender has a vested interest in such property that is recognized by the insurer.

Pro Rata Contributions – The provision that each carrier will pay a fair proportion of a loss when there is more than one policy in effect for the same property.

Requirements of a Policyholder in the Event of a Loss – A policyholder's responsibilities to an insurer in the event of a loss and claim requirements.

Appraisal – The procedures to be followed should a carrier and an insured desire to select and pay for independent appraisers to determine the value of a loss.

A Carrier's Obligations – Permits a carrier to take possession of some or all of damaged property at a mutually acceptable value after settlement, to repair, replace or rebuild the property out of materials of a similar quality and type or to settle a claim in cash.

Subrogation – The rights of a carrier to legally recoup the amount of settlement from a third party who is responsible for a loss after payment of a claim.

Standard and Nonstandard Policies
For many substantial types of coverage, a significant number of carriers utilize a standard form of contract containing identical or substantially similar terms which have developed through legislation, rules and regulations, case law or custom within the industry. Associations or organizations that are responsible for developing rates and establishing policy forms prepare, modify, and distribute standard policy forms.

There are a number of advantages to the use of uniform policies of insurance, including conformity of rates and payouts across clients, a reduction in the need for litigation, a lack of overlap between other standard policies, and a general degree of simplicity when it comes to training agents and selling to clients.

Nonstandard forms are those developed by and for a carrier that do not conform in substance to the terms and conditions of a standard insurance policy.

Terms and Conditions of a Policy
An insurance policy is first and foremost a contract, subject to all of the rules involving the interpretation of the meanings of its terms and conditions. An insurance company may establish such terms as it sees fit, so long as there is no illegality involved and the terms are not against public policy. Certain risks may be insured against and others may be excluded, as long as both the coverage and the exclusions are detailed in clear, concise and unambiguous terminology. Because the words in a policy are those of the carrier, they are generally construed by courts in favor of the policyholder and against the insurer.

The reasonable expectations of a policyholder will govern an interpretation of the terms and conditions of an insurance policy. Most insurance policies are what are referred to legally as "adhesion contracts," a type of legally-binding agreement in which there is little or no bargaining among the parties involved. There is very little give and take or negotiating that goes on between a carrier and a prospective insured when an application for insurance is taken.

Legal Interpretations
The ultimate interpreter of an insurance policy is neither a policyholder, an attorney, a carrier, a mediator, an arbitrator nor a state insurance commission. That decision lies with the courts. Questions brought before a court about the meaning of the terminology of an insurance policy result in decisions which ultimately evolve into a body of case law. A carrier is required to act in a manner consistent with such case law when the investigation, evaluation and settlement of claims are involved. To do otherwise can result in actionable "bad faith" or "unfair claims settlement"

practices.

When evaluating the relative interests of a policyholder in light of those of a carrier, courts have consistently decided quite liberally in favor of the insured. The position of a policyholder must be quite clearly erroneous before a court will rule in favor of the insurance company. Because courts have been favorably disposed toward policyholders, carriers have been compelled to adopt exhaustive measures to preserve and protect their rights and privileges under a policy.

Experts believe that the ultimate effect of a body of court decisions has been to broaden coverage and to include unwritten terms and conditions in a policy that might not have been intended by either a policyholder or a carrier. Another result is a growing body of judicially-crafted standard practices that must be followed by the insurance industry in general.

A company's attitude toward claims and claims administration and adjustment reflects a carrier's policy involving the resolution of controversial claims and the avoidance of litigation. Carriers may go to great lengths to offer superior service to policyholders by reimbursing claimants for questionable claims or those not under coverage. On the other hand, approaches to claims may reflect a policy that is inconsistent with industry practice or not in keeping with specific terms of a policy.

Chapter 9 Claims, Processes, and Techniques

Claims

Notification of a loss to an insurance company by a policyholder or a third person constitutes a claim for payment. Before satisfaction of any claim, a carrier will require an investigation of the facts and circumstances underlying the situation which gave rise to a claim. The adjustment of losses in the industry is probably most significant in property insurance because of the partial nature of such damages and the difficulty of measuring the extent of such losses. This concern does not normally affect life insurance since the loss is complete and the amount of the payment is always a certain sum, the face value of the policy.

One of the first steps in the investigation of a claim is to ascertain if the insurance carrier is responsible for payment of a loss. Infrequently, a claimant will file a claim with the wrong company or describe property that is not the subject of a policy. Other claims may be filed after a policy has expired or when the time for the payment of a premium or premiums has expired. Some losses, such as damage due to floods, may have been specifically excluded from coverage. In a few cases, coverage may not be forthcoming because an applicant filed a fraudulent claim.

Once a carrier has determined it is liable to pay for a loss, the company must then determine the actual amount of damages done. If a carrier and a policyholder can agree on the amount of coverage, the claim will be settled. If not, arbitration proceedings may be warranted. A carrier must take care not to reduce payments for legitimate losses below a level which would constitute an unfair settlement of a claim. If a claimant is willing to settle for less than what the insurer thinks the claim is worth, it would be a show of good faith for the company to pay the reasonable value of a claim.

Once a claim is accepted and agreed upon, it will be paid promptly by a carrier. If a claim is denied or if a claimant thinks the proposed settlement amount is insufficient, the insured can secure the services of a lawyer and sue the carrier.

Claims as an Insurance Company Expense

An insurance carrier is in the business of handling many risks, and the business does not come cheaply. Most insurance companies are large, bureaucratic institutions that operate with very substantial amounts of overhead, including rent, utilities, salaries, company vehicles, legal costs, sales commissions, and expenses resulting from the settlement of claims. All of such costs are

included in calculating what amount of premiums to charge. Such expenses also include the costs of frivolous, exaggerated, and fraudulent claims.

People have been known to burn down buildings and fake their own deaths in order to recover under both property and life insurance policies. Some insurance companies are owned by private investors and others by policyholders. In either case, claims are paid from funds attributable to premiums collected and from income from investing such premiums.

Parties Involved in an Insurance Claim
The parties involved in an insurance claim can involve an insured, a carrier, a beneficiary, a third party who may have suffered losses, a staff claims adjuster, an independent adjuster, a specialized investigator, a mediator, an arbitrator, a lawyer, and the state insurance department. An agent who sold an insurance contract to a policyholder may also be useful in reporting the claim directly to the carrier, keeping the policyholder advised of the investigation and the resolution and disposition of the claim.

Elements of a Valid Claim
In order for a casualty or a loss to be covered by insurance, a few basic elements must exist:

Losses must be fortuitous – Losses covered by normal wear and tear or deterioration are the result of a known condition, and therefore are not covered.

Losses must be occasioned by an extraneous factor – If a loss is caused by an inherent physical condition rather than an external agent, coverage will not apply.

Losses cannot be intentionally caused by the policyholder – Damages caused by a suicide attempt more than two years after the purchase of a policy is a typical exception to this rule.

Only legal property can be the subject of a valid claim – Illegal property cannot be the subject of a valid binding contract.

A loss must be sustained – The mere happening of a perilous occasion involving insurable property cannot be the subject of a valid claim unless an actual loss has been sustained.

There must be an "insurable interest" in the property – A policyholder must have some degree of legal interest in the property which is the subject of an insurance claim.

Rights of a Claimant
One of the most significant laws that provides protection to consumers while impacting investigation, evaluation and settlement of claims on the part of an insurance carrier is the "Model Unfair Claim Settlement Practices Act," which has been adopted in one form or another by a substantial number of states. The enumeration of such rights is not by any means exclusive as other legal rights of policyholders that have been established both by legislation and by case law. Also, such rights may serve as a guideline to some courts when confronted with the question of an unfair settlement practice.

The Impact of the Law on Insurance Claims
The claims process is a method of translating the rights provided to a policyholder under an insurance policy into a remedy.

In the past 20 to 30 years, a growing body of statutes, rules and regulations, and judicial decisions have arisen, creating new responsibilities on the part of carriers where few had previously existed. Growing statutory and case laws have proved in many instances to be quite onerous, and carriers have been encouraged to pay invalid or exaggerated claims just to avoid burdensome litigation.

There are three sets of developments that have resulted in the imposition of extraordinary burdens on insurance companies: the judicially-imposed liability for failure to pay a first-party claim, the creation of a duty to settle claims, and the elaboration of a carrier's duty to defend an insured liability. Underlying all of these developments has been a failure on the part of those who prepare insurance policies to specify clearly the corresponding rights and obligations of both the carrier and the policyholder. As a result, carriers have had an abundance of discretion in determining whether and how to settle claims and how to satisfy other contractual obligations. Some courts have managed to limit this discretion through an equitable, economic application of insurance laws.

When the terms and conditions of an insurance policy are not crafted with a great amount of specificity, sufficient detail must be provided by legislation or by case law. One method of achieving this is to tailor the terms and conditions in such a fashion as the parties would have done if they would have agreed upon the inclusion of such details in the policy. Adjusters should be aware that failure to show a claim a fair amount of diligence may constitute "bad faith" from a legal perspective. The elements of evil intent or deliberate wrongdoing are not necessarily inherent in the legal concept of bad faith. Exceeding the discretion allowed by a contract is frequently enough to constitute bad faith on the part of a carrier. It must be recognized that the term "bad faith" varies from one setting to another as well as from one jurisdiction to another.

One significant development in the legal regulation of claims that has occurred over the past several decades is the evolution of a new cause of action for the bad faith refusal of a carrier to pay claims of first parties. Prior to that, a policyholder could only recover an amount of damages equal to the policyholder's losses under conventional contract law. The measure of damages, being only what the carrier would have otherwise been obligated to pay, did virtually nothing to deter a carrier from breaching a policy. And since the policy was the product of a carrier, the inequitable situation could not be alleviated by including a fuller measure of damages in the insurance contract. More and more, courts are now awarding damages that are not contemplated by the insurance contract, such as legal fees, consequential damages, pain and suffering and exemplary or punitive damages. The great majority of bad-faith cases involve defective investigation of insurance claims which results in an inappropriate denial of claims. Unlimited recovery of damages not provided by the terms and conditions of a policy can lead to over caution on the part of the insurance industry, similar to the degree of safeguards adopted by the medical profession in over diagnosing and over treating to avoid liability. Several states have attempted to stem this development by passing laws that allow recovery of reasonable legal fees and a modest amount of punitive damages in bad-faith cases.

Generally, punitive damages can only be recovered in bad-faith litigation upon proof by the claimant of an intention on the part of an insured to inflict injury or damages. Liability often turns on the intent of the denial. A simple but erroneous conclusion that one is not entitled to coverage would probably be less than a sufficient basis for punitive damages. If denial was made with flagrant disregard of the necessity to investigate, punitive damages may be appropriate. A claim that an adjuster may initially refuse to investigate may be only one of negligence, but a stubborn and willful continuance to refuse to investigate can turn quickly into a case involving bad faith. The appropriate test for determining the existence of bad faith should be whether a carrier took improper advantage of its strategic position with respect to a claimant. Because of the new measure of liability for denial of claims, it is possible that more fraudulent, exaggerated, and frivolous claims will be filed in the future.

At the same time, another body of case law has arisen with respect to an insurer's duty to settle third-party claims against the insured that has impacted the entire procedure of claims investigation, evaluation and settlement. A first review of an ordinary insurance policy would have the reader conclude that a carrier has near complete discretion about whether to settle or litigate third-party claims. A standard provision appearing in an insurance policy typically provides that,

"the insurer shall defend any suit against the insured in which the claimant alleges property damage or bodily injury and seeks damages payable under the terms and conditions of this policy, notwithstanding that the allegations may be false, fraudulent or groundless. The company may at its own discretion conduct such investigation and settlement of any suit or claim as it shall deem appropriate."

Such discretion has frequently led to disagreements and serious conflicts between a carrier and a policyholder. The problem becomes most obvious in a situation where policy coverage is set at one amount and a claimant asserts liability in excess of that amount. If a claimant offers to settle for the limits of coverage and the carrier refuses, the insured is left with the possibility of threatened litigation and, ultimately, a judgment in excess of the policy coverage amounts. Some courts have held that a carrier owes a policyholder equal consideration when weighing the relative interests of its own with those of a policyholder, hoping to establish a deterrence against carriers making institutional decisions to create a reputation for being tough on settlements. The problem with this approach is it places a burden on a carrier to entertain a settlement offer as though there were no policy limitations on coverage, when the penalty for failing to settle a reasonable offer is liability for the entire claim on the part of the carrier. The imposition of a duty to settle reasonable claims has resulted in part in protection for the carrier against liability for coverage exceeding the limitations set forth in a policy.

The extent of a carrier's duty to defend litigation brought against the insured by a third party is also in flux. Under traditional circumstances, carriers had less motive to breach their duty to defend a policyholder against third-party liability claims than they did to refuse to settle reasonable offers, since in the first instance the insurer was typically liable only for the amount of the reasonable settlement. Bad faith was not ordinarily involved in a decision not to defend, but rather the driving force was an unbridled contractual provision in a policy which limited the duty to defend to circumstances in which the carrier could reasonably expect to have to pay the costs of the defense.

The more contemporary cases involving bad faith have effected a realignment of the balance between a policyholder and a carrier with respect to relative advantages enjoyed by both. Regulation is justified on the theory that both parties become adversaries, potential courtroom foes, immediately upon the filing of a claim. The insurer's interest is set aside if it has no ultimate duty to cover the loss of the policyholder. On the other hand, the policyholder is assured a defense in almost every case when it can be reasonably expected that one will be necessary. The readjustments do not necessarily create a mandatory obligation on the part of the insured; rather, they impose liabilities for acting unreasonably.

Investigation of a Claim

Generally, the burden of proving the existence of a loss is upon a policyholder. An insurer does not have a legal duty to prove that a loss that is the subject of a claim has not been sustained by a policyholder unless and until the claimant has met his or her initial burden of proof. Although these relative obligations on the part of a policyholder and an insurance carrier are not stated in a policy, they are accepted throughout the insurance industry and are recognized by the judicial system. Notwithstanding the general rule about the burden of proving the existence of a loss, in situations where it is extremely difficult for an insured to demonstrate a loss, a carrier must accept the policyholder's word concerning facts surrounding a loss unless it is able to obtain conflicting evidence. A carrier has a legal right to require a policyholder to prove that the value of a claimed loss is as stated in the notice to the carrier or the proof of loss. The financial burden of demonstrating a loss, including the cost of an appraisal or an estimation of repairs or replacement, is upon the claimant.

Procedural Reasons for Denying a Claim or Terminating a Policy

When an insurance company receives a claim from a policyholder, it assumes a duty to carry out a thorough and competent investigation of the claim to determine what coverage for the underlying

loss is applicable and which benefits are payable under the policy. Once a policyholder has filed a claim for insurance, the company will assign the claim to an adjuster, who is the person in charge of investigation, negotiation, evaluation and settlement of a claim. The initial task of an adjuster is to see if the policy in question is in full force and effect. If there are exclusions that apply or if premiums have not been paid timely as required under the terms and conditions of the policy, coverage may not be forthcoming. Another set of circumstances which may enable a carrier to avoid coverage is the existence of fraudulent conduct on the part of a policyholder, either at the time an application for insurance coverage was taken or when the claimant prepared the notice or proof of loss. An adjuster must also satisfy him/herself that the claimant complied with any duties imposed upon him or her by the policy that apply after a loss.

Fraud, Concealment, and Misrepresentation
The entire policy will be void if, whether before or after a loss, an "insured" has intentionally concealed or misrepresented any material fact or circumstance, engaged in fraudulent conduct, or made false statements relating to this insurance. Concealment involves a failure to divulge facts to a carrier which, if otherwise known, would have affected the decision of the carrier to grant coverage or honor a claim. Policyholders frequently try to conceal preexisting conditions in the hopes that their insurance will cover any additional costs associated with those conditions. Misrepresentation, as opposed to concealment, is a misstatement of a fact that is material to the underwriting decision, which can also lead to denial of a claim or termination of a policy.

Duties of an Insured in the Event of a Loss
Virtually every insurance policy involving the loss of property contains a provision providing what steps must be taken by a policyholder in the event of a loss. If an insurance claims adjuster determines that the policyholder failed to comply with such conditions, he or she may recommend denial of the claim to the carrier.

Claim Evaluation
The evaluation of an insurance claim involves assessing the damages or the extent of losses surrounding real and personal property, personal injury, or loss of life. In complicated cases, the process can often be quite lengthy. The first step in an evaluation of a loss set forth in an insurance claim actually occurs when a carrier sends an adjuster for an on-site inspection, investigation, and estimation of damages. The adjuster should attempt to verify that losses are covered by the policy in question.

In the case of damage or losses to property, an adjuster's task is much easier if a claimant has not made any repairs other than those essential to preservation of the property, and if claimant remains cooperative and honest throughout the evaluation process. The adjuster will probably want to verify that the policyholder did nothing to worsen the damage sustained by the property. Independent verification of the facts stated in the claim may be accomplished by reviewing any reports that were filed with the police or by conducting interviews with witnesses. Dollar losses are then calculated by taking inventory of the damages claimed. Each specific item of damage or loss is assigned a value, using either an assessment made by a claimant or a determination by an adjuster who employs external sources, such as established indexes of value or the estimates of a repair shop or a professional appraiser.

Repair estimates, receipts, service charges, and repair bills are evaluated to arrive at an estimation of the amounts which will eventually constitute a settlement. All information bearing on the evaluation of a claim presented by a claimant to an adjuster will be considered. Inadequate or irrelevant information may lead to an undervalued claim.

Disputes about Evaluation of a Claim
Disputes between an insurer and a claimant about the value of a claimed loss constitute one of the most frequent disagreements between a policyholder and an insured. During the processing of a claim, one of the most difficult tasks confronting an insurance adjuster is determining what a

claim is worth. Inherent in such determination is placing an accurate value upon the subject of an insurance claim so that every claim can be reduced to a specific dollar amount. Placing the value on a life in the event of death is arbitrary at best. The benefits of future earnings that certain of the survivors would have been entitled to, funeral expenses, and medical costs are amenable to quantification, but such other aspects as loss of consortium and companionship are not capable of being reduced to a dollar amount. Another problematic area involves the evaluation of personal property losses. Items such as family heirlooms and antiques have an intrinsic value to a claimant that can never be replaced. In situations where a claimant has lost everything, such as in a fire or a tornado, it may be impossible to provide evidence of ownership and complete or adequate inventory of every piece of personal property that was owned before the disaster.

Use of an Independent Expert
In the event of a property loss, an insurance adjuster frequently uses the services of an independent expert to evaluate a loss. Experts are typically hired by the claimant, not the adjuster, as a way of ensuring that their settlement is as high as possible. Because it is difficult for one adjuster to be intimately familiar with the costs of repairs and replacements involving every conceivable type of property, it is frequently necessary for a carrier to use the services of an expert to assist an appraiser in establishing a value for a recommended settlement.

Actual Cash Value
One of the most arduous tasks of an adjuster is a balancing act involving the assignment of a value to items that are the subject of a claim while performing his or her responsibility of reducing a claim to a dollar amount. An ordinary insurance policy covering personal or real property provides that benefits payable for damaged or lost property are the "actual cash value" of such property at the time of loss.

The actual cash value is the price that one might anticipate an article or piece of property to bring if offered for sale in a fair market where there is a willing seller and a willing buyer. A forced sale or a price obtained at a public auction would be excluded as determinative of market value. The term "actual cash value" is defined under the laws of some states, and, in other jurisdictions, customary definitions have come into use because of court definitions.

When a market exists for used goods like the kind in question which may have been stolen or destroyed, the value can be measured against the price it would have brought in the open used market. An adjuster cannot reduce a claim to a dollar amount unless he or she knows what items have been lost or damaged. An adjuster will ask a claimant to prove ownership of an item which is the basis of a claim, and may be suspicious if a policyholder asserts that he or she purchased a large amount of items for cash. When there is no public market for a used item, the actual cash value may be determined by taking the acquisition cost of a new item and subtracting an amount reflecting the used component of the item, which is called depreciation. Many carriers employ depreciation tables in evaluating what dollar amount to place on damaged property using the rule of thumb that an item loses value every year over its expected life. Even so, placing a dollar value on used personal property is quite subjective.

Replacement Cost
When old property is involved, the deduction for depreciation might reduce the settled amount to a level below the actual replacement cost. In such a case, a carrier may allow an insured to pay additional premiums for an endorsement that substitutes a replacement cost for an actual cash value. Under replacement cost coverage, settlement is conditioned upon a claimant actually replacing the damaged or lost property. If the claimant elects not to replace the property, the settled amount is limited to actual cash value.

Another exception to an actual cash value policy is a "stated value" policy, in which the insurer and the carrier agree at the time of issuing a policy that the property in question has a specific value. The carrier must then pay the stated value rather than the actual cash value.

Evaluation of Extraordinary Items
Certain items of personal property are not susceptible to replacement value coverage and should be insured separately if coverage is available. There is no rate book that an adjuster can turn to for determining the value of a loss of an extraordinary object, such as an expensive lithograph, a quilt from the Revolutionary War era, or a two-carat diamond inlaid in a customized setting. A reputable certified appraiser should have been consulted before the item in question was insured, but if that was not the case, one will have to be used by an adjuster. Other items which may be included as extraordinary for purposes of coverage include vintage vehicles, antiques, guns, and certain articles of clothing. An appraiser may seek information about whether the item has depreciated in determining the amount of the settlement.

Evaluating Minor Personal Injury Claims
In the event of a minor personal injury, a claim may be filed by the insured or a third party who was on the insured's premises during the time of an injury or may have been injured while a passenger in a vehicle belonging to the insured. Frequently, in determining how much to allow in a claim for minor personal injury, an adjuster may be bound by the consensus of what other carriers allow as well as applicable case law. In an evaluation of a minor personal injury claim, an examiner or adjuster will take the following factors into consideration:

Determination of which carrier will cover a claim – In an event where multiple carriers may be involved, an examiner will determine from police reports and statements whether another carrier should have been notified of the underlying event.

Medical expenses – Medical expenses are reviewed carefully to determine reasonableness and the possibility of double coverage, such as medical and automobile coverage both covering injuries from automobile accidents.

Loss of earnings – Wage-loss information is analyzed for lost income or earnings capacity. An insurance examiner will compare wage statements provided on a W-2, a 1099, or a recent federal or state income tax return or consult with the insured's employer.

Disability – An examiner will evaluate the underlying facts upon which a claim for disability is based. Medical reports and the nature of the underlying treatment will be examined. An adjuster will look to see if there is other evidence to prove or disprove a claim of disability.

Death Due to an Accident
In a claim involving death due to an accident, "wrongful death" statutes may apply in many states. Under such statutes, a surviving spouse, parents or children of the deceased may recover damages from the party responsible for the death. In such a case, one who could so recover becomes the claimant.

One of the first factors which must be determined is whether the deceased contributed by his or her own negligence to his or her death. Whether or not his or her actions were the sole causative factor or just one of a number of factors determines the amount of the damages which an insurance company may have to pay. Another factor to be considered in calculating damages is whether the deceased survived for any period of time after the accident occurred and if the deceased incurred pain and suffering. An examiner must determine if the deceased was conscious before his or her death for any amount of time.

An adjuster must obtain a copy of the death certificate to verify the cause of death. Traces of alcohol or drugs in the blood of the deceased may confirm contributory negligence. Police investigations and witness statements are useful in this determination and other matters affecting the cause of death.

Settlement of a Claim
The vast majority of insurance claims are paid promptly and without the involvement of a great deal of complexity. Many cases are settled or disposed of through negotiation between a claimant and an adjuster. Insurance adjusters should know that compromise is the basis of a successfully negotiated claim and that non-reciprocal compromises may constitute an invitation to litigation. Negotiations must be made in good faith for an offer to be fair and reasonable. Successful dispositions of an insurance claim, based upon a compromised settlement, must also be based upon a consideration of all of the underlying facts. Reasonable demands or concessions made at inappropriate times have an adverse impact on a settlement. Unreasonable offers should be refused. Settlement agreements should not be signed unless an adjuster and a claimant are reasonably satisfied with the terms and conditions of the proposed settlement.

Release
No matter what the type of claim, a release is the ultimate objective of an insurance company. A release is a legally-binding document which provides that the person who executed it settled the claim for a valuable consideration, and did so knowingly. After a release is signed, and notarized, if required, the insurance company dispenses a check to the party affected by the release. Once signed, the company is entitled to rely on representations by an insured that the claim is settled, and that no additional claims will be made which arose out of the same accident or set of facts.

Following are some of the more important aspects of a release:

Reading the release – A release must be in readable form and should have been reviewed and understood by the insured. A lawyer should be involved if the release cannot be understood by the parties involved.

Good faith – A release should be obtained in good faith. Material misinformation on the part of an adjuster or an insurance company may lead to a release being set aside by a court. In the event of a personal injury, a medical statement should be obtained from a qualified physician before a release is signed.

Waiting period – In a number of states, there is a legally-prescribed waiting period that must by observed before a release can be executed. The waiting period protects an insured or an injured party from receiving inadequate medical treatment or sums insufficient to remedy property damage. It also deters a carrier from avoiding its obligations under a policy. Some states require a waiting period to be 30 days in duration. If signed in less than the requisite time, a release may be invalid.

Expenses – A release typically covers all expenses, whether past, present or future, paid or unpaid. If any third parties paid expenses on behalf of the insured, those payments should be included in a release.

Assets of a Carrier – These must be sufficient to cover a release.
Other Carriers – If additional carriers are involved, they should be apprised of the release.

Negotiating a Settlement
The negotiation of a settlement is a business transaction between a policyholder and an insurance adjuster who is acting on behalf of a carrier. Personal feelings and emotions should be kept out of the negotiating environment. Objectivity should prevail. There should be no insistence on the part of either party to bend or mold contractual provisions or legal precedents. Both parties should be able to detach themselves from personal prejudices which either may hold about the other party. Threats to cancel a policy on the part of either party are out of place. Negotiation does not have to be a win-or-lose proposition. A fair and equitable disposition or settlement leaves both the policyholder and the carrier feeling like winners. A claim settled within reasonable limits is one in which an adjuster can feel that he or she has done a satisfactory job both for the insured and his

or her employer. Adjusters should expect a policyholder to approach the negotiating process with a proposed settlement that is on the high side. By being creative and doing a little extra work in approaching a claim, it is possible for an adjuster to arrive at an amount which is fair and equitable to both the insured and the carrier.

Appraisal
A method which is frequently used to settle a claim between a carrier and a claimant is an appraisal. The standard appraisal provision that is contained in an insurance policy is required under the laws of some states and is a normal provision in a policy covering personal or real property. Either party to an insurance policy has the right to demand an appraisal.

The appraisal method, used infrequently because most claimants are not aware of the process, can be employed to determine the value of real and personal property. Most of the time it is used to settle disagreements that develop over the expenses of restoring commercial, industrial, or residential property destroyed by fire. Appraisals are only appropriate when there is a significant amount of money in controversy. In order to satisfy the requirements of a competent appraiser, the one selected should have impressive credentials in a given area. Licensed contractors specializing in reconstruction of burned properties or an established art dealer when the property involved is a rare painting would probably satisfy the "competent" requirement. In actual practice, an umpire is rarely used to resolve a dispute between two appraisers. The appraisal award is binding on both parties.

Reduction and Denial of Claims
Most reductions or denials of claims result from clauses or phrases in a policy which exclude certain property or transactions from insurance coverage. In order for an exclusion to be valid it must be set forth in a policy in plain, concise and clear language, and the burden is generally on the carrier to prove that the exclusion is both clear and understandable and is applicable to the situation underlying a claim.

If an exclusion is vague, unclear or not capable of being understood, a court will ordinarily construe the language in favor of the claimant. This trend follows a 200-year-old judicial practice that if language in a policy is capable of being interpreted in two different ways, that which favors a policyholder will be upheld. When a claim is filed, an adjuster will conduct his or her examination with a view to whether or not it is payable. If a policy is not in force, if it has expired and premium payments have not been satisfied, the company may deny coverage. Many policies contain a grace period during which a policy can be reinstated if an insured brings all of the delinquent payments up to date. Another issue that must be resolved, especially where a health care claim is involved, is whether the claimant is covered under the policy. Certain medical checkups are excluded from coverage, so it becomes necessary to determine if a visit to a physician was routine or the result of an existing medical condition, disability or disease.

If an insurance application has not been filled out completely and accurately, anything which was not included may be used by a carrier to limit or deny coverage. In the worst possible case, a policy may be canceled. Inflated, overly-exaggerated, frivolous, fraudulent and deceptive claims may also result in the denial of coverage or cancellation of a policy. Claimants are entitled to a written explanation containing the reasons for the denial of a claim. Most state laws require that such an explanation be provided in writing, and failure on the part of the carrier to do so may constitute an unfair claims practice. A claimant's rights are governed to a large extent by the phrases and words included in the governing insurance policy. Claims may be denied for something as trivial as failing to follow the company's specific requirements for filing out claim forms or for failing to file such a claim in a timely manner.

Litigation
A lawsuit in which a carrier is charged with having handled a claim in bad faith or making an unreasonable refusal to pay a valid claim is costly and onerous to a carrier. Bad faith can

encompass a carrier's failure to investigate, evaluate, and settle a claim adequately or within a reasonable amount of time. Recovery will entitle a claimant at the very least to the amount of benefits explicitly provided for within the policy and, depending upon the nature of the circumstances, may lead to the recovery of incidental damages, economic loss, future damages, amounts for mental distress or punitive damages. Punitive damages are provided for by law to deter a carrier from engaging in bad faith practices. The California Supreme Court has held that insurance carriers have a relationship of trust with their clients which underlie the interest of the public. Taking advantage of that relationship, public policy dictates imposing punitive damages on a carrier and an attempt to restore the contractual relationship between the carrier and a policyholder. Some states that do not allow punitive damages provide for other kinds of damages or penalties. There are some recent judicial guidelines which must be satisfied before an award of punitive damages would be appropriate. They include:

-An ongoing practice of nonpayment of claims by a carrier.
-A constant and unremedied pattern of egregious practices by an insurer.
-Malicious disregard of the rights of a policyholder.
-The absence of any reasonable basis for the alleged misconduct.
-Actions which constitute more than just a mistake of law or fact, an honest error of judgment, over-zealousness, simple negligence, witlessness, bureaucratic inertia or human failing.

Although no dissertation on the rights of a consumer is intended, it is prudent for an adjuster to have a general awareness of what guidelines a court might use in assessing some of the factors set forth above as the basis for an award of punitive damages. In particular, with regard to the rights of a policyholder, the ones included as specific terms and conditions under a policy will be evaluated, but there are additional ones to be considered. Although it does not have the force of a law, the National Association of Professional Insurance Agents and Consumer Insurance Interest Group has adopted an Insurance Consumer's Bill of Rights and Responsibilities, which can serve as a judicial guide as to what constitutes equitable insurance practices and reliable representation by an insurance agent. Some of the items included are:

The right to a voice – A consumer should have a vote in any significant decisions which affect him or her, including the right to a response to any suggestions or inquiries made by a consumer.

The right to safeguards – A consumer is entitled to be advised of his or her rights as well as his or her obligations which arise under an insurance policy.

The right to a remedy – Claims must be handled and settled in a timely and equitable fashion. Mediation, appraisal and arbitration procedures, and an appeal to the state insurance department or commission must be available.

Although a consumer's rights are emphasized, an adjuster should also be aware that the Insurance Consumer Bill of Rights and Responsibilities imposes concurrent obligations on a consumer, including a duty to timely and accurately file claims, to read the policy before purchase and to seek professional help to aid in understanding terms and conditions, to minimize risks and losses, to report any fraudulent conduct to law enforcement authorities and regulatory agencies, to maintain accurate records and inform the insurance company of any changes, and to comply with policy provisions concerning claims and payment of premiums.

One of the most significant consumer protection laws (which was discussed briefly before), serving as another set of judicial guidelines when the appropriateness of punitive damages is at issue, is the Model Unfair Claim Settlement Practices Act, which has been adopted in one form or another by many states. Following are some unfair claims practices under this act:

-Failing to adopt and maintain sound criteria for the investigation and processing of claims.

-Misstating policy terms or relevant facts that affect coverage.

-Failing to provide for prompt and equitable settlement of claims when liability is relatively certain.

-Using advertising material that would lead a reasonable person to believe that a claim could be settled for one amount and then refusing to settle for such amount.

-Failing to inform the insured, upon request, under which part of a policy a claim has been paid.

-Failing or refusing to provide an explanation of the reasons relied on in a policy or under the laws for either compromising or denying a claim.

-Misrepresenting the statute of limitations.

-Delaying the investigation or payment of a claim by using multiple forms to obtain the same information relative to a claim.

-Failing to act promptly upon notification of a claim arising under a policy.

-Forcing an insured to sue to recover for a loss by offering to settle a claim for significantly less than what is ordinarily recovered in a suit for similar claims.

-Failing to deny or confirm coverage within a reasonable period of time after proof-of-loss requirements have been satisfied by an insured.

-Settling on the basis of a claim form that was altered by the insurer without permission of or notice to the insured or his or her representative.

-Using the threat of appealing awards or claims to force an insured to accept a lesser amount in settlement of a claim.

-Advising the insured not to obtain legal advice.

Since insurance policies are contracts, a wrongful denial of a claim can give rise to a breach of a contract cause of action as well. Under a breach of contract case, all a claimant has to prove is that he or she was entitled to recover. The motives or conduct on behalf of the carrier or the claimant is not at issue. If a claimant can prove a carrier issued a policy with no intention to pay claims, there may be cause for fraud. Other legal causes of action might include intentional infliction of emotional distress, malicious prosecution, negligence or conspiracy, depending on the underlying circumstances. Courts have held that under certain circumstances, an insurance company owes a special duty to an insured because the company stands in a special relationship with such party. Insurance companies must respond to settlement offers from third parties in a reasonable manner, and failing to respond to such an offer or rejecting a reasonable offer may result in liability on the part of a carrier for bad faith. Under a bad faith claim, an insured can recover damages, which could include the amount of an excessive judgment against a claimant. Some courts have held that the insurer is under a legal obligation to settle claims a claimant has against its own carrier as well or be liable for first-party bad faith claims.

Small Claims Court

If a disagreement between a carrier and a claimant cannot be resolved and involves a small amount of damages, typically no more than $5,000, a claimant may elect to pursue the matter in small claims court. Since some courts will not allow a defendant to employ a lawyer to appear on his or her behalf, an adjuster may have to represent the carrier. If nobody from the insurance company makes an appearance, a claimant will be entitled to a default judgment. Adverse

judgments usually can be appealed to the next highest trial court, which will result in a new trial.

Subrogation
Under the laws of most states, an insurance company which pays an insured for a loss occasioned by a third party is entitled to be subrogated or substituted in place of the insured with respect to the insured's rights to sue such third party. By way of illustration, if a pilot swerved off a taxiway and ran into a restaurant near the end of the field, the pilot would probably be liable for any damages to the restaurant. If the owner of the restaurant filed a claim with his or her insurance carrier and the carrier paid for losses to the owner's property, the restaurant owner's carrier would be entitled to be subrogated to the restaurant owner's rights against the pilot. An insurance company cannot avoid payment by insisting that an insured must first attempt to collect directly from a third party or its insurance carrier. On the other hand, the restaurant owner could not legally collect from both his or her carrier and the pilot or the pilot's insurance carrier. If the restaurant owner waived his or her right to collect for damages from the pilot or the pilot's carrier, he or she would also be waiving the right of his or her insurer to sue the pilot. In that case, the restaurant owner would be estopped from collecting damages from his or her own carrier. Subrogation does not exist with respect to life insurance policies, since such coverage is not a contract of indemnity.

Investigation Principles
The constant goal of a good investigator should be to strive to uncover evidence and valid facts. If he finds that the best information, evidence, photographs, and testimonies rest with the insured, he will be able to work out settlement negotiations for the position of the case.

Due to excessive demands, lack of liability or settlements of a claim may not be consummated and may have to be tried in court. It then becomes most important to show the facts in some tangible form that can be presented as evidence in court. This is accomplished by means of signed statements, affidavits, reporters' statements, photography, diagrams, specialists' testimonies and, where possible, by actually producing the object which was involved in the accident or allegation. It may be true that a defective faucet broke in the claimant's hands, causing his or her hand to be severely lacerated. An examination of the porcelain handle might reveal that it was struck by an object, such as a hammer, and for this reason the claims person can introduce the handle itself, as well as expert testimony concerning it in the trial. The object is naturally the best possible piece of evidence.

It is obvious that such a handle, or some similar evidence should be put in a place of safe keeping and properly identified so that someone will be able to testify at the trial that it was reserved intact and in exactly the same condition from the time immediately after the accident until the moment it is presented in court.

An effective investigation must be planned in advance and properly timed. There must be order and execution. There can be no set pattern in the investigation of a casualty claim because of the varied circumstances in each case which calls for individual handling.

A claims person need not be a politician or a press agent to be a successful investigator, but it helps to have some elements of both. By establishing friendly contacts with the various police agencies, hospital, and motor vehicle clerks, and various officials on both high and low levels, he or she will not only obtain a great deal more information, but will get information more quickly.

Once the claims person has established a good contact, a telephone call may save hours of travel and waiting time. The claims person should never antagonize those upon whom he or she may subsequently have to call for information, no matter how great the provocation. He should take the time to establish friendly relations with police sergeants, hospital officials or clerks, record clerks and others in similar positions upon whom he is calling for the first time. It will be time well spent. If certain rules or regulations require the investigator to obtain forms or go through red

tape routines which he or she feels are cumbersome, he should follow the procedure in good grace and not request shortcuts that will embarrass the clerks who have to abide by those rules.

Friendly contacts are invaluable for picking up gossip or hearsay which may often lead to pertinent information.

The scope of an investigation is determined as it develops. If the case is one to settle and if the demands are within reason, all efforts should be bent upon disposing of the case and eliminating or avoiding any investigation which will serve no ultimate purpose. Over- investigation can be just as costly in the long run as under-investigation. This is particularly applicable in property damage claims of the average kind where the liability has been determined and the damages established.

If the claims person has decided that to see the claimant first is most advantageous in a certain case, he or she will usually find it advisable to get in touch with the insured by telephone and obtain an oral version of the accident before taking the signed statement. If the claims person cannot talk to the insured right away, he or she should see that the insured is notified to give no signed statement to anyone but his own company representative and to be cautious about any verbal information he may be forced to give in making a claim of his own against the other party. Unless a claims person is handling property damage, medical payments, or other run-of-the-mill claims, the investigation will be made by personal interviews. He or she will have to meet, question and take statements from insureds, claimants and witnesses. These people come from all economic groups and have various religious, cultural, economic and national backgrounds. The claim representative must be tolerant, in the accepted usage of this term. It is a broad term and has often been misused, but tolerance includes respecting differences in point of view, politics, dress, mode of life, and other such matters as well as race, religion and foreign background. A claims person must not show prejudices of any sort.

The claims person is usually the insured's first contact with an employee of the company with which he or she is insured. Because of this the claims person's job is to make every effort to see that the interview is pleasant, affable and as smoothly-running as possible. He or she should take all the time needed to get the information necessary to protect the insured's interests, but should not drag out the interview to the point of a social visit, especially if he or she has interrupted the insured or is using time which the insured could spend profitably in some other manner.

In this interview it is best to give the insured a briefing on what may be expected of him in the event that settlement negotiations fail and the case has to be tried. If the matter is brought up by the insured, it is also well to acquaint him with those things the insurer cannot do for him. Some insureds, for example, expect the company claims person to press their claim against the third party. It must be tactfully explained that it would be both unlawful and improper to do so, unless there are subrogation rights involved.

The problem of representation before a criminal court or traffic hearing will also often come up. The same explanation must be given in this respect. If the adjuster is a company representative, he or she should remember that although he may be the local attorney of record for his company, he or she is not in the general practice of law, and it would be both improper and unwise to represent an insured in either a criminal matter, a traffic hearing, or an action against third parties not involving subrogation rights. The claims person may always attend such hearings as an observer, but to take responsibility for the outcome is inadvisable.

Unless a claims person has reached a point where it can be determined that a first-call settlement is possible, it is not advisable to make a definite commitment the first time he or she sees the claimant. Nor should the claims person decline the claim until he or she has completed the investigation. A claims person should not miss the opportunity to obtain from the claimant written permission to get the doctor and hospital records, whether he or she intends to use these immediately, or sometime in the future. The claims person will have no better opportunity to get

this permission than on the initial visit. Any attempt to get a signed statement or further information after the claimant has disclosed the fact that he is being represented by counsel is unethical and deceitful.

An investigator must remember that the control he maintains will depend upon the impression he makes upon the claimant. If he indicates by attitude and gesture, as well as by words, that he intends to act fairly and ethically within the limits set by the policy, his batting average on settlements will be pretty high. Each company has its own policy with reference to such payments. They are becoming more prevalent and have generally helped to keep some serious cases under reasonable control. The claims person will learn the attitude of his or her company concerning such payments and act accordingly.

One question the investigator will probably ask more often than any other in the investigation of casualty claims is, "Do you know or have you heard of anyone who saw the accident?" He or she will also try to learn this from the insured, the claimant, police offices, and many others as well as outside witnesses, and will scan the police and motor vehicle bureau reports to determine the names of any possible witnesses. The investigator will attend traffic hearings and criminal proceedings, and read the transcripts. He or she will interview coroners and read transcripts of the coroner's inquests to determine the names of possible witnesses to an accident.

In serious cases where the effort is warranted, he will make neighborhood investigations, and if he wants the best results, will make them at the same hour of the day when the accident occurred, and as soon after the accident as possible. Making a neighborhood investigation requires common sense and a great deal of persistence and determination. First of all, it means calling on every store in the immediate vicinity that was open at the time of the accident and finding out not only whether the proprietor or the sales people saw the accident, but also whether there were any customers in the store at the time. It also means checking with these people to determine whether they know of anyone else who saw the accident.

In addition to covering the houses in the immediate vicinity, it also normally means knocking on the door of every apartment that has a window facing onto the scene of the accident. Time after time, investigators have located witnesses who were looking out of an upper story window down onto the scene of an accident. The investigator must ask all of these people whether they know of anyone else who might have seen the accident. Sometimes this involves interviewing four or five people before he tracks down the witness. This individual may be merely described generally since no one may know his name or address.

Most people's lives are set in a fairly well-defined pattern. If buses or trolley cars were present at the time of an accident, it is not unusual to find certain people in them at the same time and place on a subsequent day. Bus or trolley drivers can usually be interviewed through the company for whom they work. Very often the claim departments in these companies will do the preliminary interviewing for the investigator. A claims person may possibly learn that telephone linemen or outside workers of other kinds were present at the scene of the accident, and he will have to track them down. If it is warranted, he should check with delivery people who may have been working in the area at the time of the accident, including mailmen, parcel deliveries, newspaper delivery men and others. After a case has gone into suit, information may be obtained that may lead to the discovery of other witnesses, by means of interrogatories and depositions. If such information is obtained, it should be followed up immediately. Occasionally, in important cases, a catchy advertisement in a local paper will bring forth a witness. All of this presupposes the fact that the nature of the accident deserves this kind of attention.

If the investigator contacts the witnesses promptly, he should be sure to obtain from them the identifying information and the names and addresses of relatives and friends who have a permanent address, and follow this up with regular periodic checkups concerning their availability so that he will have no problems locating the witnesses when he needs them. There will be

occasions, however, since no one is infallible, when he will find it necessary to locate a witness that he has lost track of because the witness no longer lives at the last address which the investigator has for him.

There are various "skip-trace" organizations that specialize in locating missing persons for a reasonable fee. All claims persons occasionally have use for such organizations. There will, however, be many instances when, because of the time element, or because other methods have been unsuccessful, a claims person may have to make every effort to locate a witness who has apparently disappeared. If so, he should know that there is no magic formula for locating a missing witness. Should the claims person use some ingenuity, imagination, and a good deal of tenacity, he will probably accomplish his object. It is very difficult for an individual in this country to disappear without leaving any trace whatsoever.

Locating the Witness Checklist
As a stimulant to the investigator's imagination, the following checklist is offered as leads for locating the missing witness:

-A registered letter, return receipt with address requested, sent to the last known address of the witness.

-Telephone directories.

-City directories.

-Interview with janitor or landlord at last known address for any possible leads, including:

-Names and addresses of relatives or friends.
-Names of company or collector on an industrial life insurance policy.
-Names of credit or collection agencies or individuals.

-Name of any federal, veterans' or other organizations that the witness may have belonged to.

-Canvass of the neighborhood or building for any possible leads from friends, relatives or acquaintances. It is essential that such investigations be repeated several times since the investigator will almost never find everyone home the first time the canvass is made. There is also always the possibility that someone he saw before has since seen or heard from a missing witness.

-Business establishments, stores and banks in the immediate vicinity.

-Churches and church organizations.

-Local doctors and dentists who may have treated the witness at one time.

-Local parochial or public schools.

-Name of a moving firm whose vehicles may have been observed by the janitor or any of the neighbors.

-Any former employer of the witness or any member of his family. From this source, the investigator may obtain:

-Union affiliations.
-Names of references on employment records.
-Type of work and employment.

-Information from fellow workmen.

-Automobile or Motor Vehicle Bureaus may have information concerning the witness' address if an automobile has been registered in his name, or if a driver's or chauffeur's license has been issued to him.

-Local election records.

-Utility and telephone companies.

-Military service or veteran's administration records.

-Credit accounts at department stores.

-Welfare agencies.

-Police records.

-Tax records.

-Marriage, birth, or death records of the witness or his immediate family.

-Judgment records.

-Golf, tennis or other athletic clubs that the witness may have belonged to, including leads to any hobbies that the witness may have had.

-Credit card organizations.

Potential witnesses comprise a variety of individuals. An insured or a claimant is an interested witness because he is interested in the outcome. One who knows neither party and is not interested in the outcome, except as a matter of justice, is a disinterested witness. Witnesses are often designated as friendly or hostile, adverse or favorable. These terms are self- explanatory. In interviewing witnesses, a claims person's approach must be one of genuine sincerity. He may have to explain to the witness why it is important to the insurance company to pay just and proper claims and to avoid time-consuming additional investigation and litigation expenses. However, if he can convince the average person that he is sincerely interested in seeing that justice is done, whether or not it affects the company adversely, he will usually get the witness' cooperation and in most cases, a signed statement, without too much difficulty.

Occasionally, a witness will give an initial impression of hostility that is merely a defense mechanism on his part. He may believe that a version unfavorable to the claims adjuster will be received with antagonism. It is up to the claims person to avoid jumping to conclusions and break this false barrier down. He should not misrepresent himself, but should gain witness confidence by his honesty and fairness. Unless the circumstances are extraordinary, it is advisable to have seen both the insured and the claimant and to have visited the scene of the accident before interviewing the witnesses. This presumes that the claimant is not represented by counsel. It does not imply that there should be undue delay in interviewing the witnesses. They should be seen as soon as possible. Time can only dim their memory.

The claims person may wish to take a key witness on an important claim back to the scene of the accident so that he can refresh his memory and familiarize himself with distances and landmarks. While it is perfectly proper and often necessary to refresh the memory of the witness, the claims person should not try to lead him in any definite direction. If the witness is important to the case,

the claims person should obtain not only his name and present address, but the name and address of someone such as a parent or other close relative who has a permanent residence and through whom the witness can always be located.

It is important that witnesses be interviewed under circumstances which are comfortable to them. The claims adjuster should not try to interview a witness at his place of business if such an interview might make him ill at ease. He should be seen at home if possible. He should take the time necessary to obtain a proper interview but he should not impose upon the witness. If there is no choice but to interview a witness at his place of employment, an attempt should be made to enlist the aid of his employer, but care must be used—it could boomerang. A good claim representative will try to find some common bond with a witness on which to establish a basis of friendship. If the witness is busy or has only a very short time to give the claims person, he should take whatever information he can, but prepare the way for an additional interview later when the witness is not so rushed. On a follow-up, the average witness will usually go overboard to give whatever information he can, since he feels responsible for the extra call.

Whenever a witness is interviewed, the claims person should obtain complete details and record them along with his impressions of that witness. Did he appear to be honest and sincere? Was he reluctant? Did he seem to be holding back any information? Did he give the impression that he was favoring either side? Was his manner of presentation such as to make him a good witness on the stand? Was his appearance favorable? Did he speak with an accent? Was he hesitant, or straightforward and direct in presentation? Did he appear intelligent and well- educated, or slow, stupid or ignorant?

Was he opinionated, timid or hesitant? Was he uncertain or positive in his statements? Was he friendly or belligerent? Did he have any speech impediment? What was the overall impression of his credibility? What is his reputation? Does he have any physical deformities? Does he appear vindictive?

Whatever his reason, if a witness persists in refusing to give information about an accident which the claims person has reason to believe he has seen or knows something about, it is important to obtain his negative signed statement so that he may be impeached if he tries subsequently to testify for the claimant at a trial.

Special Damages
Special damages is a term used in the investigation of casualty claims to denote losses that can be measured in definite sums of money. Allegations of special damages should not be taken at face value. If the nature of the case or the amount involved warrants it, the items should be checked for authenticity. If special damages have been exaggerated, it is a good indication that other features of the claim may need careful scrutiny. It is also a lot easier to dispose of a claim for a fair value after the claimant has been confronted with proven exaggerations in his special damage allegations.

Special damages which are ordinarily encountered in casualty claim work may be listed as follows:

-Lost time and earnings – It must be borne in mind that the claimant is entitled to his take- home pay only, and that he suffers no loss as a result of tax or other deductions, unless he is called upon to make up some items, such as insurance or hospitalization.

Where the employee is salaried:

-Check the employer’s payroll records. Do not be satisfied with a verbal corroboration made by some clerk. In some instances, even a written letter cannot be taken on face value.
-Check the exact lost time

-Check the exact lost earnings. The employer may have paid all or part of the employee's salary.
-Determine the amount of the regular salary.
-Determine the amount of commissions and overtime, and obtain average salary for that particular time of the year.
-Estimate tips and other gratuities, such as board and lodging.
-Determine whether the injury has necessitated a change of job or employment.
-Determine whether the injury has made it necessary for the claimant to obtain part-time work.

Where the claimant is self-employed:

-Check income tax records, including federal, state and city, if any.
-Social Security tax, if possible.
-Unemployment tax.
-Examine private books and accounts.

Property Damage – The following items will be discussed in great detail when we consider automobile property damage losses subsequently:

-Estimate of repairs.
-Appraisals and surveys.
-Difference in value before and after the accident.
-Exact amount of loss of use.

Medical Expenses

-Doctors', specialists' and dentists' bills.
-Travel expenses to and from doctors.
-Registered nurses' fees.
-Practical nurses' fees.
-Hospital or clinic bills.
-Cost of ambulance.
-X-rays.
-Laboratory fees.
-Prosthetic appliance or surgical apparatus.
-Medicines, drugs, etc.
-Funeral Expenses

Investigating Fatal Claims
In the investigation of fatal claims, the following points should be checked:

-Duration of the time the decedent lived after the accident, to determine the amount of possible pain and suffering.
-Age of the decedent.
-General health of the decedent. Determined by:
-Neighborhood canvass.
-Life insurance examinations.
-Army or school examinations.
-Medical history investigation, if warranted.
-General habits and morals, if warranted.
-Life expectancy.
-Earnings.
-Potential earning capacity and increases expected.
-Names and addresses of all close relatives.

-Age, sex and number of dependents.
-General economic condition and social status.
-Marital status with certificates or other documentary proof or written corroboration.
-Complete medical bills.
-Complete funeral expenses.
-Causal relationship between death and accident, derived from:
    -Coroner's report and transcript of hearing.
    -Death certificate.
    -Autopsy report.
    -Medical report.
    -Medical history.

You will often hear it said that the claim department is the eyes and ears of an insurance company. As has already been seen, its activities extend far beyond the old concept of routine claims handling. One of the important functions and duties of the claims person is to report to the underwriting department any information that may affect the desirability of a risk or the adequacy of the premium rate.

Ordinarily, it is not the province of the claim department to recommend the cancellation of a risk. There are many reasons why the underwriter may decide to retain a risk, despite some undesirable features. It is the duty of the claims department to bring to the attention of the underwriting department any information that may aid them in arriving at a proper decision concerning cancellation, or which may necessitate corrective action. In the course of the investigation of an accident, much information will come to the attention of the claims person that might affect the desirability of a risk. Final decision concerning cancellation, however, should rest strictly with the underwriting department.

Risk Report
Most companies have some form for this purpose which is variously termed "Questionable Risk Report," "Confidential Risk Report," or some similar designation used for the same purpose. The types and kinds of deficiencies that should be noted and brought to the underwriters' attention can be grouped roughly into five categories: Physical Defects, Moral Hazards, Physical Infirmities, Matters Affecting Premiums, and Other Hazards. Examples of each, are:

Physical Defects:
-Poor condition of an automobile or building.
-Defect of equipment, such as brakes, broken headlights, defective horn or steering mechanism on an automobile; defective machinery on compensation risks, and so forth.
-Improper equipment.
-Machinery safeguards not being used, or no safeguards provided.
-Dangerous machinery.
-Unoccupied premises.

Moral Hazards:
-Bad reputation of insured or driver with reference to speeding, reckless driving or criminal background.
-Police record.
-Philandering.
-Intoxication.
-Apparent collusion.
-Fraudulent acts or false statements.
-Illegal operation of vehicle, elevators, machinery, or equipment.

Physical Infirmities:
-Glasses required and not used, poor eyesight, or blind in one eye.

-Loss or impaired use of fingers, arm or leg.
-Insured or driver afflicted with epilepsy, heart condition or other infirmity or disease which could momentarily disable the driver.
-Insured or driver aged or infirm.

Matters Affecting Premium:

-Age of driver.
-Usual traveling distance on truck bearing local truck man's endorsement.
-Principal garaging of automobiles.
-Operations or employment not covered under compensation policy.
-Improper classification of automobile or job.

Other Hazards:

-Accident frequency or excessive traffic violations.
-Poor class of drivers or employees.
-Truck used to transport employees.
-Gross negligence or wanton disregard involved in an accident under investigation.
-Improper registration or no driver's license.
-Catastrophe hazard, such as transportation of butane gas, asphalt, or dynamite; fire hazard, and so on.
-Non-cooperation.
-Employment of minors.
-Occupational disease exposure.
-Unsafe practices.

Although it is not ordinarily the province of the claim department to recommend cancellation of a risk, as we have previously stated, a claims person should always notify the underwriting department when such cancellation might adversely affect an open claim or suit.

In some instances, involving serious accidents, it is essential that the good will and complete cooperation of the insured be maintained, especially where he or she has some influence over others, such as witnesses and perhaps even a claimant. In such instances, the claim department may wish to take a calculated risk and remain on the policy, since cancellation might antagonize the insured and result in the loss of his or her future cooperation. In this type of case, it is the duty of the field claims person to let the underwriter know the circumstances, and request that no cancellation be made until further notice by him, or upon disposition of the claim or suit.

Statements for Insurance Claims

Because the taking of signed statements takes up so much of the working time of the average casualty claims person, it is important that this phase of the operations be discussed in detail. Only a small percentage of the signed statements taken by an investigator may ever be used. However, all statements have potential importance, and the investigator must learn how to take a correct, proper and complete statement early in his training.

A claims person, therefore, may have some preconceived ideas about the manner in which a signed statement should be taken, and about the average person's reluctance to sign it. Experience will be his best teacher, but he can learn how to avoid a few of the pitfalls from the experience of others. Above all, he should relax and be natural. Anxiety is a sign of uncertainty and will be as obvious as timidity.

One should immediately get a signed statement. The longer it is delayed, the less likely that it will be obtained. If the purpose and reasons for obtaining signed statements are understood, the claims person will be that much more qualified and prepared to answer questions asked by the witnesses. Why is a signed statement so important in claims work?

Importance of Signed Statements
There are several reasons why signed statements are critical:

-It provides an opportunity to obtain details in a permanent record form while they are fresh in the minds of the witnesses. Unless an investigator can take shorthand, no notes will be as comprehensive as a complete statement taken from a witness.

-It can be used as a subsequent refresher, if memory dims the details. This may become important if the case goes into suit and eventually to trial.

-Signed statements can sometimes be used as a substitute for the witness' personal testimony if the witness is not available to give his own version. Unless statements are taken by a court reporter, are depositions, or are notarized, it might be difficult to get them admitted in evidence.

-Signed statements are subject to the same rules of evidence as other testimony.

-A witness' statement can be used to discredit him either before or during trial if he should attempt to change his story.

-Once the witness has signed a statement, he is less likely to change his story, for he realizes that his statement can be used against him.

-A signed statement is a reliable and usually accurate factual record of the information obtained for the file and for transmission to the home office.

-A signed statement can be used as a means of convincing opposing counsel of the falsity of certain allegations and make him more amenable to a fair settlement figure.

The first thing to do in preparing and planning for a signed statement is to obtain a signed statement that is logical, concise and in chronological order. The claims person must plan his strategy in advance. The average statement involving an automobile accident should not require the seasoned claims person to spend much preliminary time jotting down points of information he does not wish to forget in questioning the witness.

For the new claims person in the field, it is best to do sufficient preliminary planning on every case until the taking of certain types of signed statements become second nature. The less time that is available to take a statement, the more preliminary planning is necessary, so that the most relevant information can be obtained in the least amount of time. Ordinarily, it is not only common courtesy, but intelligent handling to see a witness when he or she has the time to spare. This is not always possible, and to arrange for another appointment without making any attempt to get a signed statement during the first interview can be disastrous. Any delay provides too many opportunities for the witness to change his mind or to be persuaded to change it.

The approach to interviewing the witness is very important. Anything that is done to antagonize the witness defeats the purpose for which he is being interviewed. The manner in which witness cooperation is gained is something personal to each claims person and cannot be learned by reading a book.

The claims person should attempt to gain the attention and interest of the insured on some common basis of appreciation or endeavor. Confidence should be gained by the sincerity and evident fair-mindedness of the claims person. He should not simply introduce himself, and then sit down and immediately pull out a writing pad. Rather, the claims person should talk to the witness first, and put him at ease. The witness will shortly begin to talk about the accident quite naturally. The claims person should let him talk, if both have the time. The claims person can then start taking notes of salient points that he wishes to include in the statement. This will be the outline

and preparation before writing the actual statement.

The claims person must watch for reactions from a witness and must be able to change his approach the moment he senses antagonism. The sight of a statement pad will often cause an immediate negative reaction. Accordingly, the claims person must put the witness at ease by explaining his mission, and he must convince the witness of his desire to get the true facts.

When the interview is concluded, the witness should be thanked for the time he has graciously given.

For the most part, taking signed statements is a matter of common sense. The new claims person however, may find a few guidelines helpful in establishing a procedure.

Principles of Handling a Claim
There are a number of elementary principles with which a person handling a claim should be familiar:

Coverage Problems – Whenever a coverage problem is involved, two separate signed statements should be obtained from the insured; one covering the facts of the accident, and the other covering the information to be obtained on the coverage problem. The statement concerning coverage problems will usually contain references to the agent or broker as well as to the insured's carrier, which should not be in the statement concerning the facts of the accident. Most states still forbid the injection of insurance coverage status in the trial of an action for negligence.

First Person – The statement should be written in the first person in order to show that the witness is doing the talking.

Separate Statements – No two people will ever see an accident exactly alike. It is, therefore, a good practice to obtain a separate signed statement from each witness. The claims person should refrain from having one witness add either his signature to the statement of another, or even a paragraph to the effect that his version of the accident corresponds with a version as stated by the other witness. There are unusual circumstances that could make such a practice acceptable where the alternative would be no statement at all from the second witness, but this should be the exception rather than the rule.

Legible Writing – The handwriting on the statement must be legible. If the handwriting of the claims person is difficult to decipher, he should get a portable typewriter or computer or have the witness write out the statement himself. Requests to have the witness write out a statement may not always be granted, but the request will usually make the witness much more amenable to signing the one written or typed by the claims person. Handwritten statements should be written in ink. Where the witness is willing to write his own signed statement, the claims person will have to help him or her with it and this could be troublesome where the statement may have to be admitted into evidence. When the witness writes his or her own statement without any direction whatsoever, it will usually be inadequate; therefore, the claims person often has a difficult decision to make regarding this issue. In any event, the claims person should never request that a witness who is self- conscious about his education or spelling write his own statement.

Narrative Form – Unless a court reporter's statement is being taken, the straight narrative form is the best form for the ordinary signed statement. The question and answer type of statement looks too legalistic for the average layman. It may breed suspicion, whereas the ordinary narrative statement would not. Narrative however, does not mean to imply that the claims person is to write a novel. He or she should be specific, brief and to the point without overlooking important material. The question and answer form usually requires a great deal of extraneous writing. It may, for instance, require a whole series of questions to obtain personal and comparatively unimportant details about the witness before the claims adjuster can get to the meat of the

statement. In addition, if the answers are not written exactly as given, it could lead to misinterpretation that might cause the entire statement to be discredited.

Arrangement – Although every effort should be made to arrange the statement chronologically for easy reading, the writer should not be afraid to add paragraphs at the end, either upon request by the witness or to cover information that he forgot to include previously in the body of the statement. In other words, he should be orderly but need not make a fixation of it. It has been said that the signed statement should be taken without paragraphing, under the belief that in breaking the statements into paragraphs, there is some opportunity for the one who holds the statement to add a few words after it has been signed. It is more important than the suspicion that might be aroused by leaving part of the line unfilled.

Solitary Interview – If the claims person can possibly avoid it, he should not try to take a signed statement from a witness when the witness is surrounded by family and friends. It is best to suggest tactfully that the noise and disturbance will be too great for concentration. Then, if possible, he should attempt to interview the witness alone where he will have his undivided attention. There are exceptions, such as if the witness is very young, in a hospital or other institution, or is illiterate or unfamiliar with the English language. Again, it is recognized that there may be times when gatherings are unavoidable and when the claims person must either take a signed statement under adverse conditions or not get one at all.

Style – Whenever it is appropriate, simple language and short sentences should be used. The written statement should record as closely as possible the witness' manner of speech, but bad grammar or objectionable language should not be used purposely. Occasionally, the investigator will take down a direct quotation. When this is done, he must, of course, use the exact language of the witness. However, bad grammar is an obvious condescension that leaves as bad an impression as the use of words that are far beyond the obvious knowledge of the witness. The claims person should refrain from using unfamiliar legal, medical or technical language.

Preprinted forms – The claims person should avoid the use of preprinted forms in taking signed statements. They serve no useful purpose and, again, will only create suspicion and be less effective if needed to be presented as evidence.

Factual Material – Whenever possible, try to give factual information and avoid opinions or conclusions. While this is not always possible or even advisable, some effort should be made to keep opinion and conclusion at a minimum, unless it is pertinent. If any statements overheard by a witness immediately after an accident are included, they should be quoted as close to verbatim as possible. If an opinion based upon obvious circumstantial evidence is included, it should be kept to a minimum and wherever possible such words as "probably" and "perhaps" should be avoided. Also, where possible, recognized designations of speed, distance and direction should be used to indicate speed. Approximate miles per hour should be used instead of such words as "fast," "slow," or "moderate." The points of a compass rather than "right" or "left" should be given, and distance should be measured from such landmarks as large trees, mail boxes, buildings, etc. While it is advisable to be as definite as possible, it is not advisable to be dogmatically so. A statement that a car was traveling at thirty-seven miles per hour could be torn to pieces on cross examination.

Insurance – All mention concerning the name of the company that is involved in the investigation, or the phrase "insurance company" should be avoided. It may be necessary to use this statement in a court trial and the introduction of insurance in any form may cause a mistrial.

Conditions Affecting Statement – A signed statement should not be taken from anyone who is under the influence of alcohol or narcotics, or who is in a state of shock following an accident. If a witness has slurred speech, seems drowsy or is unusually slow in his answers to ordinary questions, the investigator should be doubly cautious and make thorough inquiries concerning the

witness' condition before obtaining a statement from him. This is one of the few exceptions to the rule of promptness. To obtain an effective statement and to keep his ethics above reproach, the claims person must observe local laws, ordinances, or codes that regulate the time or place for the taking of statements. If, for instance, he must take a statement in a hospital under circumstances that permit it, he should try to have a nurse, attendant, or possibly doctor present as a witness. The attendant will also be able to attest to the fact that the patient was free from apparent unusual pain and from the influence of narcotics and that the witness appeared to be in a rational frame of mind.

Objectionable Phraseology – The use of objectionable words or phrases should be avoided unless the investigator is quoting what the witness said. Otherwise, any reference to race, religion, foreign background or any evidence of bigotry or obscenity should be scrupulously avoided. A completely innocent remark concerning race, intended merely as a descriptive appellation, could easily be misinterpreted by a juror.

Preserving the Statement – The claims person should refrain from physically mutilating a statement in any way. It is a valuable piece of evidence, and should not be soiled, torn or shopworn. In addition, it should not be date-stamped by an office clerk or by any other marking that might make it unacceptable as evidence.

Constructing a Statement

There will be times when, because of pressure, peculiarities of an individual, the facts of an accident, or for other reasons, the statement will not follow an orderly pattern. Most times the general construction of a signed statement should be obtained from a witness – the insured, claimant or disinterested outside witness – should follow an orderly, chronological form. This not only makes for easier reading, but indelibly impresses its pattern on the claims person so that he will automatically obtain the necessary information because it fits into his regular routine. An outline of a good construction pattern for a statement should include the following subjects generally in the order given:

Date, Time and Address – At the top and upper right-hand corner of the statement, always place the date and time when the statement was taken, and the address of the place where it was taken. By including the time, the claims person pegs down the surrounding circumstances more definitely, and makes it more difficult for a witness to later deny that he gave the statement. Identification of the Subject – The first paragraph of the signed statement should be concerned with the identification of the subject who is giving the statement. It should include his name, age and address. It is of primary concern that the authenticity of a statement be provable. Therefore, the more personal details, within reason, that can be obtained and placed in a signed statement, the less likely it is that the witness will ever be able to deny that he gave it. It is suggested that such additional information as the witness' place of employment, Social Security number or other pertinent data be added to the statement where warranted. The degree of identification of the subject should depend on the nature of the accident and the type of witness with whom the investigator is dealing.

Location and Reason for Witness' Presence – This paragraph should be devoted to a description of the location of the accident and should include the reasons for the witness being there at the time. The direction in which the witness may have been walking or riding should be given, as well as the exact spot from which he viewed the accident. Naturally, in subsequent investigations the claims person should make it a point to check on the story given by a witness to determine whether he actually could have viewed the accident from the position where he says he was. Included here should be the facts indicating what attracted the witness' attention to the accident.

Factual Details – This paragraph should include the factual information concerning the details of the accident. It should, as far as possible, be confined to facts. Hearsay information should be avoided unless it involves spontaneous remarks made directly before or after the accident, or

unless the remarks contain information which will attack the credibility of a witness. If, from the claims person's knowledge, he or she realizes that the information being given is obviously wrong because of an honest mistake on the part of the witness, he or she should try to clarify the situation before putting it down on paper. On the other hand, if there is any question of dishonesty, or if the witness stubbornly maintains his position on the situation, it should be taken down as is. By doing so, the witness will at least destroy his value as a witness for the opposition.

Physical Description – The physical description of the scene of the accident should be as complete as possible, and should include weather and lighting conditions, road surfaces, road and other measurements, and any other pertinent details. Whenever possible, some effort should be made to get the witness to draw some form of diagram, illustrating the factual situation. Drawing the diagram will help clarify the facts and impress the interested parties with the credibility of the witness. It is important to have the diagram signed as well as the statement, and is best to keep the names of other witnesses out of the signed statement. They may turn out to be unreliable and the statement, if read in court, might create an erroneous impression.

Injuries and Damage – The next section of the signed statement can include details concerning the nature of the property damage and the injuries received. This should include not only as complete a description of the damage as possible, but an estimate of the cost of repairs, if one has been obtained. Description of the injuries should be as complete and detailed as possible, and should be in the language used by the claimant. The names of all attending doctors with their addresses should also be included.
Special Damages – In statements obtained from claimants, complete lists of all special damages should be obtained and itemized. The items that make up special damages have previously been covered.

Police Action – An indication of any possible arrests or other police action should be included toward the end of the statement.

Corrections – Having finished the body of the statement, it is now the duty and responsibility of the claims person to make sure that the statement contains the exact information given by the witness and that it does not deviate in any way from the information which he gave. Now is the time to give the witness the statement to review and to point out any errors, any parts of the statement which are not clear, or any sections which the witness for any reason whatsoever wishes to have changed. Wherever possible, all changes or corrections should be made by the witness in his own handwriting. If the witness shows any reluctance, or objects to making the corrections in his own handwriting, the claims person should make sure that each correction made is initialed by the witness. Under no circumstances should any portion of the statement be erased. Rarely is a statement written first-draft without needing some minor corrections. The claims person should not look upon this as something objectionable. The fact that a witness has made corrections in the body of a statement in his own handwriting, or has initialed such corrections, is an admission that he has not only read, but studied the statement. It would be difficult indeed for him to try to testify subsequently that he had not read the statement or was not aware of what it contained after having corrected it.

Acknowledgment – Having placed the pen in the hands of the witness for the purpose of making corrections, it then becomes a mere matter of routine procedure, after he has completed his corrections, to ask him to acknowledge the fact that he has read the statement and affirms the truth by adding in his own handwriting, the words "I have read the above and preceding number of pages, and state that the information contained therein is true and correct," or words of a similar nature. This sentence should be written on the line following the end of the statement, allowing for no empty space in between.

Signature – If the claims person has obtained the acknowledgment that the witness has read the statement and affirms the information to be true, in his own handwriting, he should not have any

difficulty with the signature. Most witnesses will append it automatically. It is preferable that the claims person does not use the word "sign" in asking the witness to put his name down on the next line after the acknowledgment. The individual who continually bemoans the fact that he or she cannot obtain signed statements is one who is making excuses for certain internal deficiencies. A positive attitude (and this does not mean an overly aggressive attitude), a matter-of-fact handling of the situation, and above all, the absence of any hint of defeatism or timidity, will ordinarily accomplish the necessary results. Refusals to sign a statement should be the exception, rather than the rule. No signature will ever be obtained without some effort or attempt to get it. Nor will it be obtained with an attitude or words that signify, "You don't want to sign this, do you?" Each page of the statement should be initialed by the witness or, preferably, signed with his full name. When a witness hesitates to put his signature on the statement, the claims person may point out to him that he is merely being asked to verify the truth of the statements he has made. It sometimes helps to ask the witness what phrase of a statement he seems uncertain about. If the witness adamantly refuses to sign the statement, in some instances a third party who was present during the time the statement was taken might be induced to add his signature to a paragraph attesting to the fact that the statement was read by (or to) the witness, and that he affirmed it to be true and correct. In some instances, witnesses may refuse to add their signatures to a statement but will not object to placing the letters "O.K." at the end. Sometimes, the witness might be willing to answer the following questions as written out by the person who has obtained the statement, "Have you read the above and preceding pages?" "Is the information contained therein true and correct?" An affirmative answer to each of these questions in his own handwriting has the same effect as though the witness had signed the statement. Occasionally, the very sight of a statement pad will affect a witness as a red flag affects a bull. He will vehemently and violently tell you that there is no use in your writing out a statement since he will absolutely refuse to sign it. The claims person must not let this throw him off balance. He should put his pad away, inform the witness that he is merely attempting to arrive at the truth and ask the witness to give the facts. After the claims person has obtained the witness' version verbally and after the witness has had a chance to calm down, the claims person can then explain to the witness that he does not want to rely on his memory in order to report on the facts as given by the witness. Accordingly, the claims person can indicate that he would like to make a few notes to be certain that he reports the information exactly as given to him. In most instances, if properly explained, the witness will not object. The claims person can then proceed to write up the statement. Surprisingly enough, the witness will often feel ashamed for having given vent to his anger and may sign the statement obligingly.

Witness to the Statement – Whenever practical, signed statements should be witnessed by one or two disinterested parties who should place their full names and addresses on the statement. The claims person taking the statement should not ordinarily witness it. Occasionally, a claims person will encounter a witness who does not have sufficient understanding of the English language to be able to read the statement. In that event, it is necessary to obtain a translator's affidavit or short statement appended to the bottom of the statement obtained from the witness. The affidavit or appended statement should indicate that the translator read the statement to the witness in his own language, that the witness understood it, and affirmed the facts contained therein to be true and correct. Such a clause can read as follows: "I, John Doe, residing at [address] attest that I can fluently read and write French as well as English. I further state that I have read the above and preceding statement of Mary Smith and that I have accurately translated it into the French language which she understands. Mary Smith affirmed the fact that this is her statement, that she thoroughly understands it, and that the information contained therein is true and correct." This paragraph should be signed by the translator and either witnessed or notarized. Before obtaining the signature of the translator, the signature of the witness should be obtained at the bottom of the statement, even though written in a foreign language.

Despite the fact that the percentage of illiteracy in this country is extremely low, the claims person will nevertheless encounter illiterate witnesses more often than he or she would think likely. Sometimes an illiterate person will attempt to cover up this ignorance by what may appear

to be an obstinate refusal to confirm the statement by reading it, or to sign it. With a moderate degree of persistence, the claims person should be able to recognize this. In any event, obtaining a statement from an illiterate person requires the utmost tact and diplomacy. The claims person should read the statement to the witness, make whatever corrections are necessary and, if possible, call in the services of a notary or some other reliable person in whom the witness has confidence and who the claims person believes to be reliable.

The claims person should have the third person reread the corrected statement to the witness and obtain the witness' assurance that the statement is true and correct. Then, in place of a signature, he or she should have his or her mark placed at the bottom of the statement and append a paragraph on the same page stating that the statement has been read to the witness and that this witness has affirmed that the information contained therein is true and correct. Such an appended statement, to be signed by the third person who has read it to the witness, can read as follows:

"I, John Doe, residing at [address], read the above and preceding [#] pages to Mary Smith. She stated that she understood the statement, affirmed that it was hers, and that it is true and correct."

This paragraph should be signed by the person who read the statement to the witness and corrections should all be initialed by this individual. If a notary has been called in to assist either as translator or to read the statement to an illiterate person, the notary should add his or her own form of affidavit.

In investigating serious or important claims, the claims person will obtain leads that will direct him or her to people who will deny any knowledge of the accident. In those instances, where the denial is persistent, and where he or she believes there is a possibility that they are either covering up or may subsequently appear as witnesses for the opposition, every effort should be made to obtain a short, signed statement from such persons. It should state that they did not see the accident and from their own observation know nothing about it. Such a negative, signed statement will at least prevent that person from later appearing as a surprise witness for the opposition. If the witness does appear, it will enable the defense attorney to discredit this individual.

If a case which the claims person is investigating is of any consequence, it warrants a personal interview with every witness. Occasionally, the obstacles to personal interviews may be extreme, involving distance, weather conditions, or the element of time. The claims person may, therefore, after due consideration, and at a calculated risk, determine that the most advisable course of action is to attempt to get information from a witness through the mail. Having learned by now that the writing of a statement is an involved matter, proficiency in it requires practice.

Therefore, the claims person should not expect that the ordinary witness will always be able to write a satisfactory narrative account of an incident without help.

Again, proper judgment must be used to avoid asking so many questions that the witness is discouraged. At the same time, he should be thorough enough to get the information he needs. He should use great care and spend enough time to prepare the questions so that they will be pertinent and intelligible. As much care should be used in framing the accompanying letter to the witness as in the preparation of the questions themselves. He must remember that he is imposing on the time of the witness and that the witness is doing him a favor in complying with his request.

It has often been said that children make unreliable witnesses. It may, in fact, be quite the contrary. Some children have vivid imaginations and sometimes cross the borderline between truth and fantasy. This, however, is usually not hard to determine. For the most part, a child who has sufficient mental development can be impressed with the importance of his remarks to the extent that he will make a reliably factual statement. The average child who is able to read and

write will, for the most part, give a more straightforward and honest account than the average adult.

Whether the statement should be written in the handwriting of the child, or whether the claims person should write it out himself, is a matter of judgment involving elements of time and the child's personality, general intelligence and education. If the child has acquired reasonable skill in writing, it is advisable to have him write the statement himself. In this case particularly, it is essential that all useless verbiage be eliminated in order not to tire the child or cause him to lose interest. Such a statement should always be obtained in the presence of a parent, adult relative or friend. It is particularly important that the words used should not be incomprehensible to the child. His vocabulary will vary with his age and development.

Subrogation

Subrogation, in the insurance industry, is the term used to describe the right of an insurance carrier who has paid a claim as a result of an accident of loss covered under a policy, to recover from a wrongdoer for the damage caused, up to the amount paid by the insurer. In other words, the insurer is substituted for the insured for the purpose of making a claim against the third party wrongdoer to recover the money paid under the policy.

Subrogation plays a very important part in claims work. Proper handling of this phase of insurance can make the difference between a profitable and an unprofitable operation. Every dollar recovered after expenses is pure profit. Unlike the premium dollar, there are normally no commissions or other fees that must be deducted.

While the right of subrogation does not arise until after payment has been made to or for the insured by his insurance carrier, the claims person must be alert to the possibilities of subrogation from the very inception of the claim and must prepare his or her investigation accordingly. The right of subrogation may arise in law as a matter of equity or by contractual agreement. We are, of course, particularly concerned with the rights arising out of insurance policies.

Most casualty policies, where subrogation is a factor, contain a subrogation condition which reads as follows:

"In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefore against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights."

Exactly the same condition appears in the workers' compensation policies. Many of the state insurance statutes incorporate this or similar wording in their workers' compensation laws. Where subrogation rights are asserted under the conditions of the policy, such conditions become the sole measure of the insurer's rights. The insurer is limited to the rights of the insured and only to the extent of the amount paid by the insurer.

Subrogation may apply to the following kinds of insurance policies or bonds:

-Motor Vehicle
-Workers' Compensation
-Marine and Inland Marine
-Fire
-Fidelity-Surety

The basic principle of subrogation is the same in each instance; the insurer is substituted for the insured in any right of recovery against a wrongdoer. In workers' compensation claims, subrogation rights are subject to the laws of the various states. While these may differ in their

requirements for bringing actions against the wrongdoer, their purpose is uniform in attempting to deny double recovery to the injured and in protecting whatever subrogation rights an insurer may have. The right of subrogation does not apply to life insurance or to accident and health policies unless the latter contain a specific subrogation clause, which is rare.

In all first party claims involving a third party wrongdoer, the insured has a choice of recovery, either under his or her first party policy, or against the third party wrongdoer, or his or her carrier. Recovery, however, can only be made once. Therefore, if the insured chooses to press the claim against the third party, and makes recovery without the consent of the insurer, he or she relinquishes his right to make a claim under the first party policy.

In the event that the insured recovers under the first party policy, he or she loses the right to recover against the wrongdoer to the extent of the amount paid him by the first party insurer. Accordingly, if settlement is made under a first party policy, the claims person should be certain that the insured is advised that he or she must not try to recover against the third party for the same damage. If recovery is made from the third party (or the third party carrier) after the claim has been paid under the first party policy, the first party carrier is entitled to repayment from the insured, assuming that such recovery is made without the knowledge or consent of the insurer.

On the other hand, the wrongdoing third party could remain liable to the first party insurer if he or she knew of the first party insurer's rights of subrogation at the time the latter settled the claim. It is therefore obvious that the company must notify the third party and his or her carrier of its interest in the matter as soon as possible after receiving a report of an accident. A release given by an insured ordinarily voids the right of subrogation unless a lien or some notice has been filed with the wrongdoer.

It has been held that the mere sending of a lien letter in advance of payment of a claim is not sufficient to hold the third party wrongdoer or his or her insurance carrier in double jeopardy unless the carrier with the subrogation rights notifies the wrongdoer or his carrier that payment has actually been made on the claim. The court held in that case that the plaintiff's right to subrogation did not actually arise until the claim had been paid and since the lien letter preceded any payment made, and did not give the amount of any expected payment, it was ineffective.

Accordingly, the letter notifying the wrongdoer or the carrier of subrogation rights should be followed by a notification that payment has been made including the amount of such payment. It is just as essential that the claims person keep possible subrogation involvement in mind when making a sizable property damage settlement. As we have indicated, payment of such a claim to a third party claimant where notice of subrogation rights has been received could put the company in a position of double jeopardy.

No single form can be devised to fit all situations. The following letter therefore is given as an example only.

"John J. Jones, insured under [Insurance Co.] Policy No. [X] has made claim or damage to the [automobile] caused by the negligent operation of your car resulting from the accident which occurred on [date of accident] at [place of accident]. The [Insurance Co.], because of its subrogation rights, hereby makes claim against you for the amount [state amount if known] which it has been or will be required to pay and requests prompt settlement of this claim. If, at the time of this accident, you were insured against loss arising out of claims of this kind, we suggest that you forward this letter to your insurance company without delay. Please let us know when this has been done and send us the name and address of your insurance company. We shall appreciate it if you will let us hear from you by return mail."

Subrogation rights are not necessarily limited to first party (collision, fire, theft, etc.) or workers' compensation policies only. They may arise because of vicarious liability imposed upon a third

party insured under a financial responsibility statute or in some instances because of agency. For example, if payment is made under a non-ownership policy because of the negligence of the driver-owner of the automobile, the carrier may bring an action to recover the amount paid against the driver-owner.

In subrogation actions, suits may be brought in the name of the insured or may be required to be brought in the name of the carrier, depending upon the law of the jurisdiction involved, and the nature of the action being brought. In either event, investigation should be completed as soon as possible and action to recover should be taken without too much delay after payment has been made.

Any defense which a wrongdoer could ordinarily get away with can also be asserted against the insurer in a subrogation action. The insurer does not lose its right of subrogation by waiving any of its rights of subrogation or by waiving any of its policy defenses for breach of policy conditions such as late notice or failure to cooperate. However, the wrongdoer can defend a subrogation action against the insurer on the grounds that there was no coverage in the first place or that coverage was specifically excluded.

Subrogation rights do not extend to voluntary payments made by the insurer. Payment of a claim properly covered by an insurance policy is not construed as a voluntary payment. It is merely the fulfillment of a legal or contractual obligation. If the insurer chooses to pay a claim that is not covered, with full knowledge of this fact, he thereby becomes a mere volunteer and is not entitled to subrogation rights.

An insurer may waive his right of subrogation either by express agreement or by failure to act. If an insurer pays a claim with full knowledge of a settlement that has already been made between the insured and the wrongdoer, he waives his right of subrogation. In addition, if he induces the insured to make settlement with the third party, he loses his right of subrogation. Furthermore, if an insurer unreasonably delays a settlement, knowing that the insured has financial need, he may waive his right to subrogation in the event that settlement does not take care of the complete obligation under the policy.

Loan Receipt
An action against the wrongdoer, ordinarily brought under a subrogation clause, is usually brought in the name of the insured although, in some other instances, it may be brought in the name of the insurance company. A loan receipt is sometimes obtained for the purposes of:

-Permitting the insurer to bring an action against the wrongdoers in the name of the insured where this might otherwise be contested.

-In order to enable the insurer to pay the claim promptly because third party liability has been established.

-To further protect the insurer’s rights of subrogation.

After a first party claim has been paid by an insurance case recovery against the wrongdoer, it becomes a primary concern of the insurer. Since the insured cannot make double recovery, it is obvious that his or her interest in any further action is greatly diminished, if it is not altogether extinguished. In view of the fact that the insurance company now becomes – under the laws of most states – the real party in interest, action must be prosecuted against the wrongdoer in its own name.

Judgment must be used in determining whether or not to press any subrogation rights that the company may have. If the amount involved is small and the liability doubtful, it would be patently unwise to press subrogation rights when by so doing an otherwise quiescent claim for bodily injury

or extensive property damage may be activated. Even if the amount involved is substantial, it is sometimes inadvisable to press subrogation rights if this might result in a retaliatory claim for serious bodily injury on a case of doubtful liability. Any question about the advisability of asserting subrogation rights should ordinarily be discussed with the claims manager or home office before taking any definite action.

Factors Relating to Subrogation
Some factors which should be given consideration before making a final decision concerning subrogation are:

-The amount recoverable – A substantial amount will warrant the expenditure of more time and effort than will a nominal amount.

-Expense – The effort and expense involved in an attempt to recover should be warranted by the amount recoverable. It is not common sense to spend $20 worth of time in an effort to recover $10. This does not mean that no effort should be made to collect claims involving small amounts if this can be done through minimal efforts and without undue expense. Some effort should always be extended to make recovery by mail, telephone or personal contact when warranted. Expense factors to be considered are:

-Cost of investigation in both time and money.
-Legal fees.
-Suit expenses such as reimbursement for witnesses' testimony and so forth.

-Insurance – An attempt should always be made to find out whether the wrongdoing third party carries insurance and if so with what company and to what extent.

-Identity of the third party – It is essential to establish the exact identity of the wrongdoer and determine whether he is an agent or an individual, co-partnership, corporation or whatever.

-Financial responsibility – If the individual or his principal did not have insurance, an investigation should be made, in cases that warrant it, to determine the extent of financial responsibility of both the individual and his principal. This can be done fairly easily through one of the companies that specialize in this sort of work. There is little point in spending time and money to obtain a worthless judgment.

-Potential antagonisms – The claims person should check with the insured to determine whether there will be any business repercussions if an action is brought against the wrongdoer. In some instances, the insured's right may arise out of a manufacturer- wholesaler, manufacturer-retailer, or similar relation-ship, in which the goodwill of the wrongdoer may be important to the insured in a business way. Although this should not be the determining factor in the final analysis, as far as the claims department is concerned, it is always good business practice to discuss such matters with the underwriting department so that they can have the opportunity to decide whether any possible recovery would be worth the antagonism that might be created.

-Retaliation – Give primary consideration to the possibility that prosecution of subrogation rights might provoke a retaliatory property damage or bodily injury claim.

-Liability – Even though other factors prove favorable to pressing a subrogation action, lack of liability on the part of the third party can of course defeat all other considerations. It is usually inadvisable to spend the time, effort and money to press a subrogation claim unless it is felt that the chances of success are at least 50-50 or better.

The right of subrogation arises normally through common law, but as we have previously stated, is reaffirmed in the policy provisions. Actually a subrogation receipt adds nothing to the subrogation clause already provided for in the policy. In the event that the claims person may

encounter the unusual circumstances in which there is no subrogation provision in the policy, he would be wise to obtain a subrogation receipt. Such receipt may be worded as follows:

"Received from [insured] through [insurer] Dollars in full satisfaction, compromise and discharge all claims for loss and expense sustained to property insured under Policy No. [X] by reason of [describe the accident] which occurred [date] and in consideration of which the undersigned hereby assigns and transfers to the said company each and all claims and demands against any person, persons, corporation or property arising from or connected with such loss or damage and the said company is subrogated in the place of and to the claims and demands of the undersigned against the said person, corporation or property in the premises to the extent of the amount above named."

Knock for Knock Agreements

Agreements whereby the insurer does not press subrogation rights against another insurer as a matter of reciprocity are prevalent in the British Commonwealth of Nations and are known as "Knock for Knock Agreements." Such agreements assume that in the long run, the subrogation rights which an insurer may have are equalized by the claims which might be made against it as a result of which both parties avoid the time and expense necessary to press subrogation rights against each other.

There are several kinds of "Knock for Knock Agreements" that operate in various parts of the world. Sometimes in the United States, the idea is sponsored by local claim associations of various kinds.

A claim executives' association in Wisconsin designed a subrogation agreement that would apply to insurers who had claims against each other. This agreement outlines some thirteen specific instances which illustrate applicability of subrogation rights and the percentages of recovery in each instance. The same agreement or others patterned after it were adopted by other claim organizations. The advantage of these agreements is obvious in that it not only avoids unnecessary time and expense of individual collections, but also avoids cluttering the courts with numerous property damage claims that are disposed of without the necessity of litigation.

One of the programs sponsored by the American Insurance Association is the Inter-Company Arbitration Agreement. The purposes of this agreement are to improve claims service, to afford relief to the courts and to prevent litigation of disputes between member companies as much as possible, thereby enhancing the confidence of the public in the insurance industry.

The vast majority of inter-company cases can and are quickly resolved by arbitration. These comprise, for the most part, property damage claims, usually in relatively small amounts, that would otherwise tend to clog the court calendars unnecessarily. There is also arbitration machinery that avoids legal expense and tends to lessen misunderstandings and friction among companies in the insurance industry, in addition to other advantages previously mentioned.

Practically all motor vehicle policies today covering collision losses are written on a deductible basis. Ordinarily, an insurer has no right to represent an insured in pressing the insured's claim against the third party. As a practical matter, the deductible feature of the policy is usually the smallest part of the claim and is tied in with the subrogation claim of the insurer. The general practice is for both carriers to treat the claim as a unit and dispose of the insured's (as well as the insurer's) claims in any settlement negotiations.

Where recovery for the deductible amount has been made, the amount due to the insured is to be determined by the general practice followed in any particular locality. In some areas, legal fees involved in the recovery are apportioned. In others, the insured will receive a proportionate share in the settlement and, by agreement in some jurisdictions, the insured's deductible is paid first and the remainder kept by the insurance company. The amount involved is so small that there is

no legal precedent to follow. It becomes a matter of business and public relationships in each particular area.

Ordinarily, any recoveries made by a carrier under a subrogation action would make the excess carrier whole first. Under a district court decision in New York, the court permitted first recovery by the primary insurer because the primary insurer had taken a loan receipt. The court stated that the position of the excess insurer is no better than that of the insured. The decision gave no weight to the "custom" in the insurance industry for the proceeds of a subrogation recovery to be applied first to the payment made by the excess underwriter.

Salvage
Property upon which the total value has been paid as a result of a claim under an insurance policy is known as salvage and rightfully belongs to the insurer. Properly handled, it can be an important source of revenue for an insurance company. Despite the fact that an article may be considered a total loss for settlement purposes, more often than not, the damaged article has some monetary value. It sometimes takes a little ingenuity to find a market for some articles, but it can ordinarily be done with the use of a little imagination and effort.

Salvage is a matter to be considered not only in the disposition of first party claims but in the settlement of third party claims as well. The claims person will often find that a claimant may be willing to settle a claim for a lesser amount if permitted to keep the article that the company is paying for. In such an event, it is usually more practical and economical to permit the claimant to retain the salvage if adequate deduction is being made for the value of the property in its damaged condition. Automobile salvage is a highly specialized field in which there is usually some buyer available whether the market be high or low at the time. It must become part of a claim person's routine to become acquainted with dealers in wrecked cars so that he or she can always obtain a number of competitive bids on automobile salvage.

If the salvage involves a large object like an automobile, make sure that it is protected from weather damage as well as from theft. It is, of course, important that the claims person arranges for economical storage until such time as he can dispose of the article so that the eventual amount recovered will at least be more than the storage charges. For this reason, it is also advisable to dispose of salvage as soon as possible after having carefully explored the available market.

Handling Salvage Claims
The following summarization is an outline of steps to be considered in the handling of a claim involving salvage:

-Whenever you have paid for the total loss of an article, either obtain credit for it from the claimant or take it in salvage, assuming that it is available and has some value.

-Protect the salvage from theft, further deterioration and the elements.

-Arrange for storage at the lowest possible cost.

-Explore the market for all possible buyers.

-Dispose of the salvage as soon as possible. Retention increases depreciation as well as storage charges.

-Ordinarily, avoid selling salvage to coworkers or to yourself. You may both become dissatisfied customers and may in addition leave yourself open to unwarranted suspicion.

Contribution
Although the subject of contribution does not properly belong in the category of subrogation or salvage, proper attention to it can be an important item of possible financial gain to a company. This is reason enough to make some mention of it here. The good claims person should always be conscious of the possibility that someone else's responsibility for the payment of a loss may be equal to his company's or even greater than it. In many instances, the automobile and public liability policies may overlap – the claims person must be awake to the possibility of such a situation. For example, an insured's automobile may have been involved in an accident while on the premises of the insured.

Ordinarily (excluding the operation of guest statutes), a passenger involved in a two-vehicle accident has a right of action against the owner and driver of the car in which he was a passenger as well as the owner and driver of the opposing car. Sometimes two cars will collide and injure a pedestrian or damage property belonging to someone else. Occasionally, there will be two similar policies covering the same insured. There may be other instances, as well as these mentioned, in which it is advisable to check the possibility of contribution. This should be prominent in the thinking of the claims person during the investigation of any casualty claim.

Obtaining the Medical Information for Claims Handling
The first time a trainee copies a hospital report, he or she may come out of the experience quite bewildered. Five years later, the individual may be inclined to criticize the diagnosis and question the treatment.

The truth of the matter is that the average person can, with some diligent study, acquire a good working knowledge of medical terminology and enough of an understanding of the field in which he is interested to discuss injuries, and even treatment, quite intelligently. Of course, the physician who has spent years of his or her life studying and practicing medicine knows more than the claims person about medical problems. Therefore, while he or she should learn as much as possible, the claims person should never try to replace the physician.

Medical and legal textbooks should be available to the claims person, and he or she should be able to discuss medical problems with a resident or examining physician, or with the home office. Even if the office out of which he or she is working maintains a resident physician on its staff, there is still need for the claims person to have a certain familiarity with injuries or diseases which may result from, or may become aggravated by, accidental injury. The individual must, in any event, be able to:

-Evaluate the injury – This can be done only if he or she is able to understand the medical reports and appraise their significance. If he cannot evaluate the injury, he obviously cannot evaluate the claim and must therefore, depend entirely upon his supervisor to set a figure on its value.
Help detect fraud or malingering – Unless he or she has at least some fundamental knowledge of symptoms, causes, and effects, he or she will be completely unprepared to determine the appropriateness of a particular claim.

-Help determine whether proper treatment is being given – This is especially important in compensation claims. Claim adjusters, quite obviously, are human. They do become emotionally involved in their claims. It is natural, therefore both from the humanitarian and business point of view, for the claims person to be anxious for the claimant to receive the best possible treatment, so that he can make the quickest possible recovery.

-Learn when to order a medical examination and by whom it should be made – Ordering an examination shortly after a claimant has received a fracture and is still in a cast is not only useless, but is a complete waste of money if there does not appear to be a question about the genuineness of the injury or the honesty of the claim. On the other hand, if there is or may be an element of fraud or malingering, the claims person may find it advisable to assign a medical

examination as soon as possible, or at least after enough time has passed so that any subjective complaints would have materialized.
The best time to obtain medical information and a written authorization from the claimant to procure medical information is when the claims person first interviews the claimant.

Authorization should be phrased in simple language, and should avoid legal terminology. The authorization should state that the bearer is authorized to receive a medical report on the accident from the doctor or hospital involved, and should be signed by the claimant. Enough copies should be given so that medical information can be obtained from each attending physician, hospital, clinic, or any other person or organization that rendered medical services.

Components of Medical Information
Medical information obtained from the claimant should preferably be incorporated in a signed statement obtained from him. Whether obtained orally or in writing, the information should include:

-Detailed description of all objectives (noticeable evidence of injury).
-Detailed account of any unconsciousness, giving exact duration.
-Complete list of subjective complaints (not accompanied by noticeable evidence of injury), when they first developed, and their duration.
-Assistance rendered at the scene of the accident.
-First aid rendered and by whom.
-Name of hospital or doctor to whom the claimant was taken immediately after the accident.
-Name and address of family physician who subsequently treated the claimant.
-Name and address of any specialists who were called in for consultation and treatment
-Dates of all visits to physicians, specialists, hospitals or clinics.
-Dates of visits made by doctors or specialists to the home of claimant.
-Dates of admission to and discharge from a hospital.
-Information concerning X-rays – taken by whom, when and what part of the body they covered.
-Details of operations or casts.
-Details of the nature of the treatment rendered.
-Exact duration of confinement to bed.
-Exact duration of confinement to the home.
-Exact length of disability from work.
-Exact nature of present complaints, if any.
-Description of any scars or disfigurements (include snapshots or photographs, if obtainable).
-Complete details of previous medical history:
-Family history, including inherited tendencies or weaknesses and the history of family deaths that might have a connection with the present or future disability of the claimant.
-Names and addresses of all doctors and hospitals that were involved in previous serious ailments that might have a connection with the present disability or which might have been aggravated by the accident.
-Complete list of previous operations, with full details, including previous X-rays taken.
-Details concerning any previous protracted treatments.
-General observations regarding obesity, undue nervousness, unusual despair or other indications of a similar nature that may have a direct bearing on the injury, disability or recovery.
-History of previous disease, such as cancer or heart condition, which may have been aggravated as a result of the accident.
-History of previous ailments or diseases which might have left after-effects, such as scarlet fever, measles, and so on.
-History of any previous diseases which might affect healing in any manner, such as tuberculosis, syphilis, gonorrhea, diabetes and so on.
-Special emphasis on previous injury to eyes, ears or any part of the body that may have impaired complete function or contributed to the cause of the accident.
-Previous dental history, if applicable.

-History of all extensive previous physical examinations, such as for life insurance, armed forces, or induction to the armed forces, employment, or school examinations.

In reporting the medical information, some comment should be made concerning the competency, qualifications, and reputation of the claimant's attending physician or physicians. If these are unknown to the claims person, the qualifications of the attending doctors should be checked in the local medical directory or directory of medical specialists.

Lien Laws

Congress (Veteran's Hospitals) and a number of state legislatures have, by statute, given hospitals and doctors a means of legally protecting their bills for services rendered in connection with casualty claims by allowing them to file a lien. Such a lien requires the party on whom it is served to pay the medical bills out of any money paid in settlement of a third-party claim.

These statutes are known as lien laws. Where applicable, they require notice of lien to be given by hospitals or doctors to third parties alleged to be liable for the injuries received by the claimant. In some instances, notice is required to be given to the third party insurance carrier, if known. Sometimes the liens must be filed in the county clerk's office in order to become effective.

Failure to comply with the provisions of the lien law after notice obligates the third party or his insurance carrier to reimburse the hospital or doctor for the bills covered in the lien, regardless of any settlement which may have been made with the claimant. Accordingly, it is obviously important to note the existence of any lien and take whatever steps may be necessary to insure payment of the bill before settlement is consummated. This may be done by issuing a separate draft to the claimant and the doctor or hospital for the amount of the bill at the time of settlement, if it is still unpaid.

In many jurisdictions, recognition of the lien will permit the claims person to obtain medical information from a hospital. Usually, there are certain prescribed forms which must be completed before the information will be released. The filing of a lien can sometimes be used to advantage when all other avenues for obtaining medical information have previously failed.

Getting Medical Information

One of the most important steps in the investigation of bodily injury claims is the problem of obtaining complete medical information from the claimant's attending physician as soon as possible. Most companies provide some sort of printed form for obtaining this information. We will shortly discuss some of the items of information that should be contained in a physicians' report. No definite rules can be established concerning the advisability of using such form, or the manner in which it is to be used. This will depend entirely on the claims person's knowledge of the attending physician. He should get to know his local physicians and their secretaries as soon as possible. The latter are often the guardians of the physician's time and records.

In some cases, a mailed request enclosing the form with a stamped, addressed envelope will suffice. In others, it may be necessary to call the physician on the telephone before sending such a form. Sometimes, especially where the injury is severe, the claims person should see the doctor personally. In such instances, there is no substitute for a personal interview.

If it is believed that the reaction to the request will be favorable, the claims person should arrange by telephone for a personal interview at the physician's convenience. In other instances, it may be advisable to call on a doctor during his office hours and wait until he has finished with his last patient. In no event should an attempt be made to interview a doctor while a patient is waiting to see him, unless the doctor invites the interview. Even if the doctor refuses written information, he may provide some verbal information that could be valuable. When a definite appointment has been made, a claims person should be absolutely sure that the appointment is kept promptly, and should never keep a doctor waiting. If at all possible, a medical report form should be completed

during the interview. If the doctor is pressed for time he may request that the form be left with a stamped, addressed envelope to be forwarded at his earliest convenience.

Prompt medical information obtained from the claimant's attending physician will help to determine the need for a physical examination, and give the claims person an opportunity to prepare the case properly for defense, if necessary. If the attending physician's qualifications and integrity are unquestionable, settlement can often be effected based on his information without the delay and expense of a physical examination. It is equally important to obtain the attending doctor's report where a physical examination is needed, so that the examining physician may have the benefit of the medical allegations before making his examination.

Most casualty claim departments have some printed or copied medical report form to be completed by attending doctors. In many instances these are so detailed that they discourage a busy doctor. He may either ignore them completely or fill them out in a sketchy manner. In other instances, forms have been so whittled down that they lose much of their potential value.

Components of Effective Medical Forms
To be most effective, the medical form should contain at least the following categories:

Personal and descriptive data – This should include notation of the date, time, and place where the initial examination was made. It should also include at least the name, address, marital status, age, weight, height and occupation of the claimant.

History of the accident – Whether or not detailed questions concerning the time, place, location, and other factual details of the accident itself should be printed on the form is a matter of judgment. Suffice it to say that some provision must be made for the history or factual details concerning the accident.

Previous medical history – Here the details included in the form may vary. For a checklist of the information that can be obtained under this category, see the list provided under "Medical Information to Be Obtained from the Claimant," discussed previously.

Details concerning the initial examination – This includes any X-rays or laboratory test reports, and consultant's reports.

Treatments rendered – This includes the type and the dates of all office and home visits.

Diagnosis – This should include a detailed account of the doctor's findings concerning ailments and disability, with special emphasis on trauma.

Prognosis – This concerns the estimated disability and possibility or probability of partial or ultimate recovery with emphasis on a possible partial or permanent disability.

Conclusion and recommendations – Here the doctor should comment on recommendations concerning future treatments, operations, or further hospitalization, as well as any other details that affect the medical picture.

Diagrams – Diagrams of various parts of the body are usually imprinted on the opposite side of the medical form to enable the doctor to show scars or indicate the location of fractures, burns, or other injuries.

Doctor's bill – Provision should always be made for the doctor to show the amount of his bill up to the time the report is made, with provision for estimated future medical expense.

Dental History

In all cases involving injury to teeth, a claims person should obtain as complete a dental history as possible, including the general condition of the subject's teeth immediately before the accident, an account of any diseases of the mouth, details concerning bridge work or plates, pivots or caps, and any other information that might have a bearing on the injury allegedly sustained as a result of the accident under investigation. For instance, it is not unusual to find that teeth which may have been knocked out as a result of an accident were in advanced stages of decay.

Components of Hospital Records

When investigating serious accidents, a claims person should make a transcript of the complete hospital record. He should not be content with an abstract of the hospital records merely because the abstract will save him the bother of copying the record. This copying is admittedly a time-consuming and tedious chore, but it pays off often enough to make it worthwhile. An abstract is ordinarily only a very brief digest of the information contained in the record. If a case is important enough to warrant such an examination, every paper in the hospital records should be carefully scrutinized. The hospital records will usually contain:

Admission information – Beside the ordinary information about the date of admission and the history of the accident as given by the patient, there may be welfare board reports concerning the financial background of the claimant, policy reports, an itemized list of the clothes and possessions of the claimant at the time of admission, condition of the clothes, and other extremely valuable information. The history of the accident as given by a claimant to a hospital attendant immediately after an accident can be of extreme importance if the claimant seems inclined to change his story later.

Examination reports – These are reports by attending physicians and interns, X-ray reports, notes and instructions by interns and doctors, details concerning treatment, pathologists' and laboratory reports.

Nurses' notes – Such notes, made for the benefit of the attending doctors and interns, contain comments that are often pertinent concerning a patient's attitude and morale and will also indicate what drugs have been administered.

Diagnoses and prognoses – These must be gathered from the various attending physicians and specialists, along with the date and circumstances under which the patient left the hospital. An alert investigator should not miss the opportunity to obtain information from nurse either. Nurses typically spend more time with patients and get to know them in a much more personal manner that doctors who rarely have time to listen to a patient's subjective emotions.

Objectives of the Medical Examination

A proper medical examination can be an important source of information. It is also a valuable defense weapon but it should not be ordered indiscriminately. Consideration should be given to the ultimate objectives which are to:

-Help to determine if the allegations of disability are true and to corroborate the injuries sustained.
-Help to determine if the alleged injuries or disability resulted from the accident.
-Help to determine the true extent of any disability.
-Help to determine if the claimant is receiving proper, sufficient or too much treatment.
-Obtain the history of the accident as given to the examining physician or corroborate any conflict with the previous information he gave to the hospital or other doctors.

If the object of the examination is merely to corroborate information, then the hospital records, the reputation of the claimant's attending physician and the information he gives may be sufficient. However, in order to avoid second-guessing, where there is no allegation of further injury or disability, an attempt should be made to obtain a signed statement or report from the doctor.

Medical examinations should never be assigned routinely as a matter of course. It is a costly measure at best. When deciding on the advisability of a physical examination, the claims person should obtain as much medical information as he can from the attending physician, hospital records or other sources. Otherwise, the examining doctor may be concentrating on the effect of a fracture and completely miss a subsequent allegation of neurosis. The claims person must never forget that a medical examination can be a double-edged sword. Made by the wrong doctor at the wrong time, or without sufficient preparation, it can do more harm than good. Obviously, the doctor will be able to make a much more thorough examination, and one of greater value, if he is familiar at the outset with all the allegations and complaints.

Local custom and statutes vary with reference to the obtaining of physical examinations. When a case goes into suit, at least one physical examination is ordinarily permitted by law. However, in view of the fact that both the claimant and any attorney which he may have engaged are ordinarily anxious to obtain a settlement, they will in most instances cooperate to the extent of permitting at least one examination even when the case is not in suit. Since this may be the only examination that is permitted, the claims person must be intelligent about its use.

He or she must make the best use of the examination that is permitted. Except in the unusual or long disability case, it would be difficult to justify more than one examination. Reluctance on the part of either the claimant or his attorney to permit a medical examination is usually an indication that some attempt at exaggerating the injuries or the disability may be made. As has been said before, judgment must be used in determining when a physical examination should be made. If there is no question of fraud or malingering, or the propriety or necessity for further treatment, an examination should be delayed until the maximum healing has taken place.

Otherwise, a physical examination should be obtained as soon as enough time has elapsed to develop any subjective complaints that might be alleged in the future.

The physician making the examination should be properly qualified, impartial, honest, and should make a good impression as a witness. If the allegations require the services of a specialist, get a specialist to make an examination. Barring unusual circumstances, a jury will not give as much credence to a general practitioner as it will to a specialist. This can cause disaster if the specialist is testifying for the opposition. The claims person should not use doctors who may be even unconsciously biased in his favor. He should make arrangements with a physician who is thorough and competent, but not too busy to make a proper examination and give a proper report.

It is also important to remember the examining physician may have to testify at trial. Because some specialists rate their services quite highly, you should accordingly have an understanding with the doctor concerning costs before engaging his or her services. When the claims person has decided on a doctor, he or she should be given all the information available before the examination takes place. Under no circumstances should an examining physician advise the claimant about treatment, or suggest a course of treatment to him. Under rare circumstances, the attending physician may wish to consult with the doctor who made an examination for the company, but even here the situation must be handled with the greatest tact and diplomacy to avoid putting the company in a position where it may be accused of practicing medicine.

Finally, the claims person should make sure that the examining doctor’s report is intelligible and that he or she thoroughly understands it. If not, it is important to discuss it with the doctor until all questionable points are cleared up.

The claims person, in making an assignment to a physician for a medical examination, or the claimant’s physician, in evaluation, should know how to interpret information obtained from the American Medical Directory, or from other medical directories published in this country or abroad. Such directories give information concerning the school or university from which a doctor

graduated; the year of graduation; any specialties which he practices; any fellowships or special degrees or honors; any medical societies to which he belongs; his staff and hospital associations and other such valuable information that can help to determine a doctor's experience, education and competence.

However, it is important to remember that such background information, while exceedingly important, is not the complete picture. There are many general practitioners who are extremely competent medical practitioners, despite their lack of a specialty or higher degree, and despite the fact that they may not have graduated from a prestigious university or medical college.

Specialties
The development of medicine is marked by an ever-growing list of specialties to which practicing physicians more and more confine themselves. In fact, general practice is itself becoming a specialty. In rural areas, a country doctor must be a good practitioner who has some familiarity with all types of medicine, including surgery. In highly-populated cities, more and more medical professionals continue their studies along very specialized lines. With the growth of large clinics and medical centers, specialization is now commonplace.

In order to be able to determine the particular specialist to whom the claims person may wish to assign a physical examination, he or she should have at least some familiarity with the more common specialties which are being practiced today. Selecting a doctor that specifically specializes in the area that needs to be examined can give the adjuster significantly more information, while selecting the wrong type of medical specialist can be a complete waste of time and resources.

Veterans' Records
While some selective service records are privileged, the part of the record concerning physical disability and injury can usually be obtained without undue difficulty. This information usually contains a complete medical history and a record of any injuries, ailments, or treatments while in the service, particularly where there may have been any disability resulting in a pension. These records are most important where there is any allegation of neurological or psychiatric complications and can, if necessary, be subpoenaed in an action in federal court. In state courts, the power of subpoena with reference to such records is at the discretion of the judge.

Veteran records concerning disability are ordinarily very comprehensive and include among other items:

-Name, age and other personal data.
-Military record.
-A complete chronological medical history, including examination of admission, treatments and examination on discharge.
-A history of all accidents or injuries.
-Medical history.
-Nurses' notes, doctors' progress notes and doctors' orders.
-Laboratory tests, X-rays, electrocardiograms, etc.
-Clinical notes and outpatient records.
-Consultation records.
-Report of the Board of Medical Service.

Chapter 10 Claims Management

Habits for Responsible Claim Management
Proper claims management is a key factor in reducing insurance business costs. Giving claims their due diligence reduces fraud, keeps claimants satisfied (which reduces court costs), and helps defend the insurer against the court cases that do arise (which reduces settlement amounts).

- Don’t be a hero. This advice relates to the futile attempt on the part of a claims adjuster or claims counsel to attempt to economize on a case where the gravity of the injuries and damages of the claimant are so severe in relation to policy limits that it is an obviously futile exercise to attempt to “save” part of those policy limits. It also applies where a company has given authorization for settlement up to a certain amount, and the adjuster or defense counsel unwisely attempts to save a few dollars from the amount authorized when the authorized amount appears to be an appropriate settlement.

- Listen to the advice of defense counsel. The danger is particularly severe, since the claims files on bad faith matters are subject to discovery by the plaintiff’s attorney. Thus, if the claims file is replete with letters saying, “This is a bad one,” “You better look out,” “Pay this,” and “This one could go over the policy,” an insurer’s failure to heed such warnings could result in a powerful claim of bad faith.

- Keep the insured client advised. Relating to the Second Commandment, if claims personnel have received advice regarding the possible outcome or the amount of liability involved, there is an absolute legal obligation to inform the insured. Ad damum excess letter, sent by the insurance company, advise the insured that there is a good possibility that the claim of the plaintiff and a subsequent judgment may exceed the policy limits. It is also safe to say that the insurer is obligated to respond accurately to requests from its insured with reference to the progress of any settlement negotiation.

- Do not deplete the policy carelessly when there are multiple claims. When an insurer is confronted with multiple claims and is concerned that the policy limits will be inadequate to cover all of the claims, the law usually allows interpleader. When several claimants claim the same fund, and the insurer is uncertain which of the claimants has a right to the fund, the insurer runs the risk that, if some claimants are paid and others are not, it may subsequently incur bad faith liability. Thus, the insurer may file an “interpleader” suit, which requires the claimants to litigate their right to the fund in question. Remember, however, in matters involving insureds, there is always the duty to defend an insured, and an insurer cannot dismiss itself from the claims situation by use of the interpleader device.

- Investigate properly. Since bad faith law may evolve toward imposing liability upon insurers for ordinary negligence, it is clear that the failure to do a good job in investigating the insured’s liability obviously exposes an insurer to liability for ordinary negligence.

- Explore the possibility of settlement. At one time an insurer could sit back, relax and have no duty to initiate settlement discussion. Prior to modern discovery rules, the plaintiff’s attorney usually did not know the policy limits, and it was a cardinal rule that insurers did not volunteer this information in most cases. Consequently, the plaintiff’s counsel usually had insufficient information upon which to base a settlement demand.

- Think bad faith. The possibility of a bad faith action must be considered in all cases. However, it is particularly important in cases where there is a policy with inadequate limits. Demonstrating diligence during the investigation and intelligence during the settlement can insulate against bad faith accusations and help bolster a trial defense. Communication is also key. The adjuster must keep the claimant informed and respond immediately to communications by the claimant and his or her attorney

- Consider a client’s demands and not take all eternity. Waiting for settlements of cases until “reaching the courthouse steps” is no longer advisable. A number of court decisions have expressed impatience at such dilatory tactics, ruling that an insurer violates its fiduciary responsibility in attempting to resolve the case in a timelier manner.

- Don’t induce the insured to contribute. Years ago, some insurance companies would seek a

contribution from the insured before the insurer would deplete its policy. This is clearly not tolerated today, and courts have ruled that exhorting the insured to contribute something was in itself "suggestive of bad faith."

- Consider the insured's interest. This is the greatest of the commandments since it embraces all of the others. "The law imposes upon the insurer the obligation of good faith— basically the duty to consider, in good faith, the insured's interests as well as its own when making decisions as to settlements."

Managing Claims Better with Technology

Cost reduction through automation

The ability to automate, increase productivity, and improve workflow management in claim processing represents a major opportunity to reduce costs. Companies who work to automate processes and tasks traditionally performed by skilled labor will set new productivity standards that competitors will need to adopt to remain in the market.

Improvement in insurer "legacy" computers

The industry is woefully behind the rest of the business community with aging hardware. Most systems are easily a decade old and replacement is too big an expense at this time. Enhanced components will help automate claim management decisions and workflow tools resulting in reduced cycle time and better claim decisions. For the aging and overworked adjuster population such programs could be incredibly helpful.

Electronic and web claims processing

While the paperless claim is not quite here, a growing number of them are being processed electronically over the Internet with great results in efficiency. This is reducing the processing cycle from days and weeks to hours and minutes. This is more important in cases where large case exposure or large sums of money are involved. The same electronic processing may also reduce the prospect of multiple submissions where claims involving fraud are copied from one jurisdiction to another or where requested coverage is made for insured property that doesn't even exist or it is allegedly stolen.

Managing Claims Better with Information Collection

Identification of exceptional claims

Companies are under more pressure than ever to be more efficient in identifying "exceptional claims" that can be managed better by a skilled adjuster. Finding these claims early so they can be appropriately managed will help prevent losses and identify additional coverages. Examples might include claims with a high probability for subrogation, those need specific reserve limits as well as the ones that represent potential large losses or litigation that can be mitigated early on.

Detection of economic induced fraud

When the economy is out of sorts, a growing number of out-of-work people turn to opportunistic fraud to replace lost wages. Scams include phony workers' comp claims, auto accidents and staged personal property burglaries. Business are also part of the mix where losses are orchestrated to create insurance windfalls. Uncovering the trends and indicators for this fraud is no small task. Central databases are essential, yet privacy issues create specific and limiting obstacles.

Clients need for privacy is a priority

Privacy issues and potential invasion suits create a high level need to develop security and systems measures to protect personal and financial data collected in the claims process. This is especially acute when one considers that the sharing of claims information is important to the claims management.

Claim Response
Many times, a claim that ends up in appraisal or litigation is found to have the root of its problems traced to the early stages of the claim. In fact, many claim experts feel that the first 48 hours following a loss are unique. This is the time when losses can be minimized and excess claims and client dissatisfaction avoided.

One of the key elements in the early phases of a claim is preserving the evidence. Since recovery by subrogation is the standard in many cases, the carrier's success is dependent on his ability to pinpoint a defective product or negligent action to demonstrate its connection to the loss. Evidence that "clears the air" in a disagreement is also essential. However, in the chaos of a loss site, it is all too easy for well-intentioned individuals to compromise or destroy evidence that would have made the recovery possible.

Documenting the loss site in the earliest cycle of the loss is essential. For instance, the claim of heavy smoke damage was disputed by an adjuster who visited the scene. Unfortunately, since he did not document what he saw with photographs, his testimony at arbitration was discounted. Other times, an early photograph revealed that lost inventory claims were only a fraction of that shown.

The reduction of further building damage is another reason to proceed quickly after a loss. Activities like weather protection, restoration of heating and cooling, removing water and saturated materials, protecting floors and rapid drying as soon as possible can eliminate costly replacement later. Adequate shoring and bracing can save masonry walls from collapse and aggressive drying can save floors and electrical systems that would otherwise be lost. Site security may also be an issue. When alarm systems have been disabled by damage or loss of power, restoring them to service should be a high priority. Chemical and biological hazards pose an equal threat.

Minimizing personal property loss is yet another motivation to act early in the loss cycle. Retrieving or protecting data processing equipment, which can be the lifeblood of a business, should be a high priority. Exposure to a smoke-filled building, for instance, can generate corrosion in electronic circuits and chips in as little as 36 hours. The process is accelerated when the high humidity of fire hoses is added to the mix. What can be done? Special services are available to retrieve data, tent equipment, dehumidify rooms, "scrub the air" and equipment cleaning on short notice.

In the same vein, some companies have major investments in equipment like printing presses, office machines, processing equipment, milling machines and other high-tech production devices. They are all vulnerable to exposure to moisture, smoke, corrosion and mold. Packaged inventories are similarly affected. Airborne moisture can penetrate wrapping and cardboard storage boxes causing penetration, bowing, collapse, and mold growth. However, aggressive treatment in the first 48 hours can avoid costly replacement.

Adequate working environments after a loss are yet another goal to achieve as early as possible. Emergency cleaning and deodorizing of offices, furnishings and equipment can help minimize loss of revenue and jobs.

The role of the professional adjuster in the early stages of a loss is to inspire realistic expectations by explaining provisions and procedures in the claim process. A time line must be developed for the resolution of the claim and cooperation by the insured encouraged so that his personal preferences can be accommodated. Unfortunately, most insureds are conditioned otherwise since many automatically conclude that their best interests will not be represented by the insurer. However, an adjuster who addresses problems of the loss early, with a sense of urgency, will help build confidence and mitigate the chances of further damage or claim.