CHAPTER 18
GROUP HEALTH INSURANCE

Whereas the greatest amount of life insurance is individual policies, most people in the U.S. have health coverage through a group policy. In an individual policy the contract is between the insurer and the policyowner, but in group insurance the insurance contract is between the insurer and the sponsoring organization. Some sponsors for group insurance include employers, trade associations, labor unions, multiple employer groups, creditor-debtor groups, and lodges. For an association to obtain group insurance, it must be a natural group and have been in existence a certain period of time, usually two years.

In group insurance the sponsor is issued a **master policy.** Individuals covered under the group policy do not receive a copy of the master policy but receive a **certificate of insurance** and an outline describing benefits. The master policyholder is responsible for applying for the coverage and providing information to the insurer about the group. The master policyholder owns the policy and is responsible for making the premium payment to the insurer.

In general, benefits provided under group contracts are more extensive than individual policies. The cost for insuring someone under a group plan is less than insuring a person under an individual policy due to decreased administrative and selling expenses. Group insurance provides benefits to people who might not be able to afford the coverage on their own. Dependents may be covered under a group health policy.

There is no individual selection as to coverage under a group health policy. Benefits are predetermined by the employer in conjunction with the insurer.

ELIGIBILITY

For a group policy to be issued, the group must be formed for some reason other than to purchase insurance. This is referred to as a natural group. For instance, an employer-employee group is not formed for the purpose of obtaining insurance and, therefore, is a natural group. A “true group” is defined as one that has at least 10 members. However, California recognizes a group as having two or more members.

In group insurance the normal practice is to cover all eligible persons regardless of age or physical condition. Individuals covered under the group policy must meet certain eligibility requirements to participate in the plan. Frequently these requirements are being a full-time employee and having been employed a specified amount of time such as 90 days.

The period of time an employee must work for an employer before being covered under the group insurance is called the **probationary period**. The probationary period in a group health policy is intended for people who join the group after the policy effective date. The period of time in which to sign up for the group coverage is referred to as the **eligibility** period—normally a 31-day period after the probationary period has ended.

CONTRIBUTORY AND NON-CONTRIBUTORY PLANS

If the employer pays the entire premium for the policy, the plan is called **non-contributory** as the employee contributes nothing. In a **contributory** plan, both the employer and employee contribute to the premium payment. In non-contributory policies, the employer must cover **100%** of eligible employees. Contributory plans require **75%** participation in order to avoid adverse selection for the insurer.

The cost of insurance paid by an employer for employee benefits is a deductible business expense on income tax returns.

UNDERWRITING CHARACTERISTICS

In group underwriting, the underwriter focuses on the group as a whole. The underwriter is concerned with the group's risk profile. There normally is no medical information asked of the plan participants. In a small group there is a much greater chance for adverse selection. One bad risk in a small group could have a great impact on claims experience. Due to this, insurers engage to some degree in individual underwriting with small groups. In this way the premium charged for coverage can be adjusted to the possible loss exposure.

An underwriter will consider a number of things when underwriting a group policy. The underwriter will take into consideration: carrier history (how often has the employer changed insurance carriers); the stability of the group; prior claims experience of the group; size and composition of the group; type of business or industry in which the group is engaged; zip code (cost of care varies in different geographical areas); and length of waiting period for loss of time benefits.

Group policies normally contain a provision excluding pre-existing conditions. This commonly is defined as a condition for which the member received treatment during the three months prior to the effective date of the group coverage. Group policies will state when a condition will no longer be regarded as pre-existing (e.g. not having received treatment for the condition for a three-month period).

CONVERSION PRIVILEGE

Group health plans providing medical expense coverage contain a conversion privilege for individuals who wish to convert their group coverage to an individual policy with the same insurer when they leave their employment. The conversion must be exercised during a 31-day period. During this conversion period, the individual still is covered under the group policy whether or not ultimately exercising the conversion privilege.

Although the individual may not be turned down for insurance coverage, the insurer is allowed to evaluate the person in order to establish an appropriate premium payment. The insurer could rate the person as either a standard or substandard risk.

POLICY REPLACEMENT:

Group Life and Disability: The provisions of this article apply to all policies of group life insurance, to all group disability policies, to any group nonprofit hospital service contract, and to any self-insured welfare benefit plan issued in this state (CIC 10128).

Definitions (CIC 10128.1)

“Carrier” means the insurance company, nonprofit hospital service corporation, or other entity responsible for the payment of benefits or provision of services under a policy.

“Dependent” shall have the meaning set forth in the policy.

“Discontinuance” shall mean the termination of a policy or the termination of coverage between an entire employer unit under a group disability policy, group nonprofit hospital service contract, or self-insured welfare benefit plan, and does not refer to the termination of any agreement between any individual member under a contract and the disability insurer, nonprofit hospital service contract or self-insured welfare benefit plan.

“Employee” means all agents, employees, and member of unions or associations to whom benefits are provided under a policy.

“Extension of benefits” means the continuation of coverage under a particular benefit provided under a policy following discontinuance with respect to an employee or dependent who is totally disabled on the date of discontinuance.

“Policy” means any group insurance policy, group hospital service contract or other plan, contract or policy subject to the provisions of this article.

“Policyholder” means the entity to which a policy or contract is issued.

“Premium” means the consideration payable to the carrier.

“Replacement coverage” means the benefits provided by a succeeding carrier.

“Totally disabled” shall have the meaning set forth in a policy.

Extension of benefits

A group policy which provides life insurance, loss of time benefits, or hospital, medical or surgical expense benefits must extend the benefits for a reasonable time after the policy is discontinued for any employees who are totally disabled when the policy was discontinued and who became totally disabled while insured under the group policy. (CIC 10128.2)

When discontinued, a group policy with both life insurance and disability benefits is considered to provide a reasonable extension of benefits if:

1. The discontinuance does not affect the disability benefit.
2. The rights of conversion apply to the amount for which the person is insured when the disability benefit ends except if that benefit is a payment of income for a specified period. Then the conversion rights apply only to any amount of insurance remaining after the income is paid.
3. The insured may convert any life insurance to which no disability benefit provision applies to an individual life policy. (CIC 10128.2.b)

A policy providing benefits for loss of time or a specific indemnity during hospital confinement is deemed to have a reasonable extension if the discontinuance does not affect the benefit provided. A policy which provides hospital, medical, or surgical benefits on an expense-incurred or service basis must extend benefits for any condition causing total disability existing at the time of discontinuance for at least 12 months after discontinuance. Any extension of benefits may be terminated when the covered employee is no longer disabled or when a succeeding carrier provides coverage without limitation to the disabling condition. (CIC 10128.2 c-d)

Level of Benefits

A carrier providing replacement coverage for hospital, medical, or surgical benefits on an expense-incurred or service basis within 60 days after the prior group policy is discontinued must cover all employees and dependents who were insured under the prior policy when it was discontinued as long as they were eligible for coverage under the previous policy. A replacement carrier does not have to provide benefits for the conditions that caused an employee or dependent to be totally disabled. (CIC 10128.3.a)

The level of benefits provided by replacement coverage cannot be lower than the benefits provided under the prior policy, minus the amount of benefits paid by the prior carrier. Benefits for an employee or dependent under a replacement policy cannot be reduced or excluded because of preexisting conditions unless they would have been excluded or reduced as preexisting conditions under the prior group policy. (CIC 10128.3.b)

A prior carrier must make available to a succeeding carrier a statement of benefits so the succeeding carrier can verify benefits to be paid. A succeeding carrier may not exclude coverage on a dependent child who was covered by a prior carrier because of the fact the insured employee does not provide primary support for the child. (CIC 10128.3.d-e)

If an employee or dependent fraudulently fails to tell a succeeding insurer about a preexisting condition, the insurer can deny benefits for the individual. However, the other employees or members of the group cannot be penalized. (CIC 10128.2.f)

All policies subject to the foregoing provisions will be construed to be in compliance with the California insurance code. (CIC 10128.4)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA was enacted in 1996 and affects almost all healthcare providers. This law defines that the information in client files belongs to the client and must be protected. HIPAA has made sweeping changes in the way that medical information is handled and protected.

HIPAA, in general, is designed to make health coverage more portable for individuals who change jobs or health plans by limiting the coverage exclusions that can be imposed when such a change occurs. Employers who provide health insurance for their employees are required to offer full health care coverage immediately to newly hired employees if they previously had “creditable” coverage for 12 straight months with no lapse in coverage of 63 days or more. If an individual did not have creditable coverage, the new insurer can refuse to pay for any pre-existing conditions for 12 months. However, the individual may reduce the exclusion period if he/she had group health plan coverage or health insurance prior to enrolling in the plan. HIPAA allows an individual to reduce the exclusion period by the amount of time that he/she had creditable coverage prior to enrolling in the plan and after any “significant breaks” in coverage. If the enrollee had creditable coverage for the last eight months, there would only be a four-month exclusion period. Late enrollees in group health plans might have to wait up to 18 months for coverage for pre-existing conditions.

When someone leaves a health plan, he/she should get a “certificate of creditable coverage”. The certificate should list the following: coverage dates;

policy ID number; insurer's name and address; and insured's name as well as any family members included under the coverage. When an entire business changes health insurance carriers, certificates of creditable coverage are not necessary as the new health insurance is issued with full **take-over benefits** for all eligible members enrolled on the date that the new insurance starts. This means all pre-existing conditions are covered immediately by the new insurance policy.

HIPAA's rules apply to every employer group health plan that has at least two participants that are current employees, including companies that are self-insured. The law prohibits group health plans and health insurers from discriminating against individuals with regard to eligibility, premiums, or contributions based on any health status related factor (e.g. a plan may not require an individual to pay a premium greater than do similarly situated individuals enrolled on the basis of any health status related factor). HIPAA's rules provide no protection if a person switches from one individual health plan to another individual health plan.

TYPES OF GROUP COVERAGE

Medical expense, disability income, and accidental death and dismemberment are available on group plans. Medical expense may be group basic medical expense or group major medical expense. The **basic medical expense** policy could be one of three types: hospital, surgical, and physician's expenses. Other group basic medical expense policies include dental and vision care, prescription drugs, laboratory services, diagnostic x-rays, and home health care. A basic medical expense policy can be limited to one coverage or a combination of several of the foregoing coverages.

Group major medical expense, like individual policies, can be either a comprehensive major medical policy or a supplemental major medical policy. Such contracts will have either an initial deductible, a corridor deductible, or an integrated deductible.

As a result of a 1979 amendment to the Civil Rights Act, group medical expense plans must provide maternity benefits. This amendment requires that groups of more than 15 members must treat pregnancy no differently than any other allowable medical expense. Different waiting periods cannot be required for maternity benefits than any other medical benefit.

A characteristic of group medical expense plans is the **coordination of benefits (COB) provision**. This is an arrangement in health insurance to discourage multiple payments for the same claim under two or more policies. If payment were to be made by several companies, this could result in overinsurance. Overinsurance is a situation in which the benefits paid to the insured exceed the actual amount of the medical bills. Such a situation could

tempt an insured to make false claims in order to profit financially. When two or more group health insurance plans cover the insured and dependents, one plan will be considered the primary plan and the others will be considered secondary plans. Medical expenses not covered under the primary plan could be covered under the secondary plan.

As an example, Theo and Barbara are married and both have insurance through their own jobs and their policies also cover dependents. The primary insurance on Theo is through his own job. The insurance coverage offered by Barbara's job is secondary on Theo. Conversely, Barbara's main coverage is through her job and the coverage offered through Theo's job is secondary. If Theo becomes ill, the medical bills will be submitted to his company's insurer. The secondary insurance through Barbara's company will pay whatever the primary carrier did not pay up to its own limits.

Children could be covered by both parents' insurance. In such cases either the gender rule or the birthday rule could be used to determine the primary insurer. Using the gender rule, the father's plan is the primary carrier. This rule is discriminatory in nature. California uses the **birthday rule** which states that whichever parent's birthday comes first in the year is the primary insurer. If one parent had a February birthday and the other a July birthday, the February birthday falls first in the year and that parent's insurer would be the primary insurer for the children.

Group Disability Income Plans

In group disability income plans, the payment amount normally is based on a percentage of the employee's earnings such as 60%. These plans can be either short-term or long-term disability plans. Short-term plans can have benefit periods of short duration such as six months. Long-term plans can have benefit periods of two years or longer. If an employer were to provide both short-term and long-term disability, the short-term policy would pay first before the long-term policy would pay benefits. Frequently a long-term policy will pay benefits based on the *own occupation* definition of total disability for one or two years and, after that amount of time has elapsed, change to the *any occupation* definition of total disability.

Benefit amounts paid under a group plan usually are considered to be supplemental to workers' compensation benefits. This dovetailing of benefits is to prevent an individual from receiving more than a specified percentage of normal income.

Group Accidental Death and Dismemberment Insurance

Group accidental death and dismemberment (AD&D) insurance frequently is part of the group life insurance coverage offered by the employer.

Occasionally it is offered to employees as a separate policy for which the employees pay if they wish the additional coverage.

AD&D policies pay an additional sum if the employee dies as the result of an accident. This sum is referred to as the principal sum. If the employee suffers a dismemberment (loss of limb or sight in an eye), the policy pays a capital sum.

OTHER GROUP PLANS

Multiple Employer Trusts (METs)

A multiple employer trust provides benefits to employees of two or more financially unrelated companies. The companies may employ workers from the same labor union or those in the same industry. Employer contributions go into a common pool from which benefits are paid. Employees may transfer between employers in the fund and retain their benefits. METs have been growing as smaller employers band together to provide benefits to employees. These small firms by banding together can lower costs by taking advantage of the economies of large group underwriting.

A third party administrator (TPA) is an outside organization used to administer the managerial and clerical functions related to a multiple employer trust or self-insured employer plan.

Credit Disability

Credit disability (credit health) insurance is designed to provide monthly payments on an outstanding loan should the insured (borrower) suffer a disability due to sickness or accident.

Blanket Health Insurance

Blanket health insurance is written to cover a group of individuals who are exposed to the same risks. The individuals within the group are changing constantly and, therefore, are not named. Examples are an owner of a campground wishing to cover campers and a university wishing to cover its students.

Franchise Health Insurance

Franchise insurance (wholesale insurance) provides insurance to employees of small businesses, associations, and professional organizations. Although franchise insurance covers a group, individual policies are written on each insured person. There is no master contract issued to the sponsoring organization. Premium rates usually are discounted as a number of policies are

involved. The tax implications are the same as on other group policies as explained on the next page.

TAXATION OF GROUP HEALTH BENEFITS

An employer may deduct the amount paid for group health insurance as a business expense. The employee is not taxed on these health benefits provided by the employer. Employee contributions made on a contributory plan are not tax deductible for the employee unless un-reimbursed medical expenses exceed 7.5% of the employee's adjusted annual gross income. This percentage changes in 2013.

The amount an employer pays for group disability income insurance for employees is a tax-deductible business expense. If the employer pays the entire premium for disability income insurance, the employee will be taxed on benefits paid to him/her if the employee becomes disabled. Under a contributory policy, the portion of the benefits for which the employee paid will not be taxed; the portion of the benefits paid for by the employer will be taxable income to the employee.

GOVERNMENT REGULATIONS AFFECTING GROUP POLICIES

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 is a federal statute that applies to employers offering group insurance who have **20 or more employees**. If an employee is terminated for other than gross misconduct, the employee can elect to stay under the group policy for a period of time. The coverage must be identical to that which the employee had prior to termination. The reason for this law is to provide health care coverage for the employee and dependents until employment or coverage can be obtained elsewhere. This is not the same as the employee exercising the right to convert the group coverage to an individual plan within a 31-day period.

Employers are required to inform individuals of their eligibility for an extension of benefits under COBRA. Notification must be provided when a plan becomes subject to COBRA, an employee is covered by a plan subject to COBRA regulation, and when a qualifying event occurs. Employees have 60 days to elect a continuation of benefits under COBRA or the option is forfeited.

To be eligible for COBRA benefits, the individual must be a qualified beneficiary the day before a qualifying event occurs. Qualified beneficiaries include the covered employee, covered employee's spouse, and covered employee's dependent children.

The following are qualifying events and length of time for extension under COBRA:

- Employment is terminated for other than gross misconduct—18 months (up to 29 months if disabled).
- Reduction in hours worked (resulting in termination from plan)—18 months (up to 29 months if disabled).
- Death of employee—36 months for dependents.
- Dependent child no longer qualifies as a dependent—36 months.
- Employee becomes eligible for Medicare—36 months.
- Divorce or legal separation of employee—36 months for former spouse.

The following are disqualifying events (termination of benefits under COBRA):

- The first day a premium payment is not made on time.
- The date the employer ceases to maintain group health insurance.
- The date the individual becomes eligible for Medicare.
- The first day that an individual is covered under another group plan.

CAL-COBRA

Cal-COBRA is a state law that expands the benefits under COBRA which is a federal law. Cal-COBRA applies to employers having **2 to 19 employees**. If an employee was covered under COBRA for 18 months, he/she may be able to keep health insurance through Cal-COBRA for another 18 months for a total of 36 months coverage. Employees, who are 60 years of age or older when they become eligible for Cal-COBRA and have worked for the employer for at least five years, may continue their coverage even after Cal-COBRA until they turn 65. This rule also applies to the spouses of such employees.

If the group plan offers specialized plans, such as dental or vision coverage, they must offer them under COBRA. However, they are not required to continue these extra plans when the employee changes to Cal-COBRA.

The American Recovery and Reinvestment Act of 2009 states that former employees who were enrolled in their employer's health plan when they lost their jobs are required to pay only 35% of the cost of COBRA/Cal-COBRA coverage. Employers must treat the 35% payment as full payment. The employers are entitled to a credit for the other 65% of the COBRA cost on their federal payroll tax return. (Note: Prior to 2009 the terminated employee could be required to pay the premium which could have been up to 102% of the normal premium. The additional 2% was to cover the insurer's administrative expenses.)

OBRA

The Omnibus Budget Reconciliation Act (OBRA) of 1989 extended the minimum COBRA continuation of coverage from 18 to 29 months for qualified beneficiaries who were disabled at the time of termination or reduction in work hours. The termination must not have been for gross misconduct and the disability must meet the Social Security definition of disability.

OBRA allows an employer to terminate COBRA coverage when coverage becomes available under another health plan as long as the other plan does not limit or exclude benefits for a beneficiary's pre-existing conditions.

OBRA also states that COBRA coverage may be terminated only because of Medicare entitlement, not just eligibility. The employer must be certain that the individual has enrolled under Medicare before terminating COBRA coverage of a beneficiary at age 65.

TEFRA

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 applies to employers having 20 or more employees. The act was passed to prevent discrimination in group term life insurance plans and to amend the Social Security Act and the Age Discrimination in Employment Act (ADEA).

One goal is to prevent group term life insurance plans from discriminating in favor of key employees. Key employees are those who are officers, the top 10 interest-holders in the business, individuals owning 5% or more of the business, and those owning more than 1% who are compensated $150,000 or more annually. To be non-discriminatory, the plan must benefit at least 70% of all employees or at least 85% of participating employees who are not key employees.

TEFRA amends the Social Security Act to make Medicare secondary to group health insurance plans. It also amends the ADEA by requiring employers to offer employees between the ages of 65 and 69 and their dependents the same coverage available to younger employees.

ERISA

The Employee Retirement Income Security Act (ERISA) of 1974 was intended to bring about equality in pension plans. The act's fiduciary standards benefit plan participants and beneficiaries. This act spells out the contributions that may be made to such plans as well as the benefits they may offer. ERISA requires stringent reporting and disclosure requirements for establishing and maintaining both group health insurance and other qualified plans. Annual

financial reports must be filed with the IRS. Plan descriptions must be filed with the Department of Labor.

ADA

The Americans with Disabilities Act (ADA) makes it unlawful for employers with 15 or more employees to discriminate on the basis of disability against a qualified individual with respect to any term, condition, or privilege of employment. A qualified individual must meet the skill, experience, and educational requirements of the position. The individual must have the ability to perform essential functions of the job and should not be considered unqualified simply due to an inability to perform marginal or incidental job functions.

The rules of the ADA apply to persons (1) considered to have a physical or mental impairment that substantially limits one or more major life activities, (2) has a record of such an impairment, or (3) is considered to have such an impairment. Impairments that substantially limit major life activities include seeing, hearing, speaking, walking, breathing, performing manual tasks, caring for oneself, and learning, Other impairments that are covered include epilepsy, paralysis, HIV infection, AIDS, substantial hearing or visual impairment, mental retardation, and certain learning disabilities. Someone with a record of a disability would be covered—such as someone who has recovered from cancer. Other limiting impairments that would be covered are an individual with a severe facial disfigurement as such disfigurement may be found upsetting to other employees or customers.

Employees with disabilities must be given whatever health insurance the employer provides. An employer cannot reject a person for employment on the grounds that one of his/her dependents that would be covered under the group plan has a disability.

PREGNANCY DISCRIMINATION

The Pregnancy Discrimination Act amended Title VII of the Civil Rights Act of 1964. The law forbids discrimination in any aspect of employment which includes hiring, firing, pay, job assignments, promotions, layoff, training, and fringe benefits such as leave and health insurance. If a woman is temporarily unable to perform her job due to a condition of pregnancy or childbirth, she must be treated the same as any other temporarily disabled employee. This might include providing modified tasks, alternative assignments, disability leave or unpaid leave.

Furthermore, under the Family and Medical Leave Act (FMLA), a new parent—including foster and adoptive parents—may be eligible for 12 weeks of leave that may be used for care of the new child. This only applies to an

employee who has worked for the employer for 12 months prior to taking leave and the employer must have a specified number of employees.

REVIEW QUESTIONS

1. Who receives a certificate of insurance?

    A. Insurance carrier
    B. Employee
    C. Employer
    D. Principal

2. What is the period of time an employee must work for an employer before being covered under the group insurance policy?

    A. Probationary period
    B. Eligibility period
    C. Enrollment period
    D. Contestability period

3. An underwriter will consider which of the following in underwriting a group health policy?

        1. Carrier history
        2. Type of business
        3. Medical history of each plan participant
        4. Age of group members

    A. 1, 2, & 3
    B. 2, 3, & 4
    C. 1, 2, & 4
    D. All the above

4. What is utilized in health insurance contracts to avoid overinsurance?

    A. Probationary period
    B. Eligibility period
    C. Incontestability provision
    D. Coordination of benefits provision

5. In California, which parent's policy is considered to be primary carrier on children?

    A. The parent's policy that has been in force the longest period of time.
    B. The parent's policy whose year of birth is the earliest.
    C. The parent's policy whose date of birth comes first in the year.
    D. The father's policy.

6. Long-term disability policies frequently will pay benefits on the *own occupation* basis for a year or two and then change to the *any occupation* definition of total disability.

    A. True
    B. False

7. COBRA is a federal statute allowing the extension of life and health benefits under group plans for a terminated employee.

    A. True
    B. False

8. Which act amended the Social Security Act to make Medicare secondary to group health insurance plans?

    A. COBRA
    B. OBRA
    C. TEFRA
    D. ERISA

9.. Which act extended the minimum COBRA continuation of coverage from 18 to 29 months for qualified beneficiaries who were disabled at the time of termination?

    A. COBRA
    B. OBRA
    C. TEFRA
    D. ERISA

10. The ADA allows an employer to reject a person for employment based on one of his/her dependents having a disability.

    A. True
    B. False