Addendum: for use with Nebraska Life and Health online ExamFX courses and study guides version 26140en (Life) and 26141en (Health), per exam content outline updates effective 2/1/2022.

*The following are **content additions** to supplement your existing text unless otherwise indicated:*

Introduction

Exam Breakdown – *new exam breakdowns*

Nebraska Life and Annuities Insurance Examination
100 Questions; Time Limit: 2 hours

CHAPTER	PERCENTAGE OF EXAM
General Insurance	13%
Life Insurance Basics	17%
Life Insurance Policies	18%
Life Insurance Policy Provisions, Options and Riders	18%
Annuities	11%
Federal Taxation of Life Insurance and Annuities	8%
Insurance Regulation	15%

Nebraska Accident and Health or Sickness Insurance Examination
100 Questions; Time Limit: 2 hours

CHAPTER	PERCENTAGE OF EXAM
Customer Relations and Privacy	8%
Authority and Contracts	9%
Risk and Underwriting	11%
Individual Health Insurance Policy General Provisions	9%
Disability Income and Related Insurance	7%
Medical Plans	12%
Group Plans	12%
Dental Insurance	5%
Insurance for Senior Citizens and Special Needs Individuals	8%
Federal Tax Considerations for Sickness and Accident Insurance	4%
Insurance Regulation	15%

Nebraska Life and Annuities, Accident and Health or Sickness Insurance Examination
150 Questions; Time Limit: 2.5 hours

CHAPTER	PERCENTAGE OF EXAM
General Insurance	10%
Life Insurance Basics	8%
Life Insurance Policies	9%
Life Insurance Policy Provisions, Options and Riders	9%
Annuities	6%
Federal Taxation of Life Insurance and Annuities	4%
Customer Relations and Privacy	4%
Risk and Underwriting	6%
Individual Health Insurance Policy General Provisions	5%
Disability	3%
Medical Plans	6%
Group Plans	6%
Dental Insurance	2%
Insurance for Senior Citizens and Special Needs Individuals	5%
Federal Tax Considerations for Sickness and Accident Insurance	2%
Insurance Regulation	15%

Note that the Qualified Plans chapter is no longer on the state exam outline for Life Insurance. For Health Insurance, Customer Relations and Privacy and Authority and Contracts sections on the new outline are combined into one chapter in the course for study purposes: Producer Authority, Contracts, and Customer Relations.

LIFE AND HEALTH

A. Licensing

2. Types of Licensees

Public Adjusters

A **public adjuster** refers to any person who prepares property claims and negotiates settlements on behalf of an insured. The definition also applies to any person who advertises or directly or indirectly solicits the business of investigating or adjusting losses. Unlike independent adjusters, public adjusters are employed by an insured to protect the insured's interest, usually in respect to property damaged by fire, wind, or other covered perils.

Surplus Lines

Surplus lines insurance coverage provides risk protection for parties who have sought insurance through authorized insurers and who, after diligent efforts, have been unable to procure such insurance. A **surplus lines licensee** procures insurance on behalf of an insured from a qualified **unadmitted insurer**.

The Department, in consideration of the payment of the license fee, may issue a surplus lines license, revocable at any time, to any individual who currently holds an insurance producer license or to a foreign or domestic corporation. If the applicant is an individual, the application for the license must include the applicant's social security number. The Director may utilize the national insurance producer database of the National Association of Insurance Commissioners, or any other equivalent uniform national database, for the licensure of an individual or an entity as a surplus lines producer and for renewal of such license.

Crop Insurance Producers

Crop insurance is limited line insurance for damage to crops from unfavorable weather conditions, fire, lightning, hail, or any other peril subsidized by the Federal Crop Insurance Corporation (FCIC), including multi-peril crop insurance.

The sale or solicitation of crop insurance requires a **separate producer license**. To secure a crop license, an applicant must pass an examination related to the specifics of crop insurance.

B. State Regulation

Acts Constituting Insurance Transaction

In Nebraska, any of the following acts constitute an act of **transacting insurance**, and require an insurance license or a certificate of authority:

- Solicitation and inducement to purchase insurance;
- Preliminary insurance negotiations;
- Effectuation of an insurance contract;
- Transaction of matters subsequent to and arising out of effectuation of an insurance contract (such as collecting premiums, or delivering contracts).

Testimonials

Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. If a person providing a testimonial has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly, that information must be disclosed in the advertisement.

4. Unfair Trade Practices

False Financial Statements

False financial statements are those that are intended to deceive public officials or the general public about the financial condition of an insurer. This often occurs when an important fact about the financial status of an insurer is deliberately withheld in order to present the company in a more favorable light.

Twisting

Twisting is a misrepresentation, or incomplete or fraudulent comparison of insurance policies that persuades an insured/owner, to his or her detriment, to cancel, lapse, switch policies, or take out a policy **with another insurer**. Twisting is prohibited.

Impersonation

Impersonation (also known as false pretense) refers to the act of assuming the name and/or identity of another person for the purpose of committing a fraud. In Life insurance, impersonation may occur when an uninsurable individual applying for coverage is asking another person to take the physical examination in his or her place. In regards to agent/producer regulations, impersonation may refer to the act of impersonating a candidate during the prelicensing examination. **Any form or impersonation in insurance is illegal.**

Larceny

An insurance producer or broker who receives any money or substitute for money as a premium for a policy or contract from the insured is deemed to hold those premiums in trust for the company. If the producer fails to pay the premiums collected to the company after written demand is made, the failure is evidence that the producer has used or applied the premium for a purpose other than paying the premiums to the company. The producer, upon conviction, would be guilty of **larceny**.

Stranger-originated Life Insurance (STOLI) and Investor-originated Life Insurance (IOLI)

Stranger-originated life insurance (STOLI) is a life insurance arrangement in which a person with no relationship to the insured (a "stranger") purchases a life policy on the insured's life with the intent of selling the policy to an investor and profiting financially when the insured dies. In other words, STOLIs are financed and purchased solely with the intent of selling them for life settlements.

STOLIs **violate the principle of insurable interest**, which is in place to ensure that a person purchasing a life insurance policy is actually interested in the longevity rather than the death of the insured. Because of this, insurers take an aggressive legal stance against policies they suspect are involved in STOLI transactions.

Note that lawful life settlement contracts do not constitute STOLIs. Life settlement transactions result from existing life insurance policies; STOLIs are initiated for the

purpose of obtaining a policy that would benefit a person who has no insurable interest in the life of the insured at the time of policy origination.

Investor-owned life insurance (IOLI) is another name for a STOLI, where a third-party **investor who has no insurable interest in the insured** initiates a transaction designed to transfer the policy ownership rights to someone with no insurable interest in the insured and who hopes to make a profit upon the death of the insured or annuitant.

Acting Without a License

No person may sell, solicit, or negotiate insurance in this state for any class of insurance unless the person is licensed in the appropriate line of authority. Anyone who violates this requirement may be subject to temporary or permanent injunction.

C. Federal Regulation

Consumer Data Privacy and Security Act

The **Consumer Data Privacy and Security Act** requires businesses adhere to established standards for the collection of personal information. Businesses must receive consent from an individual, prior to the collection of personal data, unless data collection is considered reasonably necessary and permissible under the Act.

Personal data refers to any information that identifies or is linked to a specific individual. The following would not be considered personal data and would not be subject to Act requirements:

- De-identified data;
- Unreadable or indecipherable data;
- Personal information collected or used by an employer pursuant to an employer-employee relationship;
- Publicly available information; or
- Data which uses pseudonyms or other replacement identifiers.

Businesses are required to publish privacy policies, which include the type of personal data collected, purposes for which data is collected, and an individual's right to access and control their collected data. The Act also requires businesses develop and maintain a comprehensive data security program, designed to protect the security, confidentiality, and integrity of personal data.

National Do Not Call List

In 2003, the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC) worked together to create the **National Do Not Call Registry**, allowing consumers to include their telephone numbers on the list to which solicitation calls cannot be made by telemarketers. Insurance companies need to comply with this regulation when making solicitation phone calls.

To comply with the telemarketing sales rules, telemarketers must not do any of the following:

- Call any number on the National Do Not Call Registry or on that seller's Do Not Call list;
- Deny someone a right to be placed on any Do Not Call Registry;
- Call outside permissible calling hours (before 8 a.m. and after 9 p.m.);
- Abandon calls;
- Fail to transmit caller ID information;
- Threaten or intimidate a consumer or use obscene language; or
- Cause any telephone to ring or engage a person in conversation with the intent to annoy, abuse, or harass the person called.

Some exceptions to the Do Not Call Registry include the following calls:

- From or on behalf of organizations which have established a business relationship with the consumer (established business relationships last 18 months from the date of a sale or transaction);
- For which the consumer has given prior written permission;
- Not commercial or that do not include unsolicited advertisements; and
- By or on behalf of tax-exempt nonprofit organizations.

To keep in compliance with the Do Not Call rules, organizations must consult the registry every **31 days**. Any phone numbers on the registry must be dropped from the organization's call lists.

CAN-SPAM Act

CAN-SPAM legislation was established to set the rules for commercial e-mail, and to give recipients the right to reject commercial messages. CAN-SPAM covers all commercial electronic messages, including business-to-business messages, the purpose of which is the commercial advertisement or promotion of a product or service.

CAN-SPAM requires that any commercial email must contain an opt-out mechanism; all opt-out requests must be honored within **10 business days**. To be in compliance with this legislation, the entity that sends out e-mails must do the following:

- Make sure that the advertiser is identified in the from line;
- Not use misleading subject lines;
- Include an opt-out mechanism and honor all opt-out requests within 10 days;
- Include the advertiser's valid physical postal address; and
- If the message is unsolicited, it must be identified as an *advertisement* somewhere in the e-mail.

Each violation of the above provisions is subject to fines of up to $16,000. On top of that is a penalty of $250 per each noncompliant e-mail, with a cap of $2 million dollars.

Sarbanes-Oxley Act

The **Sarbanes-Oxley (SOX) Act** of 2002 was enacted to protect investors from fraudulent financial reporting by companies. The act mandates that all publicly traded companies in the United States, along with foreign companies which do business in the United States, adhere to federal financial reporting and record maintenance regulations.

Terrorism Risk Insurance Act

The **Terrorism Risk Insurance Act (TRIA)** was enacted in response to the increasing cost or altogether exclusion of coverage for losses resulting from terrorism. TRIA requires all commercial insurers who sell or solicit property and/or casualty insurance to offer insurance coverage for acts of terrorism. A portion of paid losses for terrorism are reimbursed by the federal government. Though TRIA requires insurers to make terrorism coverage available, insureds are not required to purchase it.

National Flood Insurance Program (NFIP)

The **National Flood Insurance Program (NFIP)** is a federal program managed by the Federal Emergency Management Agency (FEMA), which is allows homeowners, businessowners, and renters to purchase federally-backed flood insurance. Coverage is made available to states and communities that agree to adopt and enforce floodplain management regulations.

LIFE

Life Insurance Basics

B. Personal Uses of Life Insurance

Exemption from Claims of Creditors/Probate

An insurance contract is between the policyowner and the insurer. When the insured dies, the contractual arrangement is between the insurer and the beneficiary, and the proceeds of the life insurance belong to the beneficiary. The insured's creditors have no right to the proceeds or the cash value. The following conditions apply:

- If the insured has filed a petition of bankruptcy within 2 years, the proceeds and cash value are only exempt under certain circumstances;
- The amount of premiums paid with intent to defraud creditors is not exempt; and
- A creditor possessing a valid assignment from the policyowner may recover the amount secured by the assignment with interest from either the cash surrender value or the proceeds of the life insurance policy.

Life insurance proceeds are paid to the named beneficiary upon receipt of proof of death. The proceeds are not handled through the probate court and are not paid to the estate unless the estate is named as beneficiary.

I. Policy Issue and Delivery

Delivery/Electronic Delivery Requirements

Premiums can be paid physically (by check or cash) or electronically. Payments submitted electronically are considered electronic funds transfers (EFTs) and are made through the Automated Clearing House (ACH).

Life Insurance Policies

A. Term Life Insurance

Term-to-65 Contract

A term insurance policy with level premium and level death benefits that provides coverage until the insured's 65th birthday is called a **term-to-65** policy. Because this type of policy provides protection for a shorter period than life-expectancy policies do, the premiums will be lower.

Convertibility

The **convertible** provision provides the policyowner with the right to convert the policy to a permanent insurance policy *without evidence of insurability*. The premium will be based on the insured's attained age at the time of conversion.

Life Insurance Policy Provisions, Options, and Riders

A. Required Provisions

Insuring Clause

The insuring clause (or insuring agreement) sets forth the basic agreement between the insurer and the insured. It states the insurer's promise to pay the death benefit upon the insured's death. The insuring clause usually is located on the policy face page, and also defines who the parties to the contract are, how long coverage is in force, and the type of loss insured against.

Consideration

Both parties to a contract must provide some value, or **consideration**, in order for the contract to be valid. The consideration provision states that the consideration (value) offered by the insured is the premium and statements made in the application. The consideration given by the insurer is the promise to pay in accordance with the terms of the contract. The consideration clause is not always a separate provision, but is often included in the entire contract provision. A separate provision concerning the payment of policy premiums is usually also found in the policy.

Suicide

The **suicide** provision in life insurance policies protects the insurers from individuals who purchase life insurance with the intention of committing suicide. Insurance policies usually stipulate a period of time during which the death benefit will not be paid if the insured commits suicide. If the insured commits suicide within **2 years** following the policy effective date (issue date), the insurer's liability is limited to a refund of premium. If the insured commits suicide after the 2-year period, the policy will pay the death proceeds to the designated beneficiary the same as if the insured had died of natural causes.

E. Riders Covering Additional Insured

Family Term Rider

The **family term rider** incorporates the spouse term rider along with the children's term rider in a single rider. When added to a whole life policy, the family term rider provides level term life insurance benefits covering the spouse and all of the children in the family.

Family Term = Spouse Term + Children's Term

F. Riders Affecting the Death Benefit Amount

Accidental Death and Accidental Death and Dismemberment

The **accidental death and dismemberment rider (AD&D)** pays the principal (face amount) for accidental death, and pays a percentage of that amount, or a **capital sum**, for accidental dismemberment. The accidental death portion is the same as that already discussed with the accidental death rider. The dismemberment portion of the rider will usually determine the amount of the benefit according to the severity of the injury. The full principal amount will usually be paid for loss of two hands, two arms, two legs or the loss of vision in both eyes. A capital amount is usually limited to half the face value and is payable in the event of the loss of one hand, arm, leg, or eye. The dismemberment can be defined differently by insurance companies, from the actual severance of the limb to the loss of use.

Accelerated (Living) Benefit Rider

If an insured is faced with a terminal illness, or in some cases in a nursing home, and the policy contains the Accelerated Benefit Provision, they may immediately request payment of a portion of the death benefit for financial relief. Generally 50% of the death benefit is the maximum payable from this benefit.

If an insured withdraws a portion of the death benefit by the use of this rider, the benefit payable at death will be reduced by the amount of the portion removed, as well as the premium for the remaining policy.

State insurance regulators may adopt rules that include standards for full and fair **disclosure** of the manner, content, and required disclosures for the sale of insurance policies.

Federal Tax Considerations for Life Insurance and Annuities

Qualified Plan Requirements – *new section*

An employer-sponsored **qualified retirement plan** is approved by the IRS, which then gives both the employer and employee benefits such as deductible contributions and tax-deferred growth.

Qualified plans have the following characteristics:

- Designed for the exclusive benefit of the employees and their beneficiaries;
- Are formally written and communicated to the employees;
- Use a benefit or contribution formula that does not discriminate in favor of the prohibited group — officers, stockholders, or highly paid employees;

- Are not geared exclusively to the prohibited group;
- Are permanent;
- Are approved by the IRS; and
- Have a vesting requirement.

In contrast, nonqualified plans are not subject to the requirements regarding participation, discrimination, and vesting as qualified plans. Nonqualified plans require no government approval and are used as a means for an employer to discriminate in favor of a valuable employee with regard to employee benefits. Nonqualified plans accept after-tax contributions.

A. Taxation of Personal Life Insurance and Corporate Owned Life Insurance

1. Amounts Available to Policyowner

Accelerated Benefits

When accelerated benefits are paid under a life insurance policy to a terminally ill insured, the benefits are received **tax free**. When accelerated benefits are paid to a chronically ill insured (for example, someone who has cancer, Alzheimer's disease or other severe illness), these benefits are tax free up to a certain limit. Any amount received in excess of this dollar limit must be included in the insured's gross income.

HEALTH:

Sickness and Accident Insurance Basics

I. ACA (Affordable Care Act)

Qualified Health Plan

State insurance exchanges offer coverage through **qualified health plans (QHPs)**. Qualified health plans may not have pre-existing condition limitations, lifetime maximums, or annual limits on the dollar amount of essential health benefits.

A health plan's status as a qualified health plan will be based on the following characteristics of the plan:

- Benefit design;
- Marketing practices;
- Provider networks, including community providers;
- Plan activities related to quality improvement; and
- The use of standardized formats for consumer information.

Small Business Health Options Program (SHOP)

Each state is required to set up and maintain **Affordable Insurance Exchanges, referred to as Marketplaces**. These exchanges either serve individuals and small businesses separately, or have a combined exchange to serve both individual and small business clients under one organization. In states that have chosen not to build their own Marketplace, a **Federally-Facilitated Marketplace** (healthcare.gov) is available that helps with comparison shopping tools, eligibility, enrollment, plan

management, and consumer support. Coverage may be purchased through the Marketplace's call center, website, or by postal mail.

Under the proposed regulations, states that choose to set up an Exchange for Small Business Health Options Program (SHOP) must adopt the federal standards for the program or have a state law or regulation that implements the federal standards. Each state will establish insurance options for small employer participation. A SHOP is intended to give small employers the same purchasing power that large employers have, the opportunity to make a single monthly payment, and the ability to offer a choice of plans.

PPACA defines *small employers* as those with at least one but not more than 100 employees. Since 2017, states have been allowing large employers to purchase coverage through SHOP exchanges.

Insurance exchanges may or may not have open enrollment periods for small employers, but must admit small employers whenever they apply for coverage.

Recission

A *rescission* is the discontinuance or cancellation of coverage on a retroactive basis. Unless there is an intentional material misrepresentation of fact or fraud, plans and issuers **may not rescind** coverage. This prohibition even extends to situations where coverage was granted to ineligible participants. The law also allows for certain coverage rescissions for recordkeeping and notification errors.

Disability Income and Related Insurance

B. Individual Disability Income Insurance

1. Basic Total Disability Plan

Probationary Period

Probationary period is another type of waiting period that is imposed under some disability income policies. It does not replace the elimination period, but is in addition to it. The probationary period is a waiting period, often 10 to 30 days, from the policy issue date during which benefits will not be paid for illness-related disabilities. The probationary period applies to only sickness, not accidents or injury. The purpose for the probationary period is to reduce the chances of adverse selection against the insurer. This helps the insurer guard against those individuals who would purchase a disability income policy shortly after developing a disease or other health condition that warrants immediate attention.

Medical Plans

A. Medical Plan Concepts

Coinsurance

Most major medical policies include a **coinsurance** provision that provides for the sharing of expenses between the insured and the insurance company. After the

insured satisfies the policy deductible, the insurance company will usually pay the majority of the expenses, typically **80%**, with the insured paying the remaining **20%**. Other coinsurance arrangements exist such as 90/10; 75/25; or 50/50. The larger the percentage that is paid by the insured, the lower the required premium will be. The purpose of the coinsurance provision is for the insurance company to control costs and discourage overutilization of the policy.

Deductibles

A **deductible** is a specified dollar amount that the insured must pay first before the insurance company will pay the policy benefits. The purpose of a deductible is to have the insured absorb the smaller claims, while the coverage provided under the policy will absorb the larger claims. Consequently, the larger the deductible, the lower the premium that is required to be paid.

Most major medical policies feature an **annual deductible** (also called a calendar year deductible) that, as the name implies, is paid once in any year, regardless of the amount of claims in that year. The policy may contain an **individual deductible**, in which each insured is personally responsible for a specified deductible amount each year, or a **family deductible** (usually 2 to 3 times the individual deductible) whereby the annual deductible is satisfied if two or more family members pay a deductible in a given year, regardless of the amount of claims incurred by additional family members. Some policies contain what is known as a **per occurrence deductible** or **flat deductible** which the insured is required to pay for each claim, possibly resulting in more than one deductible being paid in a given year.

The policy may also contain a provision which applies when more than one family member is injured in a single accident, also called the **common accident provision**. In this case, only one deductible applies for all family members involved in the same accident.

Some supplemental major medical plans also include an **integrated deductible** in which case the amount of the deductible may be satisfied by the amount paid under basic medical expense coverage. For example, if the supplemental coverage included a $1,000 integrated deductible, and the insured incurs $1,000 in basic medical expenses, the deductible will be satisfied. If the basic policy only covered $800 of the basic expenses, the insured would have to satisfy the remaining $200 difference.

Some policies also include a **carry-over provision** that states that if the insured did not incur enough expenses during the year to meet the deductible, any expenses incurred during the last 3 months may be carried over to the next policy year to satisfy the new annual deductible. Disability income and long-term care policies usually have a time deductible in the form of elimination period.

B. Types of Providers and Plans

Exclusive Provider Organization (EPOs)

An **Exclusive Provider Organization (EPO)** is a type of preferred provider organization in which individual members use particular preferred providers rather than having a

choice of a variety of preferred providers. An EPO is characterized by a primary physician who monitors care and makes referrals to a network of providers.

Open Network

Open networks allow participants to consult with other participating providers of services without a referral. This is also known as "open access".

Closed Network

In closed networks, covered insureds must select a primary care provider. That provider is the only one allowed to refer the insured to other health care providers within the plan. This is also known as "closed access" and "the gatekeeper model."

C. Cost Containment in Health Care Delivery

Second Opinion

Preauthorization is a cost-containment measure requiring that the insured obtain approval from the insurer before getting an expensive surgery, referred to a specialist, or nonemergency healthcare service.

A **second opinion** is a separate assessment of a patient by a different medical professional who will then affirm or modify the patient's diagnosis and treatment plan.

Flexible Spending Accounts (FSA) – *new section*

A **Flexible Spending Account (FSA)** is a form of cafeteria plan benefit funded by salary reduction and employer contributions. The employees are allowed to deposit a certain amount of their paycheck into an account before paying income taxes. Then, during the year, the employee can be directly reimbursed from this account for eligible health care and dependent care expenses. FSA benefits are subject to annual maximum and "use-or-lose" rule. This plan does not provide a cumulative benefit beyond the plan year.

There are 2 types of Flexible Spending Accounts: a Health Care Account for out-of-pocket health care expenses, and a Dependent Care Account (subject to annual contribution limits) to help pay for dependent's care expenses which makes it possible for an employee and his or her spouse to continue to work.

An FSA is exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes, saving 1/3 or more in taxes. If the plan favors highly compensated employees, the benefits for the highly compensated employees are not exempt from federal income taxes.

Eligibility

Child and dependent care expenses must be for the care of one or more qualifying persons:

- A dependent who was under age 13 when the care was provided and who can be claimed as an exemption on the employee's Federal Income Tax return;
- A spouse who was physically or mentally not able to care for himself or herself; or

- A dependent who was physically or mentally not able to care for himself or herself and who can be claimed as an exemption (as long as the person is earning gross income less than an IRS-specified amount).

Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.

The insured may change benefits during open enrollment. After that period, generally, no other changes can be made during the plan year. However, the insured might be able to make a change under one of the following circumstances, referred to as *qualified life event* changes:

- Marital status;
- Number of dependents;
- One of dependents becomes eligible for or no longer satisfies the coverage requirements under the Medical Reimbursement plan for unmarried dependents due to attained age, student status, or any similar circumstances;
- The insured, the insured's spouse's or qualified dependent's employment status that affects eligibility under the plan (at least a 31-day break in employment status to qualify as a change in status);
- Change in dependent care provider; or
- Family medical leave.

Contribution Limits

The IRS limits the annual contribution for Dependent Care Accounts to a specified amount that gets adjusted annually for cost of living. This is a family limit, meaning that even if both parents have access to flexible care accounts, their combined contributions cannot exceed the amount.

Health Reimbursement Accounts (HRAs)

Health Reimbursement Accounts (HRAs) consist of funds set aside by employers to reimburse employees for qualified medical expenses, such as deductibles or coinsurance amounts. Employers qualify for preferential tax treatment of funds placed in an HRA in the same way that they qualify for tax advantages by funding an insurance plan. Employers can deduct the cost of a health reimbursement account as a business expense.

The following are key characteristics of HRAs:

- They are contribution healthcare plans, not defined benefit plans;
- Not a taxable employee benefit;
- Employers' contributions are tax deductible;
- Employees can roll over unused balances at the end of the year;
- Employers do not need to advance claims payments to employees or healthcare providers during the early months of the plan year;
- Provided with employer dollars, not employee salary reductions;

- Permit the employer to reduce health plan costs by coupling the HRA with a high-deductible (and usually lower-cost) health plan; and
- Balance the group purchasing power of larger employers and smaller employers.

HRAs are open to employees of companies of all sizes; however, the employer determines eligibility and contribution limits.

Contribution Limits

An HRA has no statutory limit. Limits may be set by employer, and rollover at the end of the year based on employer discretion. Former employees, including retirees, can have continued access to unused HRAs, but this is done at the employer's discretion. HRAs remain with the originating employer and do not follow an employee to new employment.

High Deductible Health Plans (HDHPs)

High-deductible health plans (HDHPs) are often used in coordination with Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs), or Health Reimbursement Accounts (HRAs). The high-deductible health plan features higher annual deductibles and out-of-pocket limits than traditional health plans, which means lower premiums. Except for preventive care, the annual deductible must be met before the plan will pay benefits. Preventive care services are usually first dollar coverage or paid after copayment. The HDHP credits a portion of the health plan premium into the coordinating MSA, HSA, or HRA on a monthly basis. The deductible of the HDHP may be paid with funds from the coordinating account plan.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that requires coverage parity for mental health benefits with benefits under the insured's medical/surgical coverage. The following coverage requirements apply to **large group plans** (with more than 50 employees) that offer mental health benefits along with medical/surgical benefits:

- Deductibles, copayments, and treatment limitations for mental health benefits cannot be more restrictive than for any other medical benefit; and
- Providers cannot impose separate cost sharing requirements for mental health benefits.

The Affordable Care Act enacted rules on how health insurance issuers carry out these requirements.

Group Sickness and Accident Insurance

D. Employer Group Health Insurance

Employee Eligibility

Insurers are prohibited from excluding part-time employees and must offer the same group health benefits to part-time employees as they offer to the employee groups of which the part-time employees would be members if they were full-time employees. *Part-time employee* means any employee who is scheduled to work 20 to 39 hours per week. To comply with the Affordable Care Act, part-time employees scheduled to work between 30-39 hours on average per week will pay the same health insurance premium as full-time employees.

Waiting Period

A **waiting period** in group health plans is usually imposed to newly hired employees. It is the period of time that must lapse before an employee or a dependent is eligible under the group plan. The most common waiting period is 90 days.

Types of Funding and Administration – *new section*

Conventional Fully-insured Plans

A conventional fully insured plan is administered and guaranteed by an insurance company. In return for the premium collected from the insured by the insurer, the insurer assumes the risk of paying the cost of medical expenses that may or may not occur during the policy period.

This is the traditional example of how insurance policies are set up. If the insured pays their premium, then the insurer will provide coverage.

Fully Self-funded (Self-administered) Plans

Under some circumstances, it is possible for a business or other organization to engage in the same types of activities as a commercial insurer dealing with its own risks. When these activities involve the operation of the law of large numbers and predictions regarding future losses, they are commonly referred to as **self-insurance**. Self-insurance applies when an organization develops a formal program for identifying, evaluating and funding its own losses.

Conditions Suitable for Self-funding

For a self-insurance program to be dependable, it must:

- Be big enough to permit the use of a sufficiently large number of exposure units so as to make losses predictable. (The program must be based on the operation of the law of large numbers.)
- The plan must be financially dependable. This means it will likely require the accumulation of funds to meet losses that occur, with a sufficient accumulation to safeguard against unexpected deviations from predicted losses.

- The individual units exposed to loss must be distributed in such a manner as to prevent a catastrophic loss. A loss that could affect all units at one time could cause financial failure to the program.
- Until the fund reaches the size where it is adequate to pay the largest loss possible, the possibility of loss is not eliminated for the individual exposure units.

Benefits Suitable for Self-funding

Smaller losses which occur frequently are a better subject for self-insurance as opposed to large infrequent losses. Self-insurance is frequently used for workers compensation where losses are fairly predictable and most states have established regulations for self-insurance.

ERISA – *new section*

Conventional Fully-insured Plans

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that was enacted to ensure that employees receive the pension and other benefits promised by their employers. ERISA also incorporates and is tied to provisions of the Internal Revenue Code (IRC) designed to encourage employers to provide retirement benefits and other benefits to their employees. Many provisions of ERISA and the IRC are intended to ensure that tax-favored pension plans do not favor the highest-paid employees over rank-and-file employees in the way benefits are provided. To achieve these ends, ERISA has a complex series of rules that cover pension, profit-sharing stock bonus, and most "welfare benefit plans," such as health and life insurance. ERISA supersedes almost all state laws that affect employee benefit plans and has thus created a single federal standard for employee benefits.

Applicability

All forms of health care, life insurance, prepaid legal services, and disability insurance (both long-term and short-term) are considered **employee welfare benefit** plans. Unfunded benefits or payroll practices, such as vacation, holidays, overtime premiums, holiday gifts, and compensation paid for time not worked are not included. Group-type voluntary insurance programs to which the employer makes no contribution are also excluded.

ERISA treats as pension plans any form of deferred compensation such as deferred profit-sharing, stock purchasing, or savings and thrift plans, as well as pension plans. Cash bonus plans, cash profit-sharing plans, and severance pay of less than 2 years are considered compensation and are not regulated by ERISA. A bonus plan, payment of which is systematically deferred and paid out over several years, is considered a pension plan.

Fiduciary Responsibilities

An employer's responsibilities under ERISA vary, depending on the type of plan involved. Pension plans, for example, are subject to all rules, including reporting and disclosure, financial management of benefit plan assets, administration of benefit plans, and participation, vesting, and funding requirements. Welfare plans (such as

health insurance) need only worry about reporting and disclosure rules and financial management and plan administration standards.

Reporting and Disclosure

Different parts of ERISA are administered by different federal agencies. In general, the Internal Revenue Service (IRS) administers the taxation of contributions and benefits. In the retirement-plan area, IRS is responsible for enforcing funding, participation, and vesting standards. The Pension Benefit Guarantee Corporation is in charge of pension insurance provisions. And the U.S. Department of Labor (DOL) administers reporting and disclosure and the fiduciary requirements of ERISA that regulate the management of plan assets.

There are reporting and disclosure exemptions for small unfunded welfare plans. Governmental and church plans, plans established solely to comply with unemployment compensation laws, workers compensation law, disability insurance laws, and plans that are designed to provide benefits in excess of the deduction limits to certain employees are exempt from ERISA requirements. Unfunded plans maintained "primarily" to provide deferred compensation for a select group of management or highly compensated employees are exempt from the participation and vesting, funding, and fiduciary responsibility requirements of the law. These plans are commonly referred to as top hat plans. They are generally subject (unless some other exemption or partial exemption applies) to the reporting and disclosure, and administration and enforcement provisions of ERISA.

Dental Insurance

PPO Dental

A **Dental PPO** is a group of dental care providers that contract with employers, insurers, or third party organizations to provide medical care services at a reduced fee. In the PPO system the dentists are paid fees for their services rather than a salary, but the member is encouraged to visit approved member dentists that have previously agreed upon the fees to be charged. This encouragement comes in the form of benefits. While the member can utilize any dentist they choose, the PPO may provide 90% of the cost of a dentist on their approved list while possibly only providing for 70% of the cost if the member chooses to utilize a dentist not included on the PPOs approved list. Prepaid dental plans and PPOs are very similar, but they differ in that PPOs are offered and managed by insurance companies. Prepaid may not even involve an insurance company, but just a group or association of dentist that agree for a certain flat amount each month and additional amount for certain procedures, to provide the services.

HMO Dental

Dental HMOs provide dental preventative treatment and dental restoration treatments for their subscribers that are normally not employer-based. Subscribers of the plan must obtain dental services from a dentist that is employed by or contracted by the HMO.

Prepaid Dental

Prepaid dental plans typically provide their subscribers routine preventive care at no charge (other than the premium) after a small copayment for the office visit. Other dental procedures are provided at a discounted rate of 25% to 50%. Most plans' benefits are not subject to waiting periods, pre-existing conditions exclusions or deductibles. Members are allowed to choose their own dentist from a list of participating general dentists. Some plans include benefit payments for procedures such as cosmetic dentistry, out of area emergency benefits and adult and child orthodontia.

Basic Services

A prepaid dental plan must provide the basic dental services listed below:

- Emergency dental services on a 24-hour-per-day basis;
- Diagnostic services;
- Preventive services; and
- Restorative services.

A schedule of benefits that includes the dental plan's basic dental services, any other services, and any associated copays must be made available by each organization offering prepaid dental services.

Limitations

Any limitations of prepaid dental services, kind of services or benefits to be provided, including any deductible or co-payment feature must be included in membership coverage contract.

Stand-alone Dental

The Exchange may offer a **stand-alone dental plan (SADP)** offering a limited scope of dental benefits as long as the plan meets all the appropriate requirements, covers at least the pediatric dental essential health benefit, and meets a Qualified Health Plan (QHP) certification standards.

Federal Tax Considerations for Sickness and Accident Insurance

Social Security Disability Benefits

Social Security disability benefits are financed through a payroll tax deducted from the employee's wages, with a like amount contributed by the employer. Employers may take a tax deduction for their share of the employee's Social Security tax. Employees, however, are not entitled to a deduction for their share of the Social Security tax.

Taxation of Social Security Benefits

Social Security benefits are generally received income tax-free. However, federal income taxes are imposed on some benefits if the taxpayer has a substantial amount of income in addition to Social Security benefits.

Health Reimbursement Accounts (HRAs)

In **Health Reimbursement Accounts (HRAs)**, the employer's contribution is tax deductible in the year in which the reimbursement is made to the employee. The employee is not taxed on receipt of the benefit. Benefits must be paid solely to the employee for medical care expenses for the employee, the employee's spouse or dependents. If funds are distributed for other than medical care expenses, the benefit is considered to be taxable income to the employee.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow consumers to take pre-tax dollars from their paycheck and deposit them in an FSA with their employer. Consumers then submit receipts for healthcare-related expenses for reimbursement, up to a specific amount set by the employer under IRS regulations. FSAs are financially advantageous for consumers because pre-tax dollars are used to pay for healthcare-related expenses.

High-Deductible Health Plans (HDHPs)

High-deductible health plans (HDHPs) are taxed in the same manner as other traditional health plans.