CERTIFIED INSURANCE COUNSELORS

Life & Health

Risk & Insurance Education Alliance

Learning Guide

CERTIFIED INSURANCE COUNSELORS

Life & Health

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A Letter from William J. Hold, President/CEO

I trust this Learning Guide finds you well and eager to embark on a transformative journey with our esteemed risk management and insurance courses. As the President of Risk & Insurance Education Alliance, it is both an honor and a privilege to welcome you to this unparalleled learning experience.

In our ever-evolving world, the importance of risk management and insurance cannot be overstated. This industry is the backbone of organizational resilience, ensuring that businesses and individuals can navigate the complexities of today's dynamic landscape.

I commend you for recognizing the significance of this expertise and taking the initiative to invest in your professional development.

At Risk & Insurance Education Alliance, our philosophy revolves around the belief that every individual has untapped potential waiting to be realized. This course is not just about acquiring knowledge; it is a platform for you to own your potential. We are here to guide, support, and empower you to discover the depths of your capabilities, enabling you to excel in the realm of risk management and insurance.

As committed professionals, you are not merely participants in a course; you are integral members of a community dedicated to excellence. Our team of expert instructors, industry practitioners, and support staff are equally committed to your success. Throughout the program, you will benefit from their wealth of experience and knowledge, gaining insights that extend beyond textbooks to real-world applications.

"Own Your Potential" encapsulates the ethos of our educational approach. It encourages you to take charge of your learning journey, embrace challenges as opportunities, and emerge as a confident and proficient risk management and insurance practitioner.

As you embark on this course, remember that your commitment to professionalism sets you apart. The skills and insights you gain here will not only elevate your individual career but contribute to the advancement of the entire profession.

I am confident that, armed with the knowledge and skills imparted in this course, you will become a committed professional who not only understands the intricacies of risk management and insurance but also actively shapes the future of these industries.

I look forward to witnessing your growth, learning, and success in the coming weeks. The journey ahead is both challenging and rewarding, and I encourage you to embrace it with enthusiasm and dedication.

Best wishes for a fulfilling and transformative learning experience.

Sincerely,

William J. Hold, M.B.A., CRM, CISR
President/CEO

DISCLAIMER

This outline is intended as a general guideline and may not apply in each situation.

For any matters of legal and/or tax issues, one should consult with competent counsel or advisor for the matter in question and in the jurisdiction in question.

The Society of CIC and any organization for which this seminar is conducted shall have neither liability nor responsibility to any person or entity with respect to any loss or damage alleged to be caused directly or indirectly as a result of the information contained in this outline.

Insurance policy forms, clauses, rules, court decisions, and laws change constantly. Policy forms and underwriting rules vary from company to company.

RISK & INSURANCE
EDUCATION ALLIANCE

EXAM INFORMATION

Examination Techniques

During the Program

1. **Listen Professionally**
   Adjust the way you listen to the pace of the instructor. Listen actively for the "big ideas" and search for facts to back them up. Listen for key words and clue phrases like "You should know…," "Three steps are…," etc. Listen to the speaker's inflection and tone. If you intend to take the examination, study and review each evening while it is fresh—don't wait for the night before the exam.

2. **Take Careful Notes**
   During the lectures, take clear notes on each topic and be sure to ask the instructor if you need clarification on a point. Each evening, review these notes, as well as the materials to be covered next. Compose your own exam questions from the material. Study with others and concentrate on the areas you are least certain of—but don't forget to get a good night's rest before the examination.

During the Examination

1. **Remain Calm**
   Some of you may have had experiences in your previous schooling that have caused you to feel anxious at the thought of taking an examination. Relax and you will do much better. You will have more access to your memory if you take the examination as a confirmation of your understanding of the material and not as a test of your value as a person. Even if you do not pass the examination the first time, you cannot fail an institute! Your mere presence here is proof of your dedication to professional education and improvement.

2. **Understand the Examination Format**
   The examination period is two hours long for the CIC institutes and CPRM courses, and two and one- half hours long for the CRM courses. It is an essay-type exam with a total value of 200 points. In order to pass the exam a participant must score at least 140 points. The examination questions are in the order of presentation of the topics and are weighted to the length of the presentations. To work at a proper pace within the two-hour or two and one-half hour period, you should allow approximately six to eight minutes to answer each question. To work slower may mean that some questions might not be answered. It is a good rule of thumb in exam writing to NEVER LEAVE AN ANSWER BLANK.

During the Examination *(continued)*

3. **Understand Each Question**
   Read the question carefully, looking for clues contained in it. Look for action words, such as: compare, contrast, define, summarize, explain, etc. Underline key points or questions. Be sure that you answer the question that is asked and not the one that you wish had been asked.

4. **Plan Before You Write**
   It makes sense to briefly outline your answer before you begin writing. This will help you make sure you understand the full scope of the question and make it less likely that you will leave something important out of your answer. Be specific and give reasons. "Yes" or "No," "Covered" or "Not Covered" are not adequate answers. Rarely will a question require only a short, one-sentence answer. Take the time to explain.

5. **Use All of Your Time**
   Even if you finish your examination early, use the extra time to carefully review both the questions and the answers. Have you really answered the question that was asked? Is your answer as complete as it should be to convey your understanding? Use all of your time. Have you answered ALL of the questions?

Sample Examination Questions and Composite Answers

Note to Candidates:

This composite set of answers to the Certified Insurance Counselors examinations is published for CIC candidates and others interested in the CIC study program. The answers have been taken from actual student papers and have been edited by the staff of the Society. The questions and answers are ***illustrative only;*** the answers are not necessarily perfect.

It should be understood that these answers may be longer and more complete than necessary to receive a high grade. Your answers will be graded on the factual response to the question asked, the instructions given, and the completeness of the answer. You should not use this set of questions and answers as a substitute for a thorough study of the subject matter.

Agency Management Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

Agency planning should be conducted through a formal process that includes several steps. Please identify the five formal steps in the planning process.

Sample Answer 1:

1. *Conduct a situation analysis*
2. *Review the agency's mission statement*
3. *Write the agency plan*
4. *Implement*
5. *Monitor/evaluate and adjust*

Sample Question 2:

Agent Best placed a Commercial Property policy with the Fire and Casualty Company. Subsequently, Agent Best's client suffered a large fire loss covered by the policy. However, because of financial difficulties, Fire and Casualty could not pay. Explain the possible liability of the agent in this case.

Sample Answer 2:

One of the agent's legal responsibilities to clients is the duty to investigate the solvency of an insurance company. This can include not only the initial placement, but also an ongoing duty.

Commercial Casualty Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

Your insured states that he understands his Commercial General Liability (CGL) Policy provides coverage for an "insured contract." He then asks, "What is an 'insured contract'?" Answer your insured's question by listing the six "insured contracts" found in the CGL policy.

Sample Answer 1:

1. *Lease of premises, except for fire damage to the rented premises.*
2. *Sidetrack agreement.*
3. *Easement or license agreement, except construction or demolition on or within 50 feet of a railroad.*
4. *An obligation to indemnify a municipality as required by ordinance, except in connection with work for municipality.*
5. *Elevator maintenance agreement.*
6. *That part of any other contract, pertaining to an insured's business, assuming tort liability of another to pay a third party.*

Sample Question 2:

The Workers Compensation and Employers Liability Insurance Policy is composed of three coverages. Name each coverage and briefly describe the purpose of one of the coverages.

Sample Answer 2:

Must Name All Three Coverages:

Workers Compensation Insurance
Employers Liability Insurance
Other States Insurance

Provide Any One Description:

Workers Compensation Insurance provides coverage for workers compensation benefits to employees as required by state law.

or

Employers Liability Insurance provides coverage for liability other than state mandated benefits arising out of an employee's work-related injuries.

or

Other States Insurance provides temporary automatic coverage for new operations in other states, plus coverage for incidental exposures in other states. The states must be listed in Item 3C on the Information Page for other states insurance to apply.

Commercial Property Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

MAP Company insures its corporate headquarters under an unendorsed Building and Personal Property Coverage Form with the Special Causes of Loss Form. The building is insured for $600,000 and the business personal property for $200,000. The 80% coinsurance requirement is satisfied. Ms. Peterson, the comptroller, asks the following questions. How would you respond to each question? Support your answer.

A. "Part of our premises includes an unattached retaining wall for decorative effects. The value of this wall is $15,000. What coverage applies if someone runs their car into the wall?"
B. "Will our policy pay for loss to our employees' belongings while they are at work?"

Sample Answer 1A:

No coverage. Retaining walls that are not part of the building are defined as Property Not Covered.

Sample Answer 1B:

Covered. Under the Coverage Extension Personal Effects And Property of Others coverage applies up to $2,500 at each described premises. However, loss or damage by theft is not covered.

Sample Question 2:

A prospect of yours decides to purchase Business Income Coverage from your agency. This prospect asks you the following question: "How is the term 'Business Income' defined?" Please respond to the client's question.

Sample Answer 2:

Business Income is defined as Net Income that would have been earned/incurred and continuing normal operating expenses including payroll.

Life & Health Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

The following policy provisions are commonly found in most major medical insurance policies: (a) coinsurance clause, (b) deductible. Describe each provision.

Sample Answer 1:

(a) The coinsurance clause requires that the insured pay a portion of each dollar loss after the deductible has been exceeded.

(b) A deductible is an amount of money paid by the insured. It must be satisfied before the insurance contract responds.

Sample Question 2:

One of the standard provisions found in most life insurance contracts is the reinstatement provision. Explain the reinstatement provision and list the requirements needed to reinstate a policy.

Sample Answer 2:

After the expiration of the grace period, the insured may request the reinstatement of the contract. Requirements: proof of insurability, payment of all back premiums, interest, and policy loans.

Personal Lines Institute

Sample Examination Questions and Composite Answers

Sample Question 1:

John has his home insured on a Homeowner 3 - Special Policy that has a $200,000 Coverage A – Dwelling limit and a $300,000 Coverage E - Liability coverage.

A. John has an apartment above his detached garage that he rents to a college student. The tenant accidently starts a fire that causes $25,000 damage to the garage/apartment. The fire also causes $6,000 damage to the tenant's personal property. Ignoring any deductible, how much of this loss is covered by John's Homeowners Policy? Include the reason for your answer.

B. While John was on vacation, a neighbor cared for his dog as a favor. When the neighbor failed to shut the gate to the fence, John's dog got out of the yard and bit a child. The parents of the injured child have fire a$500,000 lawsuit against both John and his neighbor for the bodily injury to the child. Will John's Homeowner Policy provide coverage to both him and his neighbor? Explain your answer.

Sample Answer 1:

A. While fire is a covered peril, the homeowners policy does not cover another structure rented or held for rental to others unless used solely as a private garage. The tenant's property is not covered as the homeowner policy excludes property of tenants.

B. John is an insured and is provided coverage for bodily injury caused by his dog. The neighbor is also an insured while caring for John's dog as the neighbor is not in the business of caring for animals. The maximum the policy will pay is the $300,000 per occurrence limit.

Sample Question 2:

Sue is the named insured on a Personal Auto Policy on which she insures her 2014 Toyota. The policy has Part A – Liability limits of 50,000/100,000/25,000. Sue also has a company car provided by her employer.

A. Sue has an at-fault accident while driving her company car. The driver of the other car is seriously injured, and the other vehicle is totaled. Explain whether or not Sue's Personal Auto Policy will provide liability coverage for the injury to the other driver and the damage to the other vehicle.

B. Sue is helping her friend move. While driving her Toyota, Sue has an accident and the friend's property in her car is damaged. Explain whether or not Sue's Personal Auto Policy will pay for the $1,500 damage to her friend's property.

Sample Answer 2:

A. Sue's policy does not provide liability coverage while she is driving her company car. There is an exclusion for a vehicle furnished or available for her regular use.

B. Sue's policy will not cover the damage to her friend's property. There is an exclusion for property damage to property being transported.

The Society of

Certified Insurance Counselors

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Section 1

LIFE AND ANNUITY POLICIES

Resources

Available at:
riskeducation.org/LHResources

- Glossary
- Sample Conditional Receipt
- Life Insurance Needs Analysis Worksheet
- History of Annuities

Life and Annuity Policies

Section Goal

The Life and Annuity Policies section provides participants with the core knowledge and tools necessary to deliver information and counsel regarding life and annuity products to their clients and prospects.

Learning Objectives

1. Use knowledge of life insurance contracts' **general uses** and **legal elements** to provide counsel to clients and prospects.

2. Determine the **appropriate type and amount of life insurance coverage** to help a client or prospect develop a financial plan.

3. Apply knowledge of the **components** of **Term Insurance, Universal Life Insurance, and Whole Life Insurance** policies to advise clients and prospects on selecting the life insurance products that best meet their needs.

4. Apply the **Standard Provisions of a Life Insurance Contract** and an understanding of taxation of premiums, death benefits, and cash value to meet client needs.

5. Use knowledge of **classifications, types, provisions, and payout options** of annuities to meet client needs.

Life Insurance Concepts

Learning Objective 1:
Use knowledge of life insurance contracts' **general uses** and **legal elements** to provide counsel to clients and prospects.

General Uses of Life Insurance

Protect Your Clients: "Build a wall around them!"

Create an Estate: (Provides a lump sum of cash) Where time or other circumstances have kept the estate owner from accumulating sufficient assets to care for their loved ones, life insurance can create an instant (income-tax-free) estate. Most people simply do not have a large estate; if they do, it is usually illiquid and not easily converted to cash.

Pay Estate (Death) Taxes: (Prevents the erosion of estate values because of settlement costs.) The federal estate and gift tax exemption amounts are $13.61 million per individual for gifts and deaths occurring in 2024. Due to the current exemption rules, very few estates are subject to estate taxes. Those that are may see as much as 50% erosion of the total estate value because of the tax and associated settlement costs. Federal estate taxes are generally due nine months after death.

Fund A Business Transfer, Business Continuation, Or Buy-Sell Agreement: Business owners often agree to buy a deceased owner's share from his or her estate after death. Life insurance provides ready cash to finance the transaction.

Pay Off A Home Mortgage: Many people would like to pass the family residence to their spouse or children free of any mortgage. Often, a decreasing term policy is used, which decreases the face amount as the mortgage balance is paid down.

Provide an Education Fund–College Fund for Children or Grandchildren: Cash value increases in a policy on the parent's life (or child's life) can be used to accumulate funds for college or other educational program. If the insurance is on the parent's life, the death benefit could also fund this expense should death occur prematurely. A grandparent could "gift" the premium on such a policy.

Protect a Business from The Loss of a Key Person: (Valuable Employee) Key employees are difficult to attract and retain. The untimely death of a key person may cause a severe financial strain on the business.

Create or Supplement a Retirement Fund: Current insurance products provide competitive returns and are a prudent way of accumulating the necessary funds for retirement years.

Comply with a Court Order: A divorce settlement with minor children involved may include a court-ordered life insurance policy on the payor with the payee as the irrevocable beneficiary. This life insurance would continue the child support in the event of the death of the payor before the support order ends.

Make a Gift: Life insurance is often used to make gifts to individuals or charities.

Rewarding and Retaining Valuable Employees: Life insurance (and its cash value) can be used for rewarding and retaining valuable employees. An Executive Bonus (162 Plan) is a simple, discriminatory, and tax-advantaged way employers can accomplish this goal.

Equalize Inheritances: When the family business passes to children who are active in it, life insurance can give an equal amount to the other children.

Use Any Cash Value as an Emergency Cash Fund: Cash value in permanent life insurance is liquid and usually easily accessed.

Replace Lost Income: Anyone who depends on another individual for income contribution to the household, such as a working spouse or partner, should consider life insurance as protection from the loss of that income.

Final Expenses: Funeral expenses are not cheap, and the sudden loss of a loved one will be compounded by the cost of a funeral and associated expenses.

Legal Elements of a Life Insurance Contract

Agreement:

1. Offer
2. Acceptance
3. Consideration (premium)

Competent Parties:

1. Parties to the contract must have the legal capacity to enter into the contract
2. Those not considered legally competent to enter into a contract include:
    - Anyone under the influence
    - Anyone considered mentally incompetent
    - Minors – "age of majority" is 18 in most states, except for certain activities such as drinking alcoholic beverages

Legal Purpose

1. Insurance cannot be issued for an illegal or immoral purpose
2. There must be **insurable interest**, meaning a relationship that exists between parties that justifies one owning life insurance on the other at the time of **application**, which is defined as the statement of information given when a person applies for life, health, or disability insurance
3. Property-Casualty coverage at the time of loss

Applying Contract Knowledge to Client Needs

Learning Objective 2:
Determine the **appropriate type and amount of life insurance coverage** to help a client or prospect develop a financial plan.

Planning for Personal Needs

Appropriate steps to implement during the planning phase:

1. Identify issues by gathering information via a fact-finder discussion:
   - Worksheets
   - Questioning techniques
   - Listening techniques

2. Assign priorities, establishing goals and objectives:
   - Replace lost income
   - Final expenses
   - Pay off home mortgage
   - Provide an education fund

To see a Life Insurance Needs Analysis Worksheet, visit riskeducation.com/LHResources

3. Analyze the information and suggest solutions and a plan

   - If complete and accurate information has been obtained (including goals and objectives in priority order), then the process is ready to begin
   - Many life insurance companies have advanced sales specialists in the home office who can assist in the analysis and recommendations for an agent who has not really worked in this area before
   - Remember – your prospects want recommendations!
     Sound recommendations come from understanding what they have and want to achieve.

     What unforeseen events could jeopardize or totally derail their plans?

Early death	Disability
Unemployment	Inflation
Tax law changes	

4. Develop a plan with client involvement

   - Life insurance, annuities, etc., require a life/annuity license
   - Securities and other investment vehicles (e.g., variable annuities, stocks, bonds, CDs, real estate) will obviously require agents/brokers to have the proper state (or FINRA) license
   - Some "non-funding" choices may be necessary – with wills, trusts, tax planning, etc., the use of competent professionals may be necessary (e.g., attorneys, CPAs, trust officers)

5. Implement the plan/solution

6. Periodically repeat the process to monitor and revise as needed due to:

   - Death or divorce
   - Sale of a business
   - Receiving an inheritance
   - Job change

Determining the Proper Amount of Life Insurance

Note:
Virtually every life insurance company, agent, financial planner, association, etc., has developed their own approach to determining the amount of life insurance a person might need.

Total Needs Analysis

1. This method determines the present and future funds necessary to accomplish specific financial goals and income needs of the family unit; several goals should be considered (Refer back to the General Uses of Life Insurance)

2. This method requires in-depth questioning on the agent's part–usually, a detailed fact finder is used; all current and future income sources are considered, including current insurance, eligible social security benefits, potential inheritance, etc.

3. Assumptions of interest rates, taxes, and inflation are necessary; **always use the client's assumptions, not yours**

4. Situations to consider (not an exhaustive list):

    - Last expense
    - Readjustment income
    - Dependency period
    - Education

- Blackout period – the time during which a surviving spouse stops receiving Social Security survivor's benefits (when the youngest child turns age sixteen) and begins receiving Social Security retirement benefits
- Mortgage
- Income for parents

5. Advantages of using this method

- More realistic numbers
- Client involvement

6. Disadvantages of using this method

- Time-consuming
- Results can be overwhelming
- Client may be reluctant to share information

For a Life Insurance Needs Analysis Worksheet, visit riskeducation.org/LHResources

Multiple of Gross Earning Method

1. This method uses the pre-tax annual earnings and multiplies them by a factor, such as 6, 8, or some other number

2. Advantages to using this method

   - Quick and simple for the agent
   - Easy to understand for the client

3. Disadvantages to using this method

   - Less accurate than the income needs approach
   - Large mortgages, loans, numerous children, and special considerations **may** not be accounted for
   - Social Security benefits are not included
   - Current-in-force is not considered

"Scientific" Guess Method

1. Advantages – quick, simple, and easy to understand

2. Disadvantages – tends to be the least accurate approach of the three methods

Knowledge Check

You are sitting with a prospect who has no idea about his social security benefits or his employee benefit amounts. He is concerned with family debt in the event of premature death or disability and is limited as to the amount of time he can spend with you.

Which planning method would be most appropriate given the information above?

Why?

Types of Life Insurance Contracts

Learning Objective 3:
Apply knowledge of the **components** of **Term Insurance, Universal Life Insurance, and Whole Life Insurance** policies to advise clients and prospects on selecting the life insurance products that best meet their needs.

Term Insurance

Definition: "Term" is precisely what the name would imply: insurance for a specified period of time.

Characteristics

1. Face amount payable only if death occurs during the years specified
2. Protection is only for a limited number of years
3. Pays nothing if the insured lives past the end of the term coverage period

Purpose and Uses

1. Identifiable or specific need (mortgage or loans)
2. Often sold when the need is great, but the money is little
3. Protects future insurability if converted

Features and Advantages

1. Easy for buyer to understand

2. May be renewable and/or convertible

   An important feature to look for in a term contract is its renewability or convertibility. Can the policy be *renewed*, and if so, how many times or until what age?

   Convertibility means the policy can be exchanged for a permanent type of coverage without the need to prove **insurability** (attributes that applicants possess that qualify them as insurable risks). When a term policy is renewed or converted, the premium for the new contract will be based on the insured's attained age, which is the age at the time of renewal or conversion.

3. Initial low cost

4. Return of premium

Disadvantages

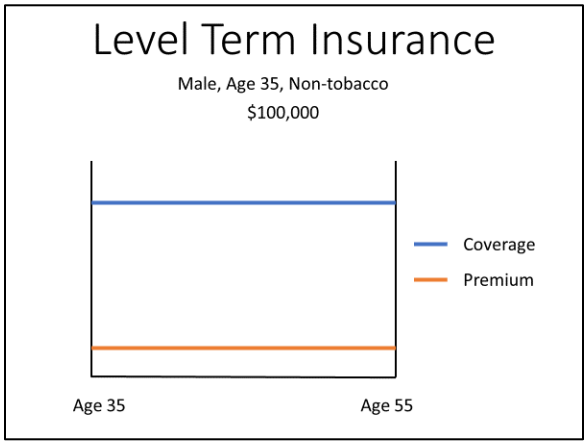
1. No cash value

2. Coverage is designed to end before death

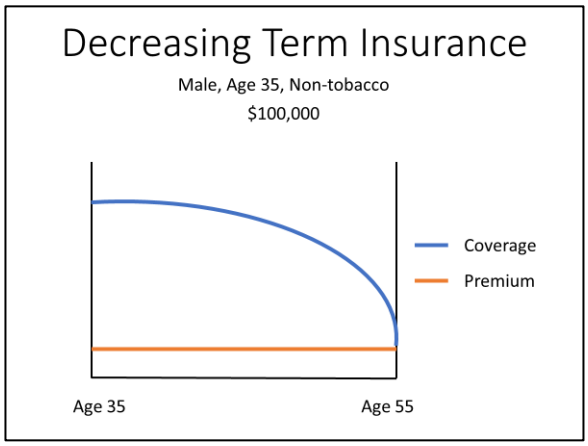
Types of Term Insurance

1. Level term: The premium and face amount remain level. However, the policy is only for a specified number of years, such as 5, 10, 15, 20, or 30 years. Some companies write a level term to age 65, and some allow a level term of short duration (e.g., five years) to be renewed but only to a certain age, such as 65.

   Note:
   Many insurance carriers that issue level term insurance can also issue the contract with a "return of premium" feature.



2. Decreasing term: The face amount decreases as the premium remains level. Usually, this type is used for mortgage insurance. While the traditional decreasing term declines on a straight line, many companies can design a contract's face amount to decrease consistent with the unpaid balance of a mortgage. The mortgage interest rate and years remaining on the note determine the amortization schedule.



Note:
Many companies that issue term policies can also issue a **term rider** that can be added to a permanent policy.

Whole Life Insurance

Definition: This policy type includes those forms where the face amount is paid on the death of the insured whenever death occurs. Should the owner pay all the premiums–which will contractually never increase–the policy will remain in force until death.

Characteristics

1. The face amount will be paid regardless of the age at death of the insured

2. Continuous or limited premium payments

3. Growth of cash values

Purpose and Uses

1. Permanent protection

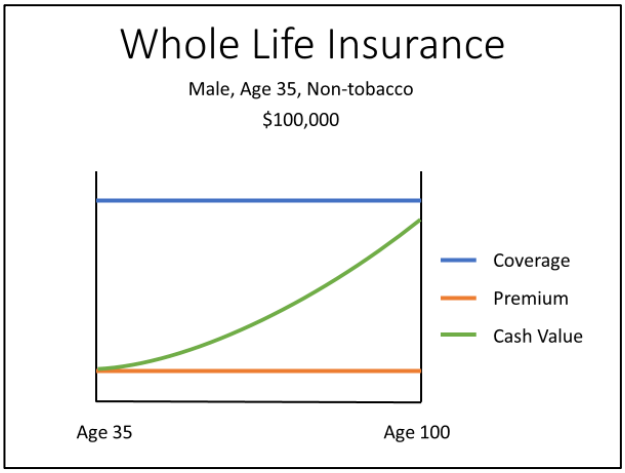
2. College planning

3. Estate protection

4. Retirement planning

Features and Advantages

1. The premium remains the same throughout the life of the contract

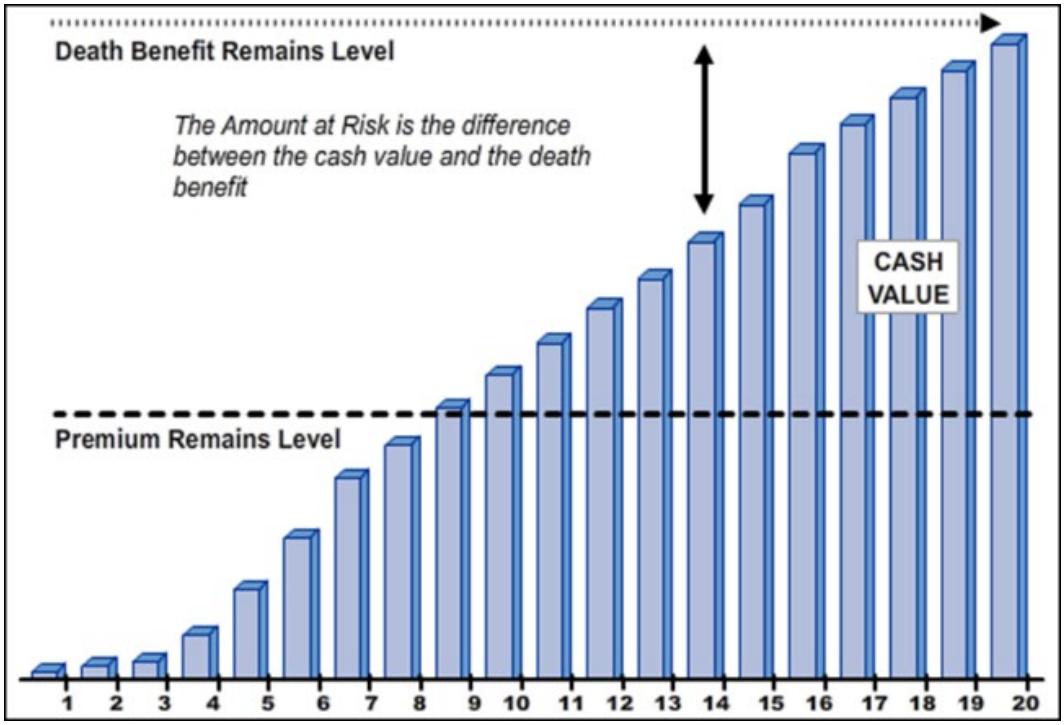


2. In case of a lapse, the policy may stay in force via Automatic Premium Loan (APL)

Automatic Premium Loan
▪ APL applies only to whole life policies and is usually elected on the application or, in some cases, automatically included by the insurance company.
▪ The premium will be paid by the cash value after the grace period expires.
▪ This provision keeps the policy in force and prevents the automatic use of the non-forfeiture clause.

3. Cash values (growing tax-deferred) are available for loans, assignments, emergency use, etc.

4. **The net amount at risk**, which is the difference between the face amount of insurance and the accumulated cash value, decreases as the insured grows older



Disadvantages

1. The initial cost is higher than term insurance

2. Cash value NOT paid in addition to death benefit; however, dividend options (discussed later) may address this

3. Lost investment opportunity

Non-forfeiture Options (Whole Life Policies Only)

After the contract has built cash values, the owner may wish to exercise one of the options below to stop premium payments or to terminate the contract. If the owner does not select an option, the company will select one (typically extended term). A non-forfeiture option is a choice that the owner of a life insurance policy has regarding the disposition of the cash values when they surrender a life insurance policy. Once a non-forfeiture option has been selected, it cannot be changed.

1. **Cash**: Values are stated on the schedule page of the policy. The owner may use the cash as they wish–full surrender ("cash it in"), loan, policy assignment, etc.

2. **Reduced Paid-up Insurance**: The cash value is used to purchase a reduced death benefit that is fully paid up. No future premiums are payable by the owner.

3. **Extended Term Insurance**: Cash value is used to "one-pay" for a term contract. The full death benefit will be paid if the insured dies within the scheduled time period. If the owner does not select a non-forfeiture option, this is the option the company usually invokes. If the grace period expires and the automatic premium loan provision has not been elected, this option is commonly invoked by the insurance company.

Age 35 male, $100,000 original face amount NON-FORFEITURE TABLE — TABLE OF GUARANTEED VALUES				
END OF POLICY YEAR	GUARANTEED MINIMUM CASH VALUE	PAID-UP INSURANCE AMOUNT	PERIOD OF EXTENDED TERM INSURANCE	
1	0.00	0.00	YEARS	DAYS
2	0.00	0.00		
3	200.00	1,500.00	0	233
4	1,000.00	6,800.00	2	326
5	**1,900.00**	**12,200.00**	**4**	**364**
6	2,800.00	17,100.00	6	263
7	3,700.00	21,600.00	8	58
8	4,700.00	26,200.00	9	192
9	5,700.00	30,300.00	10	222
10	**6,700.00**	**34,000.00**	**11**	**162**
11	7,800.00	37,800.00	12	84
12	8,900.00	41,200.00	12	305
13	10,000.0	44,200.00	13	105
14	11,200.0	47,400.00	13	262
15	**12,500.00**	**50,600.00**	**14**	**41**
16	13,800.00	53,500.00	14	134
17	15,100.00	56,000.00	14	185
18	16,500.00	58,600.00	14	235
19	17,900.00	61,000.00	14	254
20	**19,400.00**	**63,400.00**	**14**	**276**
At Age 60	27,200.00	72,900.00	14	100
At Age 65	35,900.00	80,200.00	13	19

Dividends: This is a distinguishing feature between participating (mutual) policies and non-par (stock) policies. Non-par policies do not pay dividends. A dividend paid on a participating policy is classified as a *return of excess premium*. Depending on the insurance company, there may be numerous options the owner can choose from at the time of application. The most common dividend options are:

C	**C**ash (not subject to income tax)
A	**A**ccumulation of interest (interest is taxable)
R	**R**educe premium
P	**P**aid-up additional insurance*
O	**O**ne-year level term

***What are Paid-Up Additions?**

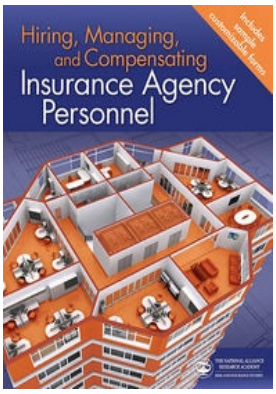
Paid-up additions are amounts of permanent insurance with their own cash value, which generate their own dividends. Each year, the base policy dividend is used to buy a single-premium paid-up policy at the insured's attained age. The base policy death benefit is then increased by the face amount of the paid-up accumulated addition, and the guaranteed cash value is increased by the cash value of the accumulated paid-up additions. Since paid-up additions are whole life insurance, they, in turn, earn dividends, which are then credited in the same manner as the base policy dividend.

RECOMMENDED READING

Fundamentals of Life & Health Insurance

Life and health insurance are the cornerstones of protection for the financial future of individuals, families, and businesses. This book is designed to provide a foundational understanding of the mechanics of life and health insurance products including Annuities, Long Term Care, Medicare, and more.

Visit the bookstore at: nationalalliancebooks.com



Hiring, Managing and Compensating Insurance Agency Personnel

A valuable resource to supplement the information provided in the Agency Management CIC curriculum.

Provides a practical and comprehensive look at human resources from the insurance agency perspective.

Visit the bookstore at: nationalalliancebooks.com

Limited Payment Contracts

Definition: These contracts provide for the payment of the face amount upon the death of the insured, regardless of the age at death. However, they differ from the whole life policy in that the premium payments are contractually charged for a limited number of years. After the stipulated number of years has been paid (usually 10 or 20 years, or to age 65), the policy becomes fully paid-up

Universal Life

Definition: A flexible premium, adjustable death benefit life insurance contract. They were introduced in the early 1970s because high interest rates on money market accounts and aggressive sales by competing financial services and other non-insurance financial products forced life insurance companies to become somewhat competitive regarding financial returns.

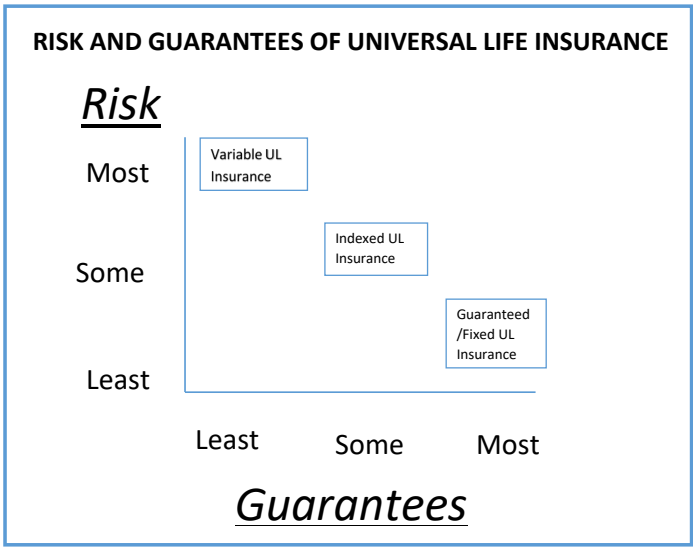
Purpose and Use: The contract can function just like term or whole life. A Universal Life (UL) contract can be a high premium or low premium.

Types of Universal Life

1. Guaranteed/Fixed – Guarantee principal with interest credited on a fixed basis. Although the interest earned is considered fixed, the company may adjust the rate of interest payable based on current assumptions of rate of investment return and/or mortality.

2. Indexed – A form of fixed universal life insurance. The principal is guaranteed if the client holds the contract for a certain period of time. Gains can be attractive, with minimal investment risk.

3. Variable – Principal, for the most part, is not guaranteed; the individual investor assumes the investment risk in that they may lose principal if the market turns downward. HOWEVER, the attraction for any investors interested in variable universal life is that the dollars invested should be able to keep pace with inflation.



Features and Advantages

1. Contract flexibility

2. Insured can assist in the design of the plan

Disadvantages

1. Non-guaranteed mortality charges

2. Low guaranteed interest rate

Option A vs. Option B

Option A – Includes the cash value within the death benefit–cash values grow FASTER than option B

Option B – Pays the cash value in addition to the death benefit–cash values grow SLOWER than option A

Six Components of a Universal Life Insurance Policy

1. CASH (premium or any additional deposit) is paid into the policy account.

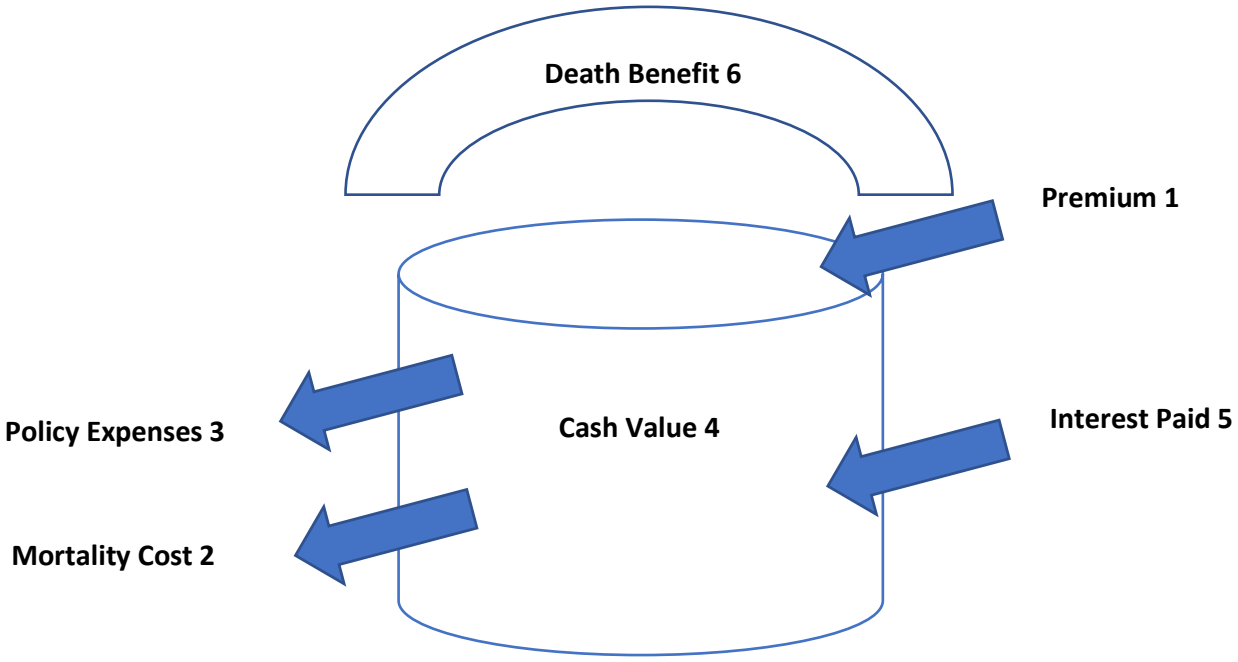
2. MORTALITY CHARGE (cost of term life insurance needed to pay death benefit) is deducted from the policy account.

3. POLICY EXPENSES (to cover the insurance company's administrative costs) are deducted from the policy account.

4. CASH VALUE (what is left after the mortality charge and policy expense are subtracted from the premium payment) accrues in the policy.

5. INTEREST is credited to the cash value (accrued cash value is invested in a combination of bonds [to cover the guaranteed interest rate] and other options [such as mutual funds] to maximize earnings so a higher than guaranteed interest rate can be paid).

6. DEATH BENEFIT (Life Insurance) is maintained in the policy.



The Flexibility of a Universal Life Policy

1. Premiums can be skipped.

   The contract may become fully "self-supporting" ***if*** the level of cash value is sufficient to cover the future mortality charges. Changes in the policy's expense charges and interest rates can also impact the future of the contract. Among the flexible features are the ability to:

2. Increase or decrease the face amount

   If the amount of insurance is increased, then standard underwriting would be required for the new "at-risk" amount.

3. Lengthen or shorten the protection period

   For example, initially design the policy to look like a ten-year term policy paying only mortality costs and expenses. This gives the owner (usually the insured) the option to make larger deposits, create cash value and have a permanent plan of insurance.

4. Increase or decrease the level of premiums

   Insurance companies will impose a minimum amount of required premium for the first 1 to 3 years. After that time, the owner may decrease (or suspend) premiums as they wish. In the late 1970s, the federal government imposed a maximum amount of premium that can be paid into universal life to keep the cash value growth tax-deferred.

5. Lengthen or shorten the premium paying period

   Pre-pay with larger sums of cash to be able to stop payments at some future date and make the policy self-sustaining.

6. Contribute or withdraw lump sums of money and have either partial surrenders or loans

The Bill Carter Story

This is a basic illustration only, an illustration is not intended to predict actual performance, interest rates, dividends, and values outlined in the illustration are not guaranteed, except for items clearly labeled as guaranteed.

The Flexibility of the Universal Policy {Indexed Universal Life)

(Illustrated at 6.24%)

	End of Year	Age Age	Premiums	Non-Guaranteed Cash Value	Death Benefit
Age 31. Bill purchases a $150,000	1	31	1,600	0	150,000
Indexed Universal Life policy.	2	32	1,600	0	150,000
Annual premiums are $1,600	3	33	1,600	321	150,000
Age 34. Bill takes a new job and	4	34	1,600	0	250,000
loses his Group Life Insurance.	5	35	1,600	650	250,000
He increases the face amount of					
his IUL policy to $250,000. No	6	36	1,600	2,162	250,000
change is premium.	7	37	1,600	3,865	250,000
	8	38	1,600	5,644	250,000
	9	39	1,600	7,480	250,000
	10	40	1,600	9,401	250,000
	11	41	1,600	11,976	150,000
Age 43. Bill receives a company bonus	12	42	1,600	14,017	250,000
He puts $7,000 into his IUL policy.	13	43	7,000	22,003	250,000
Age 44. He increases his	14	44	2,400	25,885	250,000
contributions to $2,400	15	45	2,400	29,538	250,000
	16	46	2,400	33,446	250,000
	17	47	2,400	37,604	250,000
	18	48	2,400	42,087	250,000
	19	49	2,400	46,883	250,000
	20	50	2,400	52,006	250,000
Between **Age 51-54,** he withdraws	21	51	-5,000	49,977	244,750
$5,000 for his child's college	22	52	-5,000	47,892	239,238
education. Contributions are	23	53	-5,000	45,720	233,449
suspended for this period.	24	54	-5,000	43,701	227,372
Age SS. College is over. Bill	25	55	3,500	50,684	226,240
Resumes contributions, increasing					
them to $3,500 a year. He is	26	56	3,500	58,165	225,052
concerned about retirement.	27	57	3,500	66,221	223,805
	28	58	3,500	74,889	222,495
	29	59	3,500	84,234	221,120
	30	60	3,500	94,709	219,676

Age 61 Bill has an insurance review and decrease his death benefit.	31	61	3,500	105,395	168,160
	32	62	3,500	117,395	166,568
	33	63	3,500	130,496	170,249
	34	64	3,500	144,636	184,565
	35	65	3,500	159,863	199,576
Age 66. When he retires, he stops Making payments and withdraws $18,364.	36	66	-18,365	153,170	193,657
	37	67	-18,365	146,442	187,597
	38	68	-18,365	139,689	181,386
	39	69	-18,365	132,942	175,608
	40	70	-18,365	126,275	168,608
	41	71	-18,365	119,713	159,068
	42	72	-18,365	113,308	149.032
	43	73	-18,365	107,135	138,494
	44	74	-18,365	101,266	127,440
	45	75	-18,365	95,811	115,880
	46	76	-18,365	90,663	112,203
	47	77	-18,364	85,865	108,980
	48	78	-18,364	81,456	106,255
	49	79	-18,364	77,495	104,097
Age 80. **Bill has withdrawn $275,475 (INCOME TAX FREE), still has $74,022 of cash value and a death benefit of $102,550. (based on this scenario, Bill could continue receiving his annual withdrawal to age 100.**	50	80	-18,365	74,022	102,550

Universal Life	Whole Life
Face amount can vary	Face amount fixed
Flexible premium/mortality cost	Fixed premium/mortality cost
Minimum guaranteed rate of interest plus additional rate tied to market	Guaranteed cash value
Option "A" or "B"	Cash values are not paid in addition to death benefit
Loans or partial surrender	Loans only; interest charged

Annual Reports

Due to the flexibility and transparency of a UL contract, an annual report is prepared for the insured/owner.

The following four pages illustrate the six components and show the difference between Option A and Option B death benefits and cash values.

Life Insurance Annual Statement

Summary of your policy for the policy year ending 3/23/2021

Policy Type: Indexed Universal Life
Policy Number: 0102428933
Issue Date: 02/23/2015

Statement Date: 04/07/2021
Your Insurance Representative is:
Sam Jones
Smart Insurance Agency
201 Main Street
Brenham, TX 77833

Jon Hill
2000 Geney
Brenham, TX 77833

Issue age: 31
Policy Death Benefit $150,000
Current Death Benefit $150,000
Death Benefit Option: A

We currently bill you $1600 ANNUALLY

Monthly Financial Summary

Pol Mtn	Premium Payments	Expense Charges	Cost of Insurance	Interest Credited	Cash Values (Excluding Loans)	Death Benefit
Mar	$1,600	$18.72	$24.45	$90.16	$950	$150,000
Apr	0	$18.72	$24.45	$90.24	$1,042	$150,000
May	0	$18.72	$24.45	$90.56	$1,134	$150,000
Jun	0	$18.72	$24.45	$91.12	$1,215	$150,000
Jul	0	$18.72	$24.45	$91.95	$1,344	$150,000
Aug	0	$18.72	$24.45	$92.34	$1,455	$150,000
Sep	0	$18.72	$24.45	$92.86	$1,576	$150,000
Oct	0	$18.72	$24.45	$93.52	$1,753	$150,000
Nov	0	$18.72	$24.45	$94.10	$1,884	$150,000
Dec	0	$18.72	$24.45	$94.98	$2,033	$150,000
Jan	0	$18.72	$24.45	$95.57	$2,158	$150,000
Feb	0	$18.72	$24.45	$97.04	$2,265	$150,000
Total	$1,600	$224.64	$293.40	$1,022.10		

Note. The current assumption values are projected using the new money interest rate of 6.34%. Current interest rates and risk charges are not guaranteed for the future.

Without future premiums, assuming the current interest rates and risk charges will continue, your policy will remain in force through 1/23/2046.

Without future premiums and assuming guaranteed interest and risk charges, your policy would remain in force through 9/23/2037.

With future premiums and assuming the current interest rates and risk charges, your policy will remain in force through 6/23/2214.

With future premiums and assuming the guaranteed interest rates and risk charges, your policy would remain in force through 9/23/2088.

This statement is a snapshot of one year. The cost of insurance will typically increase annually.

Life Insurance Annual Statement

Summary of your policy for the policy year ending 3/23/2021

Policy Type: Indexed Universal Life
Policy Number: 0102428933
Issue Date: 02/23/2015

Statement Date: 04/07/2021
Your Insurance Representative is:
Sam Jones
Smart Insurance Agency
201 Main Street
Brenham, TX 77833

Jon Hill
2000 Geney
Brenham, TX 77833

Issue age: 31
Policy Death Benefit $150,000
Current Death Benefit $150,000
Death Benefit Option: B – Increasing

We currently bill you $1950 ANNUALLY

Monthly Financial Summary

Pol Mtn	Premium Payments	Expense Charges	Cost of Insurance	Interest Credited	Cash Values (Excluding Loans)	Death Benefit
Mar	$1,950	$23.47	$27.50	$74.35	$4,280	$154,280
Apr	0	$23.47	$27.50	$74.90	$4,334	$154,334
May	0	$23.47	$27.50	$75.44	$4,848	$154,848
Jun	0	$23.47	$27.50	$75.95	$4,990	$154.990
Jul	0	$23.47	$27.50	$76.65	$5,112	$155,112
Aug	0	$23.47	$27.50	$77.24	$5,260	$155,260
Sep	0	$23.47	$27.50	$77.83	$5,385	$155.385
Oct	0	$23.47	$27.50	$78.20	$5,524	$155,524
Nov	0	$23.47	$27.50	$78.75	$5,690	$155,690
Dec	0	$23.47	$27.50	$79.15	$5,840	$155,840
Jan	0	$23.47	$27.50	$79.80	$5,970	$155,970
Feb	0	$23.47	$27.50	$80.12	$6,115	$156,115
Total	$1,600	$281.64	$330.00	$928.38		

Note. The current assumption values are projected using the new money interest rate of 6.34%. Current interest rates and risk charges are not guaranteed for the future.

Without future premiums, assuming the current interest rates and risk charges will continue, your policy will remain in force through 2/23/2044.

Without future premiums and assuming guaranteed interest and risk charges, your policy would remain in force through 8/23/2035.

With future premiums and assuming the current interest rates and risk charges, your policy will remain in force through 6/23/2214.

With future premiums and assuming the guaranteed interest rates and risk charges, your policy would remain in force through 7/23/2078.

This statement is a snapshot of one year. The cost of insurance will typically increase annually.

Knowledge Check

Your clients would like to have a permanent insurance program but are concerned about additional expenses the family will incur while their children are in college in the next ten years.

Explain how the flexibility of universal life would allow for coverage to remain while premiums could be adjusted during years with higher family expenses.

Group Life

Group Term Life Insurance Plans

Plan	Overview	Features
Basic Term Life	Employer-paid benefits can give employees a sense of added security, as well as engagement with the company	• Varying level of available coverage • Accelerated benefits for terminal illness • Benefits for death of spouse and children
Supplemental Term Life	By providing coverage above and beyond the basic term life plan, this optional, employee-paid solution offers additional peace of mind	• Optional Accidental Death & Dismemberment (AD&D) coverage • Accelerated benefits for terminal illness • Benefits for death of spouse and children

Available in a variety of supplement and contribution options, group term insurance provides benefits to employees' beneficiaries in the event of death or a disabling accident. IRC section 79 provides an exclusion for the first $50,000 of group-term life insurance coverage provided under a policy carried directly or indirectly by an employer. There are no tax consequences if the total amount of such policies does not exceed $50,000. The imputed cost of coverage in excess of $50,000 must be included in income using the IRS Premium Table and is subject to Social Security and Medicare taxes. The annual imputed cost is included on the employee's W-2 tax form.

Benefit Schedules

Flat schedule

Earnings schedule (most common)

Occupation or position schedule

Benefit Schedule for Group Life and AD&D

	Life Benefits*	AD&D Benefits*
Plan 1 **Flat Schedule**	$10,000	Same as life amount
Plan 2 **Earnings Schedule** (Multiple of annual salary)	1 x Income Min – $10,000 Max – $50,000	Same as life amount
Plan 3 **By Occupation** Partner/Owner/Proprietor Manager/ Supervisory/All Other	$30,000 $15,000 $10,000	Same as life amount

* The plan may limit the maximum coverage for new enrollees over the age of 60. An employee's Life and AD&D coverage may be reduced or terminated based on plan specifications.

Life Insurance Contract

Learning Objective 4:

Apply the **Standard Provisions of a Life Insurance Contract** and an understanding of taxation of premiums, death benefits, and cash value to meet client needs.

Standard Provisions of a Life Insurance Contract

Each state has enacted standard policy provision laws, which require life insurance companies to include certain provisions in every life insurance policy. The company may select the actual language, but the state Department of Insurance must approve the wording. State insurance codes require that specific provisions be included in all life insurance policies sold and/or delivered in that state.

Incontestable Clause: Claims cannot be denied after two years from the date of issue.

Entire Contract Clause: The application becomes part of the policy, so the insured has a copy. Without it, the incontestable clause could not be used. If a copy of the application was not attached to the policy, the company is prohibited from denying a death claim in the first two years due to a misstatement of a material fact.

Grace Period: This is a stated time period (usually 30 or 31 days) in which the premium must be paid to prevent the policy from lapsing. The policy will continue in force during the grace period, and any death benefits are payable if death occurs during the grace period. The unpaid premium will be deducted from the death benefit. ***Reminder:*** An automatic premium loan in a whole life policy may pay a late premium.

Misstatement of Age or Sex: If the age (or sex) of the insured has been misstated in the application, the contract stays in force. The future death benefit will be adjusted to reflect the benefit that the premium would have purchased had the age/sex been stated correctly (or, in event of overpayment, a refund is paid).

Suicide: A death benefit will not be paid if suicide occurs during the first one or two years of the contract. The company usually will refund all premiums.

Note:

Individual state statute determines the length of the suicide clause.

Reinstatement: Allows for the reinstatement of a lapsed policy generally up to 2-3 years. It does require that the owner repay all back premiums (plus interest), repay any loans, and prove to be insurable.

Right to Examine (also called the Free-Look Provision): Allows the applicant a specified number of days following *physical* receipt of the policy to examine it and, if dissatisfied for any reason, they can return the contract to the company for a full refund of the deposit premium (if any). The free-look period can vary by state and is generally no fewer than 10 days.

Exclusions: Generally speaking, an un-endorsed life contract has no exclusions. Some contracts may allow the company the right to invoke a *war clause exclusion*. This clause will provide no benefit other than the return of premium plus interest should the insured be killed as the result of a war-like action. This clause cannot be added to an existing contract. It is only for new applications and is typically removed after the war ends. Other "*cause-of-death exclusions" rider* can only be added at the time of issuance, such as a hazardous sports exclusion or an unusually hazardous occupation exclusion.

Ownership Rights: The named insured does not have to be the owner of their policy. A parent can be the owner of a policy on their child. A spouse can be the owner of a life policy on their spouse. A business can be the owner of life insurance on "key executives." A trust can be the owner of a grantor's policy. The **owner** has the exclusive right to exercise the following:

C	Change beneficiary (unless irrevocable, in which case the beneficiary cannot be changed without the consent of the current irrevocable beneficiary)
A	Assignment of policy
R	Receive dividends, returns on excess premium, and favorable loss experience on participating life insurance policies
B	Borrow cash value
S	Surrender policy

IRC section 79 provides an exclusion for the first $50,000 of group-term life insurance coverage provided under a policy carried directly or indirectly by an employer. There are no tax ˜consequences if the total amount of such policies does not exceed $50,000. The imputed cost of coverage in excess of $50,000 must be included in income, using the IRS Premium Table, and is subject to social security and Medicare taxes. The annual imputed cost is included on the employee's W-2.

Assignment of Life Contracts: The policy owner has the right to assign a life policy. There are two types of **assignments,** which are the transfer of all or part of the policy owner's legal rights under the policy contract to another person or entity**:**

1. ***Absolute assignment***: the owner gives up the policy irrevocably and cannot recover rights (permanent)

2. ***Collateral assignment***: the owner gives up some policy rights, but only temporarily, to fulfill the requirements of a loan; once the loan is satisfied, the total ownership reverts back to the owner

Regarding the assignment of a life insurance policy by the owner:

1. The insurance company must be notified or is not bound by the assignment

2. The insurance company is not responsible for the validity of the assignment

3. Most states require the assignee (the bank) to be notified of the premiums due and receive any lapse notice

Premium Paying Options

1. Modal premium payment

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
	$1,000	X .51 = $510	X .26 = $260	X .086 = $86
TOTAL	$1,000	$1,020	$1040	$1036

2. Pre-payment: Paying a multiple of annual premiums at one time will result in a discount, subject to individual insurance company policy

3. Policy Fee: An annual fee that may be as low as $25 and as high as $125 that is added to the base premium of life policies. This fee does **not** contribute to the cash value. It may or may not be subject to commissions.

Beneficiary

The **owner** may change the beneficiary to whomever they wish at any time after the policy issue. The only exception relates to an irrevocable beneficiary.

EXAMPLES OF COMMONLY USED BENEFICIARY DESIGNATIONS

(1) *Insured's Estate*: The Executor (individual named in a will and approved by a Probate Court to carry out the provisions of the will) or Administrator (person appointed by a Probate Court to handle the disbursement and settlement of an estate if no executor is named in a will) of the Estate of the Insured.

(2) *One Beneficiary:* Mary E. Doe, Wife.

(3) *Two Primary Beneficiaries:* John A. Doe, father, and Jane M. Doe, mother, share alike or survivor.

(4) *Several Named and Unnamed Children, Primary Beneficiary:* Allen S. Doe, son, Bo J. Doe, son, and Jo Ann Doe, daughter, and any other children hereafter born of the union of the Insured and said wife, share alike, survivors or survivor.

(5) *Wife, Primary Beneficiary; Named Children and Unborn Children, Contingent Beneficiary:* Mary E. Doe, wife, if living, otherwise Allen S. Doe, son, Jo Ann Doe, daughter, and any other children hereafter born of the union of the Insured and said wife, share alike, survivors or survivor.

(6) *Wife, Primary Beneficiary (No Children living); Unborn Children, Contingent Beneficiary:* Mary E. Doe, wife, if living, otherwise any children hereafter born of the union of the Insured and said wife, share alike, survivors or survivor.

(7) *One Primary and One Contingent Beneficiary:* Mary E. Doe, wife, if living, otherwise Bo J. Doe, son.

(8) *One Primary Beneficiary and Two or More Contingent Beneficiaries:* Mary E. Doe, wife, if living, otherwise Allan S. Doe, son, and Jo Ann Doe, daughter, share alike, or survivor

(9) *One Primary, One First Contingent, and One Second Contingent Beneficiary:* Mary E. Doe, wife, if living, otherwise Frank J. Doe, son, if living, otherwise Jane M. Doe, mother.

(10) *Trustee as Beneficiary Under a Written Trust Agreement:* The First National Bank of Gotham City, as Trustee, under Agreement of Trust dated June 11, 1999, if said agreement shall then be in force, and if not, the Executors or Administrators of the Estate of the Insured.

(11) *Unequal Distribution; Use fractions with a Common Denominator:* Three-fourths (3/4) of the proceeds to Mary E. Doe, wife, if living, and one-fourth (1/4) of the proceeds to Jo Ann Doe, daughter, if living, otherwise all to the survivor.

Primary (Jane S. Doe**,** wife)

1. May list more than one primary beneficiary

2. If listing more than one primary beneficiary, the owner must designate the percentage of benefit each is to receive; the company will typically not allow dollar amounts

3. Listing more than one beneficiary can create problems; consider what happens to the benefit due to a primary beneficiary if they predecease the insured (See the exhibit "How are Life Insurance Proceeds Paid Should a Named Beneficiary Die Before the Named Insured's Death?")

4. Consider restrictions if a minor becomes a beneficiary

5. It is inadvisable to name "the estate of" as a beneficiary – general creditors may attach the proceeds

How are Life Insurance Proceeds Paid if a Named Beneficiary Dies Before the Named Insured's Death?	
Per Capita – A method of paying life insurance proceeds to those equally related to the decedent without regard to the lines of descent. This means that the unnamed children of the deceased beneficiary will receive nothing. This is the default method of a life insurance policy.	Per Stirpes – A stipulation that, should a beneficiary predecease the named insured, the beneficiary's share of the proceeds will go to their heirs in equal percentages. This method must be specifically added to a life insurance policy.

Contingent (e.g., Jane S. Doe, wife, if living; otherwise, Mary C. Jones, sister)

1. This person (or persons) will become the beneficiary if the primary beneficiary predeceases the named insured

2. The same considerations as pertain to primary beneficiaries need to be addressed

Common Disaster Clause: If the named insured and beneficiary die in a common accident, and it cannot be determined who died first, this provision allows the benefits to be paid directly to the contingent beneficiary regardless of the sequence of deaths

Uniform Simultaneous Death Act – USDA (1993): The act provides rules for the passage of joint property when death legally occurs and exceptions to the 120-hour rule. It is possible in wills and other instruments to waive or vary the rule. **USDA (1993)** also provides for a presumption of death after five years if a person is missing or a body cannot be found.

Revocable: The owner is free to change the designation as desired

Irrevocable: The owner may change the designation **only** with the beneficiary's consent

Who and **why** do we name certain beneficiaries?

- **Estate**: 1) Creditors may attach proceeds, and 2) proceeds are added to the insured's estate for federal estate tax purposes and subject to probate

- **Named persons**: Proceeds are added to the insured's estate for Federal Estate Tax (FET) purposes should the insured also be the owner

- **Classes of persons**: For example, "all my children." However, an unknown illegitimate child may surface and make a claim as a beneficiary unless the designation is qualified, as in *"all children of this said union of marriage."*

- **Business organizations**: Buy/sell agreements, key persons, executive bonuses, etc.

- **Trust**: 1) Excellent tool to avoid FET on proceeds, 2) distribution of proceeds is professionally managed, and funds are prudently invested, and 3) trust costs, fees, and taxes must be considered

OWNERSHIP & BENEFICIARY CONSIDERATIONS OF LIFE INSURANCE					
Owner/ Beneficiary	Insured Controls the Policy?	Unsecured Creditor Problems?	Cash Value Included in Beneficiary Estate?	Death Benefit Included in Insured's Estate?	Extra Cost?
Insured/Estate	Yes	Yes	No	Yes	No
Insured Owns/ Individual Beneficiary	Yes	No	No	Yes	No
Insured Does Not Own/Individual Beneficiary	No	No	Yes	No	No
Insured Owns/ Trustee Beneficiary	Yes	No	No	Yes	Yes
Trust Owns/ Trust Beneficiary	No	No	No	No	Yes

Life Insurance Settlement Options

Death Claim Settlements: The following primarily applies to death claim settlements as elected by a beneficiary or pre-selected by the owner prior to death. However, some options apply for distributions of cash values to the owner while still living. The insured may have accrued a substantial cash value over the life of the contract. Perhaps they would want the funds paid to them in a manner other than lump sum. Some of these are the same options available from an **annuity**, a periodic payment beginning at a specific date and continuing for a specific period or the remainder of a designated life, and will be described in greater detail during the Annuities presentation.

1. Fixed Amount or Installments

   The insurance company pays equal installments until all proceeds (death benefit and earned interest) are paid out. An example would be that the beneficiary will receive $1,000 a month.

2. Life Income or Annuity

   The death benefit is used to purchase an annuity; equal installments will be paid during the beneficiary's lifetime. The payout may include a guaranteed payment period. More on annuity payout options will be discussed in the annuity section.

3. Life Income with Period Certain

4. Installment with Refund

LIFE INSTALLMENT TABLE – OPTIONAL METHOD 3					
Age of Payee When 1st Installment is Payable		Monthly Installment for Life That $1000 Will Obtain			Life With Installment Refund
Male	Female	Life	10 Yr. Certain	20 Yr. Certain	
50	55	$4.61	4.50	4.18	4.18
51	56	4.72	4.60	4.24	4.26
52	57	4.83	4.69	4.30	4.34
53	58	4.95	4.79	4.36	4.42
54	59	5.07	4.90	4.41	4.50
55	60	5.20	5.01	4.47	4.59
56	61	5.34	5.12	4.53	4.68
57	62	5.48	5.23	4.59	4.77
58	63	5.64	5.35	4.64	4.87
59	64	5.80	5.48	4.70	4.98
60	65	5.97	5.61	4.75	5.09
61	66	6.15	5.74	4.80	5.20
62	67	6.34	5.87	4.85	5.32
63	68	6.54	6.01	4.90	5.44
64	69	6.75	6.16	4.94	5.57
65	**70**	**6.97**	**6.30**	**4.98**	**5.70**
66	71	7.21	6.45	5.02	5.84
67	72	7.46	6.60	5.05	5.99
68	73	7.73	6.76	5.09	6.15
69	74	8.02	6.91	5.12	6.31

Riders

Guaranteed Insurability Rider (GIR): A rider that can be attached to a whole life, endowment, or universal life contract. The policyholder is guaranteed the right to make periodic additions to their life insurance at standard rates without medical examination or occupational consideration. The options can be exercised at stated ages *or* events (marriage or childbirth) in specified amounts. This amount usually is the face amount of the original policy, not to exceed a contract-set maximum such as $50,000.

GUARANTEED INSURABILITY RIDER

The benefit shown below can be purchased by the policyholder/owner **without evidence of insurability** or any statement of health, finances, occupation, lifestyle, and/or hobbies made by applicants that underwriters use in deciding if the risk is acceptable for insurance.

Age at Original Policy Issue	Maximum Benefit Each Option Age/Date is the Lesser of Face Amount of Base Policy, Or:	Option Ages
0-24	$35,000	25,28,31,34,37,40
25-27	$40,000	28,31,34,37,40
28-30	$45,000	31,34,37,40
31-33	$50,000	34,37,40
34-36	$60,000	37,40
37-40	$70,000	40

Regular option periods begin 30 days before and end 30 days after the regular option date. The option date is always the anniversary date of the contract.

Waiver of Premium: Should the insured become totally disabled by bodily injury or disease, the insurer waives the payment of subsequent premium. There is usually a 90- or 180-day waiting period before the company will waive the premiums. If the insured is still totally disabled after the waiting period, most companies will reimburse the insured for the premiums paid during the waiting period. When this rider is attached to a UL Policy, it must define exactly what portion of the contribution is being waived since premiums to the plan can vary. Some waive *only* the cost of insurance, while others waive the entire planned periodic payment.

Accidental Death Benefit: This rider provides for the payment of an amount in addition to the standard benefit payable in the event of an **accidental death** or a death resulting from a sudden, unexpected, and unintentional injury. Accidental death is usually defined as "a death resulting directly and independently of all other causes from bodily injuries effected solely through external, violent, and accidental means and occurring within 90 days from the date of such accident".

Payor Benefit: This rider waives the premium should the "payor" (usually the mother or father) die or be totally disabled while paying the premium for an "insured" (child). This rider typically terminates at the insured's (child's) age of 25.

Accelerated Death Benefit: The insured can collect on their own life insurance policy if diagnosed with a terminal illness. Generally, an attending physician must certify that the individual has one year (or less) to live. Some companies will pay up to 90% of the face amount.

Family Insurance: A family rider allows the purchase of term insurance for a spouse and/or children of the insured. Insureds purchase units of coverage (i.e., $1,000, $2,000, $5,000, etc.). Under specific conditions, many policies allow conversion to a permanent life insurance policy without evidence of insurability.

Term Rider: A term insurance rider provides an additional amount of temporary coverage, which may be attached to an existing permanent policy for a specified period of time. Typically, the insurer offers this option when the policy is issued initially.

Return of Premium: When a return of premium rider is attached to term life insurance policies, the **policy owner**–the individual or entity controlling all rights, benefits, and privileges of a life insurance contract–returns the premium paid if the insured outlives the term. One disadvantage of term insurance is that it is designed to expire before the insured dies. If the policy is kept in force for a specified time period, this rider refunds some or all of the premium paid. A return of premium rider may increase a standard premium by 25% to 50%.

Knowledge Check

The client has ten grandchildren and wants to leave each of them a $50,000 death benefit from the same life insurance policy. If a grandchild predeceases the client, the client wants that grandchild's heirs to inherit the money.

How would this objective best be achieved?

Conditional Receipt

Note:
Failing to understand and follow the insurance company rules regarding the conditional receipt is a potential E & O exposure for the writing agent!

1. Issued by the agent after completing the application and receiving money

2. Coverage is in force as of the application date or medical exam date, if later

3. If death occurs during underwriting, the face amount is payable if the company would have accepted the risk

4. Amount paid under a conditional receipt is limited to the face amount, not to exceed a company maximum

5. Conditional receipt wording is non-standard and can vary greatly; it is critical that the agent understand the exact conditions and limitations of each insurance company for which they place business

Banner Life® Insurance Company

1701 Research Boulevard
Rockville, Maryland 20850-3191
(301) 279-4800

CONDITIONAL RECEIPT

NOTICE TO PROPOSED INSURED AND OWNER. No coverage will become effective prior to delivery of the policy applied for unless and until all the conditions of this receipt are met. No agent or broker has the authority to alter the terms or conditions of this receipt. This receipt shall be void if altered or modified.

No payment may be accepted with the application if, within the last 24 months, any person proposed for coverage has been treated for or diagnosed by a member of the medical profession as having: AIDS or any other immunological disorder; heart trouble; stroke; cancer; alcoholism; drug dependency; insulin dependent diabetes; or any blood pressure condition requiring medication.

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE POLICY:

1. An amount equal to the modal premium indicated on the application must be submitted; the mode must be either annual, semi-annual, quarterly or pre-authorized check plan (two months' premium required); and
2. All medical examinations, test, x-rays and electrocardiograms initially required by the Company's published rules with regard to age and amount requested must be completed within ninety (90) days from the date of this receipt; and
3. The proposed insureds are, on the Effective Date indicated below, risks acceptable for insurance exactly as applied for on a standard premium basis according to the Company's rules and practices, without modification of plan, premium rate or amount; and
4. On the Effective Date the state of health and all factors affecting the insurability of each person proposed for coverage must be as stated in applications required by the Company, and;
5. Any check or money order given in payment is honored when first presented.

EFFECTIVE DATE. If all the conditions above are met, then insurance, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the latest of: (a) the date of application; (b) the date of application - part II; (c) the date of completion of all underwriting requirements stated in (2) above; or (d) the special policy date requested in the application, if any.

MAXIMUM AMOUNT. The total amount of life insurance available under this receipt shall be the amount shown in Part 1, Question 25 of the application. This amount, together with any insurance now applied for or pending issue with the Company, including Accidental Death Benefits, shall not exceed $1,000,000 to issue age seventy (70).

There is no coverage beyond age seventy (70); there is no coverage for any Last Survivor product applied for.

RETURN OF MONEY. If any of the above conditions is not met, the liability of the Company will be limited to the return of the amount remitted with this receipt. All returns will be made without interest to or for the benefit of the owner.

AGREEMENT. I agree that: (1) the limited amount of insurance that may begin prior to policy delivery will not exceed the Maximum Amount as defined above; (2) this limited amount of insurance will not begin unless all of the CONDITIONS listed above are first met exactly; (3) this receipt will be void if the application or this receipt contains any material misrepresentation or the Proposed Insured dies by suicide; and (4) this receipt will be of no legal effect on and after the earliest of the following: (a) the date the entire amount remitted with this receipt is returned, or (b) the date a policy is delivered to the Owner; and I further agree to any remaining terms, limits, and conditions of the Conditional Receipt and the Agreement in the Application.

_____	____/____/____	_____
Signature of Proposed Insured	Date of this Receipt	Signature of Owner (if other than Proposed Insured)

BROKER STATEMENT.

Amount Remitted: $_____ Person from whom Received: _____

On the Date of this Receipt, I received the amount indicated above in exchange for this receipt. This receipt bears the same date as the Application - Part 1. I have accurately represented the terms and conditions of this receipt to the Proposed Insured and Owner. I know of no reason why any person to be covered may not be eligible for insurance.

_____
Signature of Broker

LU1271 (3/08)

Taxation of Premiums, Death Benefits, and Cash Value

Life insurance premiums are not tax deductible. An exception exists for the premiums paid by an employer for the benefit of employees in a group life policy.

Generally, death proceeds are not subject to federal income tax when received by the beneficiary. There are minor exceptions to this rule, and they typically only apply when a non-group policy is transferred to an employee/owner under the transfer-for-value rule.

<table>
<tr><th>PREMIUM</th><th>DEATH BENEFIT</th><th>CASH VALUE</th></tr>
<tr><td rowspan="2">Premiums paid for personal life insurance are NOT tax-deductible</td><td>The death benefit is NOT subject to federal income tax</td><td rowspan="2">Cash value grows income tax deferred First In, First Out (FIFO), and distributions are not subject to such tax until withdrawals exceed the basis</td></tr>
<tr><td>The death benefit can be arranged to avoid inclusion for federal estate tax (the insured must not be the owner)</td></tr>
</table>

The proceeds will be included in the owner's estate for federal estate tax purposes should the policy be owned by the insured. Certain credits do apply, and proper planning can minimize (or even eliminate) this estate tax problem. To properly eliminate the life insurance proceeds from the owner's estate, there must be no “incidents of ownership” by the insured. An in-force policy that is transferred to an irrevocable trust will still be included in the owner's estate if death occurs within three years of the transfer.

Cash values grow tax-deferred until received (First In, First Out — FIFO). When cash values are withdrawn, those that exceed the premium outlay are subject to ordinary income tax. Cash values paid in addition to a death benefit, such as Option B in universal life, are considered death benefits and are generally not subject to income tax.

Example of FIFO, as it relates to life insurance cash value:

Over the years John has paid premiums totaling $7,000 to his universal life policy. His policy has $8,000 in cash value. John needs to take all $8,000 due to an emergency and cancel (surrender) his policy.

The first $7,000 of his withdrawal is considered a tax-free return of premium (FIFO) and the balance will be taxed as ordinary income. Taxation of income earned that exceeds the paid premiums is deferred until actual distribution.

Had he taken a *loan* (as required in the case of a whole life policy), federal income tax would not be due in this tax year. It would be deferred to a later date, and if death occurred before it was due, then no tax would be imposed.

Note:
A loan would have to be less than the full $8,000 to keep the policy in force. Any full surrender with cash value greater than basis (premium paid) will create a taxable event.

Annuities

Learning Objective 5:
Use knowledge of **classifications, types, provisions, and payout options** of annuities to meet client needs.

What is an Annuity?

The term "annuity" derives from a Latin term meaning annual and generally refers to circumstances where principal and interest are liquidated through a series of regular payments made over a period of time.

Annuities can be used as a long-term savings plan, accumulating assets on a tax-deferred basis for retirement and then liquidated over a period of time. An annuity is a contract between a person (or trust) and an insurance company.

- Life Insurance provides financial protection against the risk of dying prematurely

- An annuity provides financial protection against the risk of living too long and being without income during retirement

For a History of Annuities,
visit riskeducation.org/LHResources

Two Main Objectives of an Annuity

To accumulate retirement assets on a tax-deferred basis
One of the key benefits of an annuity is that it allows the investor to save money without paying taxes on the interest until a later date. Unlike 401(k)s and IRAs, annuities have no contribution limits.

To convert retirement assets into a stream of income you cannot outlive
Another significant benefit of annuities is the creation of a predictable income stream to fund retirement. With an annuity, you don't have to worry about outliving your savings. This is a major advantage in the post-pension age.

Phases of an Annuity

Accumulation Phase (Savings)
Annuity premiums, less any applicable charges, accumulate in the contract on a tax-deferred basis until the annuity starting date (payout) (Premiums and Interest Growth)

Distribution Phase (Withdrawal Phase) (Payout Phase) (Income Phase)
The time the value of the annuity is converted into a stream of income (annuitized)

Parties to an Annuity

Insurance Company: The insurance company designs the product, determines and collects premiums, holds and invests the money, calculates returns, and ultimately pays the money out according to the contract terms. Financial strength and stability of the insurance company are important.

Policy Owner: The individual or entity that contributes the funds. They typically have the right to terminate the annuity, to gift it to someone else, to withdraw funds from it, and to change the annuitant or beneficiary.

Annuitant: The individual whose life (mortality) is used to determine the payments during the payout phase (may or may not be the same person as the owner).

Beneficiary: The individual or entity that receives any proceeds payable on the death of the annuitant.

Features of an Annuity

In its most general sense, an annuity contract is a legally binding, written agreement between you and the insurance company that issues the contract. This contract transfers your longevity risk—the risk of you outliving your savings—to the insurance company. In exchange, you pay premiums as outlined in the contract.

Tax Deferral on Investment Earnings

Many investments are taxed year by year, but the investment earnings in annuities–capital gains and investment income–aren't taxable until you withdraw money. This tax deferral is also true of 401(k)s and IRAs; however, unlike these products, there are no annual limits on the amount you can put into an annuity. Moreover, the minimum withdrawal requirements for annuities are much more liberal than those for 401(k)s and IRAs.

Protection from Creditors

If you own an immediate annuity (that is, you are receiving money from an insurance company), generally, the most that creditors can access is the payments as they're made since the money you gave the insurance company now belongs to the company. Some state statutes and court decisions also protect some or all the payments from those annuities. And your money in tax-favored retirement plans, such as IRAs and 401(k)s, are generally protected, whether invested in an annuity or not.

An Array of Investment Options, Including "Floors"

Many annuity companies offer a variety of investment options. You can invest in a fixed annuity, which would credit a specified interest rate, similar to a bank CD. If you buy a variable annuity, your money can be invested in stock or bond (or other) mutual funds. In recent years, annuity companies have created various types of "floors" that limit the extent of investment decline from an increasing reference point.

Tax-Free Transfer

In contrast to mutual funds and other investments made with after-tax money, variable annuities have no tax consequences if you change how your funds are invested. This can be particularly valuable if you are using a strategy called "rebalancing," which many financial advisors recommend. Under rebalancing, you shift your investments periodically to return them to the proportions that you determine represent the risk/return combination most appropriate for your situation.

Lifetime Income (Guaranteed)

A lifetime immediate annuity converts an investment into a stream of payments that lasts as long as you do. In concept, the payments come from three "pockets:" your investment, investment earnings, and money from a pool of people in your group who do not live as long as actuarial tables forecast. It's the pooling that's unique to annuities and enables annuity companies to guarantee you a lifetime income.

Benefits to Heirs

There is a common misconception about annuities that goes like this: if you start an immediate lifetime annuity and die soon after that, the insurance company keeps all of your investment in the annuity. That can happen, but it doesn't have to. To prevent it, buy a "guaranteed period" with the immediate annuity. A guaranteed period commits the insurance company to continue payments after you die to one or more beneficiaries you designate; the payments continue to the end of the stated guaranteed period–usually 10 or 20 years (measured from when you start receiving the annuity payments). Moreover, annuity benefits that pass to beneficiaries don't go through probate and aren't governed by your will.

Source: Insurance Information Institute, "Annuities Basics" – http://www.iii.org/article/annuities-basics

Annuity Classifications

Classifications are Based on Four Categories:

1. **Number of lives covered:**

   - Single life
   - More than one life (joint and survivor)

2. **Time benefits begin:**

   - Immediate – benefit begins immediately after purchase
   - Deferred – benefit deferred for a later date

3. **Premium payment method:**

   - Single premium – may be used with immediate and deferred
   - Installment payments – (fixed or flexible premiums) deferred annuities only

4. **Tax treatment:** Whether qualified or non-qualified, accumulations are on a tax-deferred basis.

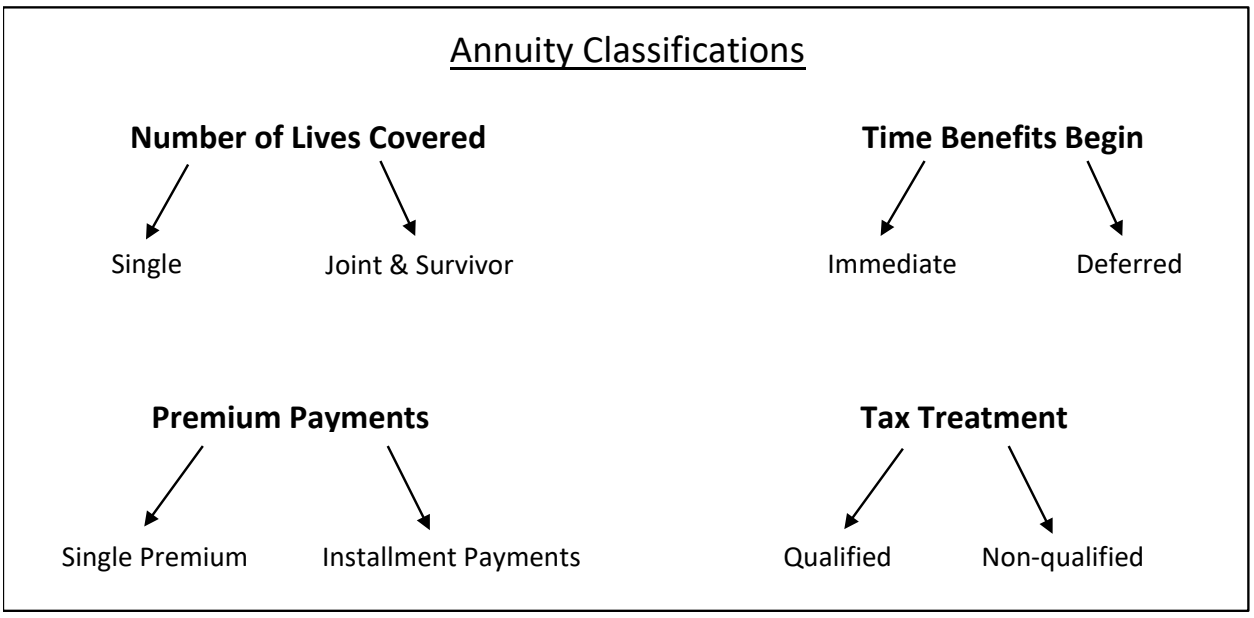
   - Non-qualified or after-tax annuities
     - Annuities purchased outside qualified pension plans do not receive tax-favored treatment of premium payments (non-deductible)
     - Non-qualified annuities can be purchased by any individual or entity, but premium payments are NOT tax-deductible

- Qualified or pre-tax annuities

  – Provisions of the IRS code pertaining to qualified retirement plans (401(k) plans, 403(b) tax-sheltered annuity plans, traditional IRAs, etc.) permit annuities used to accumulate money in such plans to receive tax-favored treatment of premium payments

    For additional information, go to https://www.irs.gov/retirement-plans/annuities-a-brief-description

  – Such premium payments (contributions) to the account are tax-deductible



Types of Annuities

Fixed Annuities

1. Accumulation Phase (deferred annuity)

   - Principal is guaranteed by the insurance company (subject to surrender charges)
   - Minimum guaranteed interest rate
   - Interest growth is tax-deferred
   - Death benefit

2. Distribution phase (deferred and immediate annuities)

   - Annuitization – payout options that provide guaranteed income for life or a specific period of time. With qualified annuities, the entire distribution is subject to ordinary income tax. For non-qualified annuities, part of each annuitization payment is a tax-free return of premium, and part is subject to ordinary income tax.
   - Partial income withdrawals – Unlike life insurance, where withdrawals from the cash value are initially viewed as a return of premium and not taxable, partial withdrawals from an annuity are first viewed as withdrawals of the gains. As such, withdrawals are initially fully taxable as ordinary income until the interest earned has fully been withdrawn (LIFO– last in first out). Then, the remaining partial withdrawals are viewed as a tax-free return of premium. A 10% penalty may apply if withdrawal is taken prior to age 59 1⁄2

3. Regulation

   - Fixed annuities sales are regulated by the state department of insurance
   - Salesperson must have a valid life insurance license to sell fixed annuities

Variable Annuities

1. Accumulation phase (deferred annuity)

   - Annuity owner assumes investment risks, including loss of principal
   - Growth potential through market participation
   - Annuity owner can choose from a broad array of variable investment options or subaccounts, very similar to mutual funds, plus guaranteed interest accounts
   - Optional income riders (GLWB–Guaranteed Lifetime Withdrawal Benefit)
   - Death benefit

2. Distribution phase (deferred and immediate annuity)

   - Annuitization – Variable annuity contract owners who choose to annuitize their contracts must decide at the time of annuitization whether to elect fixed annuitization or variable annuitization.
     – **Fixed Annuitization –** same as fixed annuities
     – **Variable Annuitization –** Variable annuity contract owners who choose to annuitize under a variable settlement option assume the risk that periodic payments may fluctuate up and down based on the performance of the separate account (i.e., investment risk). By choosing a variable life annuitization settlement option, contract owners hedge against the purchasing power risk since periodic payments could increase to keep pace with future inflation.
     – **Partial income withdrawals** – same as fixed annuities

3. Regulation

   - The sale of variable annuity products, which are classified as securities, is regulated by the state Department of Insurance AND the Securities and Exchange Commission (SEC) through the Financial Industry Regulatory Authority (FINRA)
   - The salesperson must have a valid life insurance license for the states where they do business, AND they must also have a registration with FINRA (Series 6 and 63 licenses)

Indexed Annuities

1. Accumulation Phase (deferred annuity and characteristics of the fixed annuity and the variable annuity)

   - The principal is guaranteed and protected against financial market declines (if the annuity is held through the surrender period)

   - The indexed interest rate credited is based upon a company-specific formula applied to changes in one or more linked indexes (S&P 500) subject to a maximum rate of interest; a minimum interest may be credited, but if the specified index has a negative return, the annuity is credited 0% for that crediting period. ZERO is HERO–*If the index goes up, you get it, but you don't lose anything if the index goes down. How can an insurance company do that? When it goes up, you don't get all of it!*

   - Indexed interest rate limiting factors

     The indexed interest rate to be credited, based upon a company-specific formula applied to changes in one or more linked indexes mentioned earlier, may also be subject to one or more of these limiting factors:

     – Participation rate – The participation rate is the percentage of the index interest rate that (subject to any other limitation) is credited to the funds in the fixed index annuity

     Example: Susan's fixed index annuity has a participation rate of 80%. If the interest rate determined under her index was 5%, her account would be credited with 4% (80% of 5% = 4%), assuming no other limiting factors apply.

     – Spread – A spread is a percentage that is deducted from the interest rate determined by the change in the equity index (and possibly modified by the participation rate) before being credited to the funds in a fixed index annuity

     – Cap rate – A third limiting factor is the cap rate. The **cap rate** is an upper limit on the interest rate applied to the funds in the annuity. It is the last limitation imposed after the annuity's participation rate has reduced the indexed interest rate, and any margin has further reduced it. For example, if the fixed index annuity has a cap rate of 6%, the credit applied to the policyholder's annuity will never exceed 6%.

- Optional income riders
- Death benefit

2. Distribution phase (deferred and immediate annuity)

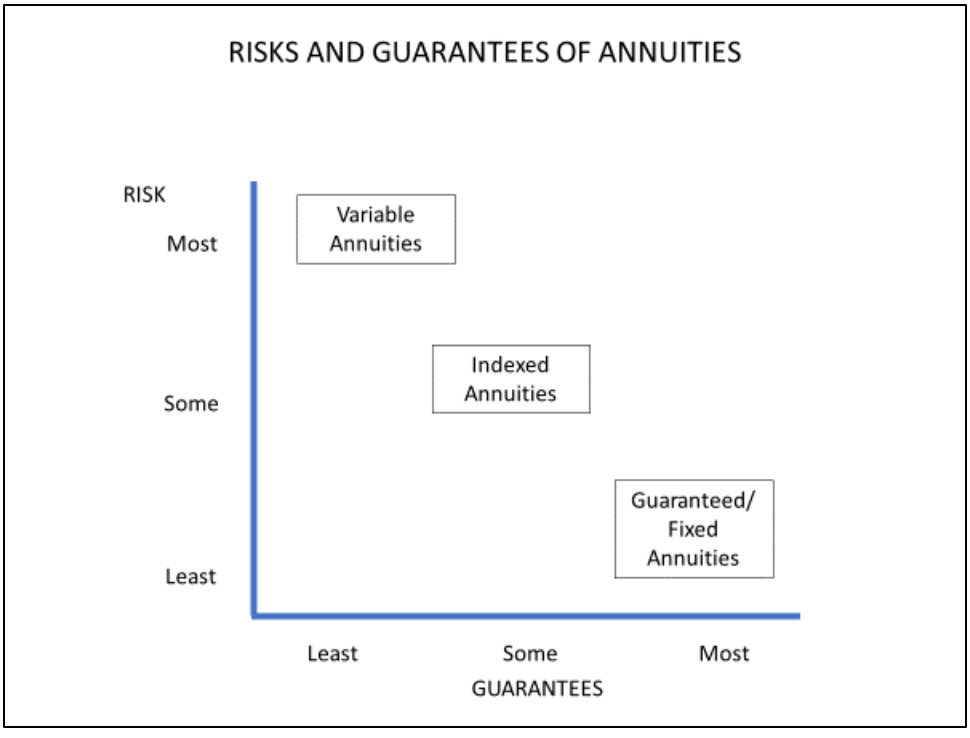
   - Annuitization – same as fixed annuities
   - Partial income withdrawals – same as fixed annuities

3. Regulation

   Because indexed annuities are structured as fixed annuity products (sometimes called fixed indexed annuities), sales are regulated by the state Department of Insurance; a salesperson must have a valid life insurance license to sell indexed annuities.

Annuity Comparisons			
	Fixed Annuities	Variable Annuities	Indexed Annuities
Minimum Guaranteed Return	YES[1]	NO[2]	YES[1]
Choice of Investment Options	NO	YES	NO
Opportunity to Earn A Higher Return	NO	YES	YES
Possibility of Losing Principal	NO[1]	YES	MAYBE[3]
Tax-Deferred Growth	YES	YES	YES
Minimum Death Benefit	YES[1]	YES[1]	YES[1]

1 Subject to the claims-paying ability of the issuing insurance company.
2 Unless 100% of premiums are placed in a guaranteed fixed interest subaccount.
3 It is possible to lose principal while a surrender charge is in effect.



Policy Provisions

Age Restrictions

1. Issue ages

   - This is more a function of the underwriting process than a policy provision, but most contracts will have maximum age limits over which a contract cannot be issued. Age 85 is typical, although a few companies will issue policies up to age 95.

   - Some contracts impose a lower maximum age for the annuitant than the owner, and some contracts only impose maximum age requirements on annuities that will be paid out over the annuitant's lifetime

2. Maximum age for benefits to begin

   This provision states that the annuitant must begin benefits before reaching the maximum age stated in the contract; *this is not the same as the requirements imposed by the IRS on qualified plans*

Surrender Charges (Deferred Sales Charges)

1. Charges are designed to make moving money out of the annuity less attractive to the owner. With fixed annuities and some indexed annuities, a surrender charge allows the entire premium to go to work in the annuity (no up-front sales charges).

2. Charges, expressed as a percentage, are usually applied to a surrender (full or partial) made within a certain number of years; many annuity contracts waive the charges in the event of death or disability; a*lso, many annuity contracts allow a free 10% of account value once a year*

YEAR	SURRENDER CHARGE
1	7%
2	6%
3	5%
4	4%
5	3%
6	2%
7	1%
8	0%

Note:
Various states have maximum percentages and durations regarding surrender charges. Surrender charge maximums can be set by states.

Surrender Charge Waivers Found in Some Annuities

Death Benefit Waiver

This waiver passes on your annuity to your beneficiary if you die before you annuitize; that is, you die before you begin to receive payments from your annuity, presumably at retirement. For example, Prudential's Discovery Select Variable Annuity will pay the greater of the following: the fund value as of the date proof of death is received; the total of all payments made into the annuity less withdrawals and related withdrawal charges; or the highest contract fund value, as calculated every third year on your contract anniversary date (adjusted for withdrawals you may have made). Your annuity contributions remain unchanged even if your subaccounts have lost value.

Terminal Illness Waiver

Your annuity might contain a provision that waives surrender charges if you become terminally ill, thus allowing you access to your money when you may need it most. While the definition of terminally ill may vary slightly from company to company, it's generally a condition that will result in your death within six months to a year. Security Benefit Life's Variflex annuity, for instance, defines a terminal illness as "an incurable condition that, with medical certainty, will result in death within one year." Prudential's Discovery Select Critical Care Access provides annuity income for either terminal illness or nursing home confinement. Prudential's waivers are triggered when you're diagnosed with a life expectancy of six months or less or after a three-month nursing home stay. As with the nursing home waiver, an insurance company will want certification from your doctor, and perhaps from their doctor as well, that your life expectancy is indeed only a matter of months.

Disability Waiver

The risk of disability is greater than the risk of death at all ages between 20 and 65. That said, it makes sense to protect yourself financially if you do become disabled, and that includes annuity considerations. Unfortunately, relatively few insurers offer a disability waiver. Allmerica Financial, however, does offer it on its Delaware Medallion III and purposefully leaves the definition of "disability" fluid. The company simply states that if you're unable to work and thus can't earn a living, and your doctor attests to this, Allmerica will allow you full access to your annuity without imposing surrender charges. This is unique, as many other companies impose a more stringent definition of disability.

Nursing Home Waiver

When you use a nursing home waiver, you won't be charged surrender fees, and you'll be allowed access to some or all of your annuity if you're confined to a nursing facility. While a 90-day confinement period before benefits kick in may be typical, Lincoln Benefit Life, for example, imposes a 180-day confinement period to a "licensed nursing facility." Your doctor will usually be asked to then submit an attending physician's statement, along with a completed claim form. The insurer will want to be certain of your incapacitation, and having their doctor examine you is not unusual.

Optional Riders: Living Benefit Riders (Available in some variable and indexed annuities)

1. **Guaranteed Lifetime Withdrawal Benefit (GLWB)**: This rider guarantees that regardless of stock market or index performance, the entire principal invested plus interest earned will be returned to you over your lifetime through withdrawals of a fixed percentage of the account even if the account value is depleted. (Sometimes called a Guaranteed Minimum Withdrawal Benefit rider (GMWB).

2. **Guaranteed Minimum Income Benefit (GMIB):** The GMIB is a variable annuity rider that guarantees a minimum value to the annuitant after the accumulation period or another set period, usually somewhere close to 10 years. The GMIB rider protects the value of the annuity from market fluctuations.

3. **Guaranteed Minimum Accumulation Benefit (GMAB):** Guarantees that after a specified period, typically 10 years, the value of the annuity will be equal to or greater than the guaranteed accumulation amount.

These living benefit riders are optional and require payment of an additional fee.

Accessing the Cash Value of an Annuity

Annuitization

- Straight life – Lifetime income payments are guaranteed until the annuitant's death. Maximum income for the lowest cost. No beneficiary.

- Life and refund certain – Lifetime income payments until the annuitant's death. If total income payments received by the annuitant are less than the account value of the annuity, the balance is paid to the annuitant's beneficiary either in a lump sum or in installments.

- Life and period certain – Lifetime income payments are guaranteed until the annuitant's death. If the annuitant dies prior to the end of the minimum period certain (10 or 20 years) payments continue to the beneficiary for the remainder of the guaranteed period.

- Joint and survivorship life – Lifetime income payments for two or more annuitants. Income payments continue until the death of the second annuitant.

- Joint and survivorship life with period and refund certain – Lifetime income payments guaranteed for two or more annuitants. Income payments continue until the death of the second annuitant. If total income payments received by the annuitants at death are less than the account value, the balance is paid to the annuitant's beneficiary either in a lump sum or installments.

- Joint and survivor life with period certain – Lifetime income payments guaranteed for two or more annuitants. Income payments continue until the death of the second annuitant. If annuitants die prior to the end of the minimum guaranteed period (10 or 20 years), payments continue to the annuitant's beneficiary for the remainder of the guaranteed period.

Simple Systematic Withdrawals

- Set amount – The annuity owner can sometimes elect to withdraw a set amount each month or year without any contract fee or surrender charges being applied.

- Living benefits – This type of benefit allows you to receive a percentage, usually 4% to 6%, of your original investment for as long as you live. These benefits also allow your income to increase if you experience positive investment performance. These benefits are usually age-based, so you may be able to take out a greater percentage of your original investment if you are older.

- These benefits are pretty straightforward. As long as you live, we will pay you. So, if you invest $100,000 and your age-based withdrawal rate is 5%, you will be able to take out $5,000 per year for the rest of your life. There are many variations on this type of benefit, and every company has a different name for it. Remember, this is an income benefit, not a lump sum benefit. The benefit is available on indexed and variable annuities, and there is a charge for the benefit.

Lump Sum Cash Out

Income Tax Aspects

Premium Payments

- Premiums paid into a non-qualified annuity are generally not deductible
- Premiums paid into qualified annuities, such as Tax-Sheltered Annuities (TSAs) and IRAs or Keogh plans funded by annuities, are deductible subject to IRS rules

Accumulations

For non-qualified annuities, the interest credited to an annuity each year is generally not taxable at the time the interest is credited. Income tax WOULD, however, be due at the time annuity benefits are received, but tax would only be assessed on the interest portion of the benefit. (See withdrawal discussion later.)

Loans

Amounts received as loans or as value of part of an annuity contract pledged or assigned to cover a loan are taxable. Amounts assigned from the annuitant to another individual are still taxable as income to the original annuitant.

Ten Percent Premature Distribution Penalty Tax

- Tax is imposed to discourage the use of annuity contracts as short-term tax-sheltered investments
- The 10% tax applies to the portion of any payment that is taxable
- The tax is imposed on taxpayers under age 59 ½ who receive distributions from annuities; see the "Exceptions to the Early Distribution Penalty Rule Imposed by the IRS" table.

Exceptions to the Early Distribution Penalty Rule Imposed by the IRS

- Distributions made as a result of the death of the annuity owner
- Distributions made as a result of the disability of the taxpayer
- Distributions made under an immediate annuity
- Distributions from a qualified retirement plan (IRAs, TSAs, etc.), but it should be noted that these plans are subject to a 10% penalty
- Distributions made under a qualified funding asset (structured annuity purchased to pay for damages as a result of a liability from a physical injury or illness)
- Distributions made under an annuity purchased and held by an employer upon the termination of a qualified retirement plan
- Distributions which are part of a series of substantially equal periodic payments, made not less frequently than annually, for the life or life expectancy of the taxpayer or the joint lives or joint life expectancies of taxpayer and his/her designated beneficiary

Withdrawals

Withdrawals are received as interest out first. Therefore, payments (until all interest is paid out) are subject to income taxation as ordinary income in the year in which payments are received. In addition:

- For persons under age 59½, there is also a tax penalty of 10% of the taxable amount received
- For persons over age 59½, the tax penalty does not apply

Taxation of Annuity Benefit Payments

- For a non-qualified annuity, payments are considered to be part principal (cost basis) and part interest (the interest portion of each payment is considered to be taxable as income in the year in which it is received); calculation is done by the insurance company and is called the "exclusion ratio."
- For a qualified annuity, the entire payment is taxable as income in the year it is received since a qualified contract has had the benefit of a tax deduction

Knowledge Check

Your best friend, Lucky Luciano, has just hit it big at the casino, winning $100,000 cash on a slot machine! He decides to invest the entire amount in an annuity with you to supplement his personal retirement when he plans to retire 20 years from now.

1. List the four annuity classifications that Lucky must consider when purchasing an annuity.

2. Lucky also asks you about payout options when he does retire 20 years from now. Describe for him the difference in payout benefits between a straight life and the 10-year period certain option.

Review of Learning Objectives

1. Use knowledge of life insurance contracts' **general uses** and **legal elements** to counsel clients and prospects.

2. Determine the **appropriate type and amount of life insurance coverage** to help a client or prospect develop a financial plan.

3. Apply knowledge of the **components** of **Term Insurance, Universal Life Insurance, and Whole Life Insurance** policies to advise clients and prospects on selecting the life insurance products that best meet their needs.

4. Apply the components involved in the **Standard Provisions of a Life Insurance Contract** and an understanding of taxation of premiums, death benefits, and cash value to meet client needs.

5. Use knowledge of **classifications, types, provisions, and payout options** of annuities to meet client needs.

Knowledge Check – ANSWERS

You are sitting with a prospect who has no idea about his social security benefits or his employee benefit amounts. He is concerned with family debt in the event of premature death or disability. He is limited in how much time he can spend with you.

Which planning method would be most appropriate given the information above?

Answer:

Multiple of earnings method

Why?

Answers will vary; here is a sample opinion:

As a courtesy to the prospect and his limited time, the multiple of earnings methods will at least determine how much lost income the family would suffer without him. And if the calculated sum to be insured is five times the annual income, the family can have an income stream for a time to pay bills that would be paid if the prospect had lived longer.

Knowledge Check – ANSWERS

Your clients would like to have a permanent insurance program but are concerned about additional expenses the family will incur while their children are in college in the next ten years.

Explain how the flexibility of universal life would allow for coverage to remain while premiums could be adjusted during years with higher family expenses.

Answer:

Overfunding the policy early (as much as possible) will allow excess cash value to be utilized later, keeping the policy in force during years of higher family expenses. After that period of time, the family can return to increased premiums and return the coverage to replicate WL permanent insurance.

Knowledge Check – ANSWERS

The client has ten grandchildren and wants to leave each of them a $50,000.00 death benefit from the same life insurance policy. If a grandchild predeceases the client, the client wants that grandchild's heirs to inherit the money.

How would this objective best be achieved?

Answer:

Purchase a $500,000 life policy (preferably permanent), name the ten grandchildren beneficiaries for 10% each, and request the beneficiary designation be listed as "per stirpes." That will allow proceeds to go to a beneficiary's heirs if they predecease the insured.

Knowledge Check – ANSWERS

Your best friend, Lucky Luciano, has just hit it big at the casino, winning $100,000 cash on a slot machine! He decides to invest the entire amount in an annuity with you to supplement his personal retirement when he plans to retire 20 years from now.

1. Describe the four annuity component classifications that would make up the annuity you would sell to Lucky.

   Answers:

   Number of lives covered

   Premium payment

   The time when benefits begin

   Tax treatment

2. Lucky also asks you about payout options when he does retire 20 years from now. Describe for him the difference in payout benefits between a straight life and the 10-year period certain option.

   Answer:

   A straight life annuity pays a monthly sum but only until the annuitant dies.

   A ten-year certain annuity also pays a monthly sum until the annuitant dies.

   AND

   It guarantees that at least 10 years of payments will be made. If the annuitant dies before 10 years are paid, the designated beneficiary will receive the balance of the 10 years of payments.

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Section 2

BUSINESS LIFE CONCEPTS

Resources

Available at:
riskeducation.org/LHresources

Glossary

Sample Buy-Sell Agreement

IRS Form 8925 Report of Employer-Owned Life Insurance Contracts

Business Life Concepts

Section Goal

The Business Life Concepts section provides participants with the core knowledge and tools necessary to deliver transformative information and counsel to their clients regarding business life concepts.

Learning Objectives

1. Explain the steps an agent should take when placing Employer-Owned Life Insurance (EOLI) on an employee.

2. Evaluate the features of a key person's life insurance policy in relation to client needs.

3. Explain how an employer can use a Section 162 Executive Bonus Plan as a means of providing an employee benefit.

4. Describe the important elements of a business succession plan, including the issues created by the death of a partner or shareholder, methods of funding buy-sell agreements, and the structures of insurance policy ownership.

Business Life Insurance

Learning Objective 1:
Explain the steps an agent should take when placing Employer-Owned Life Insurance (EOLI) on an employee.

Employer-Owned Life Insurance

The concept known as Employer-Owned Life Insurance (EOLI) came under close federal scrutiny in the early to mid-2000s. The revised law is the IRC 101(j)(4). This Internal Revenue Code section may affect any EOLI, including key person and buy-sell funded contracts. You should be aware of the following:

Effective date: Generally, the law applies to contracts issued on August 18, 2006, or later. These rules also apply to policies issued before that date ("grandfathered policies") that undergo material increases in the death benefit or other material changes.

Penalty: The death benefit will be subject to ordinary income tax.

Exemptions: It is essential that life insurance agents NOT render specific tax or legal advice in these cases and strongly urge their clients to seek competent guidance. Contracts that an employee/owner pays for and is the beneficiary for the life of another employee/owner (such as a cross-purchase buy-sell) might be exempt.

IRS form:

Form **8925**
(Rev. September 2017)
Department of the Treasury
Internal Revenue Service (99)

Report of Employer-Owned Life Insurance Contracts

► Attach to the policyholder's tax return. See instructions.
► Go to *www.irs.gov/Form8925* for the latest information.

OMB No. 1545-2089

Attachment Sequence No. **160**

Name(s) shown on return		**Identifying number**	
Name of policyholder, if different from above		Identifying number, if different from above	
Type of business			
1	Enter the number of employees the policyholder had at the end of the tax year	**1**	
2	Enter the number of employees included on line 1 who were insured at the end of the tax year under the policyholder's employer-owned life insurance contract(s) issued after August 17, 2006. See *Section 1035 exchanges* on page 2 for an exception	**2**	
3	Enter the total amount of employer-owned life insurance in force at the end of the tax year for employees who were insured under the contract(s) specified on line 2	**3**	
4a	Does the policyholder have a valid consent for each employee included on line 2? See instructions . . . . . ☐ **Yes** ☐ **No**		
b	If "No," enter the number of employees included on line 2 for whom the policyholder does not have a valid consent	**4b**	

Specified EOLI Exceptions

In general, if the "Notice and Consent" requirements of the law are satisfied, policy death proceeds may be received income tax-free (subject to existing transfer for value and alternative minimum tax rules) if any of the following exceptions are met:

Recent Employees Exception: If the insured is no longer employed but was an employee during the 12-month period before death, the death proceeds will keep their income tax-free status.

Directors and Highly-Compensated Employees Exception:

If, at the time the policy was issued, the insured was:

1. A director

2. A highly compensated employee, as defined by the IRS:

   - They owned more than 5% of the interest in the business at any time during the year or preceding year, regardless of how much compensation that person earned or received

     OR

   - For the 2024 plan year, an employee earning over $150,000 in 2023 is considered highly compensated.

3. A highly-compensated individual under the rules for self-insured medical reimbursement plans, looking at the highest paid 35% of employees (i.e., generally one of the five highest-paid officers; among the highest paid 35% of employees; or more than 10% owner by value of employer stock)

Death Benefits Paid to Heirs Exception:

Benefits are payable to the extent that death proceeds paid in the taxable year are received:

1. By a family member of the insured

2. By an individual who is the designated beneficiary of the insured (other than the employer)

3. By a trust established for the benefit of any such family member or designated beneficiary

4. By the estate of the insured

Buy-Sell Exception: This exception applies to the extent that death proceeds are used in the taxable year they are received to purchase an equity (or partnership capital or profits interest) in the business from a family member, beneficiary, trust, or estate.

Notice and Consent Form

Requirements

The following requirements must be satisfied **before** the policy is issued or **before** there is a material increase or other material change to a grandfathered policy:

1. The employee must be notified in writing that the employer intends to insure the employee's life.

2. The employee must be notified in writing of the maximum face amount for which the employee will be insured at the time the policy is issued.

3. The employee must provide written consent to being insured under the policy and that such coverage may continue after the insured terminates employment.

4. The employee must be informed in writing that the employer will be a beneficiary of any insurance proceeds payable on the death of the employee.

Agent Responsibilities

What should the agent do?

The employee and employer must sign a "Notice and Consent" form. If received, **AND** certain specified exemptions are met, the death benefit of a life insurance policy, owned and payable to an employer on an employee's life, will generally remain income tax-free. *If these rules are not satisfied, the death benefit will generally be taxable.*

Knowledge Check

While visiting a commercial account during an annual review of their business insurance, your client asks if it is possible for the business to have a life insurance policy written on their sales director.

What concerns would you address with your client regarding the business's life insurance on the employee?

Key Person Life Insurance

Learning Objective 2:
Evaluate the features of a key person life insurance policy in relation to client needs.

Definition of Key Person: One whose death or disability prior to retirement will have an adverse economic effect on the business, evidenced by a loss of profits or credit standing and the extra expense of hiring a capable replacement

Characteristics of a key person: In most businesses, this is the OWNER!

- Size of salary
- Decision-making powers
- Ability to get things done
- Source of capital to the business
- Possesses unique talent

Rationale for Purchasing Key Person Insurance

The key person is integral to the success of the organization. Replacing such a unique talent is costly and time-consuming.

Employer Insurable Interest established: In the case of *Emeloid Co., Inc. v. Commissioner of Internal Revenue,* U.S. Court of Appeals, 3rd Circuit (1951), the judge stated: "What corporate purpose could be more essential than key man insurance? The business that insures its buildings, machinery, and automobiles from every possible hazard can hardly be expected to exercise less care in protecting itself against the loss of two of its most vital assets—***managerial skill and experience***."

Benefits of Key Person Insurance While an Employee Is Alive:

- It bolsters the credit of the business.
- It accumulates cash value (available for borrowing).
- It makes a good investment for surplus funds.
- It improves morale.

Benefits of Key Person Life Insurance at the Death of the Employee:

- It indemnifies the employer for shrinking revenues and business value due to the loss of the key person's services and abilities.
- It provides funds to attract and pay for a capable succession.
- It provides cash value (if it is a permanent type policy) that can be used to fund **deferred compensation.**
  - Deferred compensation allows selected individuals to defer the receipt of income in accordance with a written agreement with their employer.
- It provides cash value or death benefits that can be used to hire a replacement.

Methods for Determining Key Person Life Insurance Amount

The following may be used alone or in combination:

- **Earnings approach** – Determine what portion of the net business profits is attributable to each key person, then multiply this figure by the number of years needed to find and train a replacement.

- **Replacement cost approach** – Determine the key person's *excess salary* (calculated as the difference between the key person's salary and the salary that would be paid to someone performing the routine duties of the key person), then multiply this figure by the number of years needed to find and train a replacement.

- **Present value method** – Determine the present value of each key person (retirement age minus current age multiplied by profit per year), then discount this figure by a reasonable interest rate.

- **"Seat-of-the-pants" approach** – Nothing scientific here; the owner simply picks a figure, such as, "You are worth $250,000."

Steps in Implementing a Key Person Insurance Plan

1. A written agreement or board resolution is created.

2. The business applies for insurance on the key person.

3. The business pays the premium (not the deductible).

4. The business owns the policy.

5. The business is the beneficiary (death benefit is not subject to income tax).

6. The business retains all ownership rights.

Non-Qualified Bonus Plan – Section 162 Executive Bonus Plan

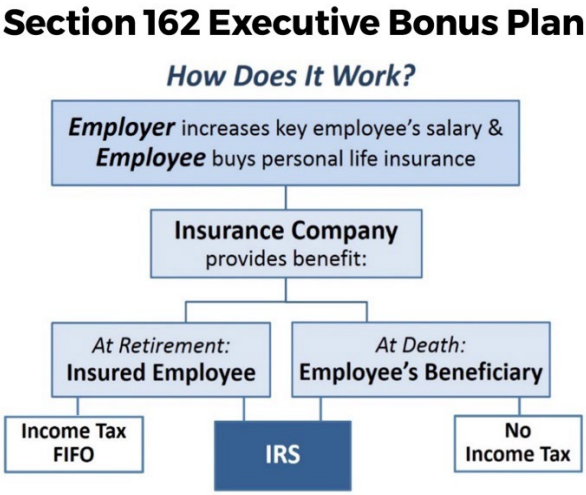
Learning Objective 3:

Explain how an employer can use a Section 162 Executive Bonus Plan as a means of providing an employee benefit.

Definition of Section 162 Executive Bonus Plan: A non-qualified plan under which the key executive owns a permanent life insurance policy on their life. The employer pays the life insurance premium either directly or indirectly to the insurance company by means of a bonus paid to the executive.

The additional income used to pay the premium is deductible by the employer and reported by the executive as compensation. (The IRS may apply a "reasonable compensation for services rendered" test to the total bonus paid to the executive.)

Often, the employer will "gross up" the income to cover the extra taxes associated with the increased income. This is referred to as a "double bonus."



Disadvantage to the Employer: Should the employee leave the company's employment, the paid premiums (actually classified as paid compensation) cannot be recovered by the employer from the employee, nor can the employer recover the life insurance policy. See "restrictive bonus plan" on the next page.

Features and Advantages to the Employer:

- The employer has a key executive (can be themselves).
- Should the executive be a non-owner, the issue of "golden handcuffs" may be a key concern.
- The employer wants a simple, easy-to-understand plan.
- The employer would like to discriminate (offer the plan to whom they wish).
- The employer likes the idea that it is tax-deductible.
- It is simple to understand and implement—no IRS approval is needed.
- Discrimination is allowed; there is no minimum nor maximum number of covered lives.
- The employer determines the amount of the contribution.
- The plan gives the employer some measure of control and helps them provide an incentive for long-term employment.
- Restrictive bonus arrangements (REBA) can be implemented to place a degree of control on the employee's access to loans, cash values, etc.
- Minimal paperwork is required.

Advantages to the Executive/Employee

- It is simple to understand and implement.

- It provides flexibility in the choice of life insurance plans (Whole Life, Universal Life, Variable Life).

- The employee is the owner of the contract and has complete control, including naming and amending the beneficiary.

- Should the plan be arranged as a "restrictive bonus arrangement (REBA)," certain restrictions will be placed on the owner/employee, such as the right to make loans or assignments and access to cash values.

- It is a very inexpensive way to buy or own life insurance as the employer is paying for it; should a double bonus arrangement be used, there is no cost to the employee.

- The death benefit is received income tax-free by the beneficiary.

- Future cash values are received FIFO (first in, first out) for income tax purposes.

- The policy cash values can be a source of retirement income for the executive.

Hypothetical Life Insurance Contract for Use in an Section 162 Executive Bonus Plan

Key Executive: Doug Brady, Vice President of Sales
Age at Issue: 40
Employer: ABC, Inc.

Base Policy Face Amount = $507,912 (amount stated in the policy that is payable at the death of the named insured or at policy maturity)
Annual Premium = $10,000

Participating Whole Life Insurance – Life Paid-Up at 65
Dividends Used to Purchase Paid-Up Additions

Double Bonus Example

Tax Bracket: 24%

Bonus would be $13,158

Pays premium and the taxes on the bonus

Age	Total Employer Bonus (Premium)	Annual Dividend End of Year	Death Benefit Payable to Beneficiary	Total Cash Value End of Year (Non-Guaranteed)
40	$10,000/yr.	$498	$509,831	$498
45	$10,000/yr.	$581	$517,591	$32,633
50	$10,000/yr.	$2,318	$542,007	$93,800
55	$10,000/yr.	$5,410	$594,457	$173,764
60	$10,000/yr.	$10,208	$685,822	$287,371
65	Paid Up @ 65	$15,011	$810,585	$442,101

The illustration shown is from a major US life insurance company and is for an LP65, which is a whole life contract that is "paid-up" at age 65. **No additional premium is due.**

Dividends are not guaranteed and are subject to significant fluctuations over the lifetime of a policy. Non-guaranteed cash value numbers assume use of a 2019 dividend scale to purchase Paid-Up Additions (PUAs).

Note that beyond age 65, dividends continue to grow each year at a rate of approximately $1,000 per year, creating more cash value and death benefit through PUAs (e.g., at age 70, the annual dividend is $18,928). At any point, the insured/owner can choose to leave dividends, buy PUAs, or begin to take the dividends in cash, perhaps as a retirement supplement.

Knowledge Check

Explain how an employer can use a Section 162 Executive Bonus Plan as a means of providing an employee benefit.

You have a commercial client who owns a C-corporation and is considering purchasing additional personal life insurance. Your client has asked if it is possible for them to deduct their personal life insurance premiums as a company business expense.

What counsel would you provide?

Business Continuation

Learning Objective 4:

Describe the important elements of a business succession plan, including the issues created by the death of a partner or shareholder, methods of funding buy-sell agreements, and the structures of insurance policy ownership.

Issues Created by the Death of a Business Owner

Sole Proprietor

1. Loss of value or goodwill

   - Liquidating or selling the business – At a sole proprietor's death, the goodwill value will likely be lost. Because a successful business consists of more than its physical assets, this loss diminishes its value.

   - A major asset of any business is the favorable reputation the company has built over the years—the willingness of customers to continue doing business with the firm. The death of the proprietor could jeopardize that goodwill.

   - Another reason the real value may not be fully realized has to do with the price a buyer would be willing to pay for the physical assets. Prices at liquidation sales are often much lower. The buyers know the executor must sell the assets quickly and is usually not in a position to demand the full market value that the asset might command in an ongoing business situation.

2. The executor operates the business temporarily.
   (Be aware: the executor may be held liable for any losses.)

3. Business interest could be transferred to others via a will.

4. Business interest could be sold to employees as an ongoing business. (*But at what price?*)

5. Creditors will be concerned.

General Partner

1. **Dissolution or continuation**

   - In the absence of a continuation of agreement, the death of a general partner, by operation of state law, usually dissolves the partnership of which the deceased was a member.

   - If a continuation agreement is in effect, the partnership can be reorganized; survivors could accept the decedent's heirs into the business.

     – Other options would be for the decedent's heirs to sell their interest to an outsider; for survivors to accept the outsider into business; or for survivors to buy out the heir's interest.

2. **Dissolution and winding up**

   Because the partnership creates an agreement in which the partners are bound together, share profits, and have a voice in management, the death of a partner dissolves the partnership. This does not necessarily mean the termination of the business. The partnership must continue until the partnership's affairs have been wound up and completed.

3. **Changes to roles and responsibilities of surviving partners**

   Surviving partners become the **liquidating trustees** and must, without delay, perform such functions as completing partnership transactions entered into before the partner's death, collecting accounts receivable, paying partnership debts, converting the remaining assets to cash, and paying the deceased's share of the partnership funds to the heirs.

Limited Partner

- Death does not dissolve a partnership.

- Termination follows the same steps as in a general partnership.

Shareholder

1. Death of a majority shareholder – When a majority shareholder dies, the surviving shareholders and the heirs of the deceased shareholder are faced with several possibilities:

   - The surviving shareholders could continue the business with the heirs; in a corporation, unlike a partnership, the owners may be forced to accept persons they do not want as co-owners.

   - The surviving shareholders could buy out the heirs or vice versa; the purchasing party must have the cash to make the purchase.

   - The heirs or the surviving shareholders could sell their stock to outsiders. However, there is often no market among outsiders for close corporation stock, especially when it is a minority interest.

2. Death of a minority shareholder – The deceased minority shareholder's immediate family will often find that their income from the corporation has stopped if that income was in the form of the deceased officer's salary. The heirs' minority interest will not be enough to guarantee that another family member will become an officer or employee of the corporation, nor is the minority interest large enough to force dividend payments.

   From the surviving shareholders' point of view, there may be no reason to pay dividends or give a job in the corporation to someone unfamiliar with the business.

   Because of the minority shareholder's right to inspect the books and vote for the shares, the family could still cause inconvenience for the surviving shareholders. If the heirs sell their shares to an outsider—especially a competitor—the outsider might harass the controlling shareholders from within the corporation.

   The most practical solution is, of course, for the heirs to sell their interest to surviving shareholders, provided the survivors have the cash to make the purchase.

LLC Member

- The operating agreement determines whether the LLC is continued or dissolved.

- The operating agreement typically determines a member's ability to transfer their membership.

- If the agreement doesn't address the death of a member, the consequences may be governed by the remaining members' decisions and state laws; most state laws will default to the dissolution of the LLC.

Knowledge Check

Ralph owns a very successful fast-food franchise and has recently taken on a partner in the business. Ralph is 55 and a widower with two grown sons. His new partner who bought into the business is Jason, age 35, and married with three young children. Jason's wife is an attorney currently serving as counsel for a group of local physicians.

Use knowledge of the various issues created by the death or disability of a partner/shareholder to help develop a process of business succession. Consider the issues you would discuss with Ralph and Jason.

What is your recommendation?

Buy-Sell Agreement

Definition of a Buy-Sell Agreement: a legally binding agreement used to reallocate a share of a business in the event an owner dies or leaves the business

Role of the Insurance Agent in a Buy-Sell Agreement:

- To understand the basics of the buy-sell agreement
- To know how life insurance fits in
- To encourage the client's collaboration with competent legal and accounting advisors
- To collaborate with the succession planning team

A valid buy-sell agreement should consider an appropriate course of action for the following risk contingencies:

- Death
- Disability
- Retirement
- Termination of employment
- Valuation method
- First right of refusal to purchase business
- Possible terms of finance

Valuation of a Business

- **IRS guidelines:** While it is possible to follow IRS guidelines in making the valuation, it is impossible to say for certain that the IRS will be in 100% agreement when the estate is settled. That is why the valuation itself should be left to the specialists in the field (IRS Revenue Ruling 59-60).

- Eight factors for the valuation of the business:

    1. History and nature
    2. National economy and specific industry
    3. Financial condition
    4. Earning capacity
    5. Dividend-paying capacity
    6. Goodwill
    7. Previous sale of stock
    8. The fair market value of publicly traded stock in a comparable business

Funding the Buy-Sell Agreement

Personal Funds: Most successful business owners do not have large sums of liquid assets. They normally have their money "working" in the business.

Sinking Fund: A method of depositing funds on a regular basis so as to accumulate the amount necessary to fund the buy-sell.

- Such a fund will be inadequate if the death is premature; also, the time of need is uncertain, and any such investments would be subject to tax on their growth and also subject to the claims of creditors.

- This may be the only option for an uninsurable situation.

Borrowed Funds

- The loss of a key person may impair credit, and interest costs may be excessive.

Installment Payments to Heirs

- The business may fail, which is a risk for the noteholder.

- The principal and interest are burdensome and a risk to the business.

Life Insurance

1. Complete financing is guaranteed from the beginning.

2. Proceeds are income tax-free.

3. Cash values can be used for a buyout due to retirement or disability.

4. It is the most economical method because it uses discounted dollars; also, the cost is a known quantity and can be budgeted each month/year.

5. Credit is strengthened.

6. Everyone benefits from an INSURED buy-sell

   - Before the death of an owner

     – Peace of mind and family security

     – The business can use cash values for emergencies, expansion, or any other business need.

     – Creditors, suppliers, customers, and employees are assured that the business owner's death will not disrupt day-to-day business operations.

   - After the owner's death

     – All surviving business principals are given the opportunity and CASH to purchase the deceased principal's interest at a fair price.

     – The deceased owner's heirs are virtually guaranteed to have a "market" for their newly inherited business interest.

     – The deceased owner's estate is now liquid; this is most useful if there is an estate tax problem.

Options to Structure Ownership of Life Insurance in a Buy-Sell Agreement

Sole Proprietor: An agreement with a key employee or friendly competitor is entered into. If no such person exists, a policy should be sold to the proprietor for the value of the business. Heirs may be able to use funds to hire someone to run the business.

Partnership

- **Cross-purchase plan:** Each partner purchases (owns, pays, and is a beneficiary of) a life policy on the other partner(s).

- **Entity purchase plan:** The partnership (the entity) purchases (owns, pays, and is a beneficiary of) a separate life policy for each partner.

Corporation

- **Cross-purchase plan**: Each stockholder purchases life insurance on the other stockholders.

- **Stock-redemption plan**: The corporation purchases life insurance for all stockholders.

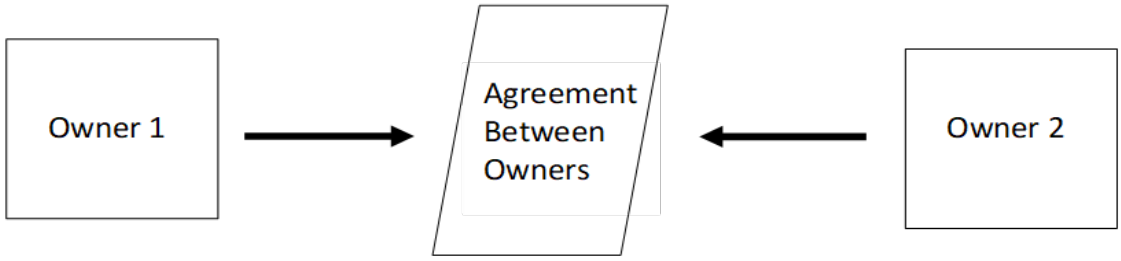
LLC – Cross-Purchase Plan (life insurance policies on all members)

Cross-Purchase – Partnership

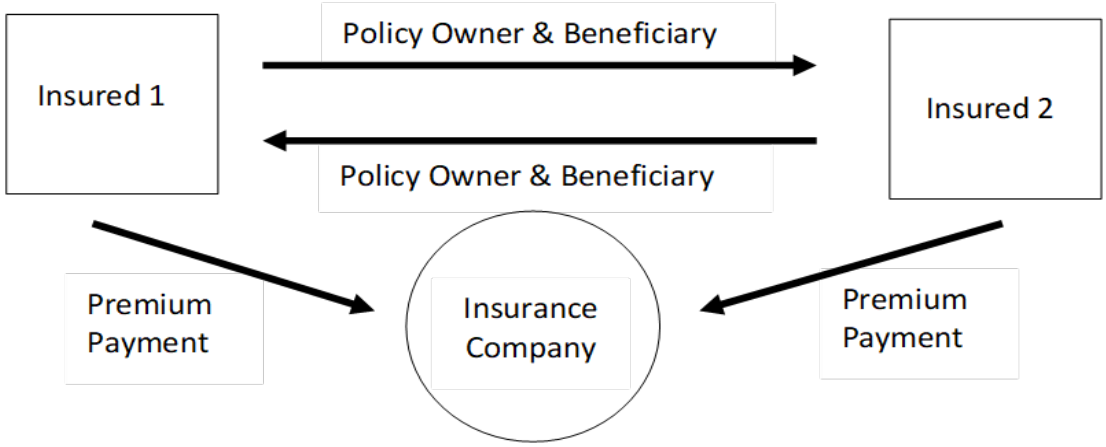
Stock Purchase – Corporation

(Same process for both entities)

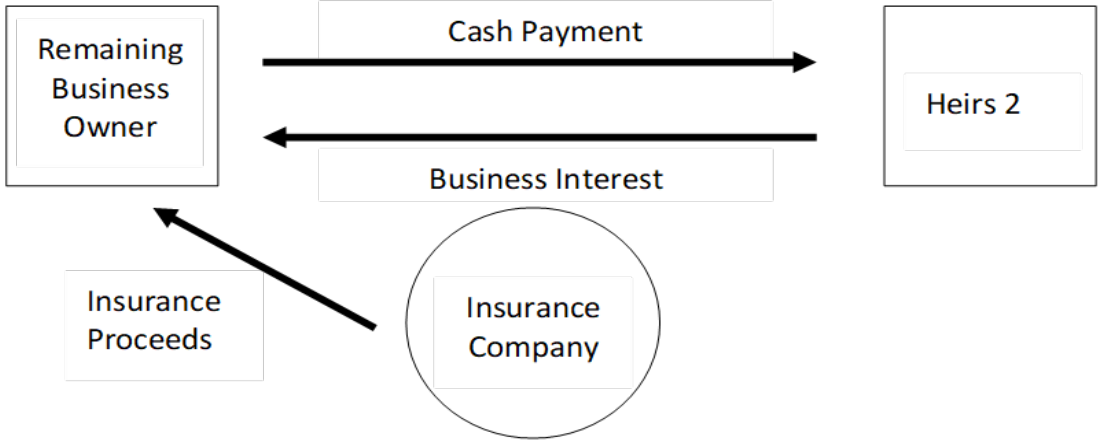
Agreement Structure



Insurance Structure

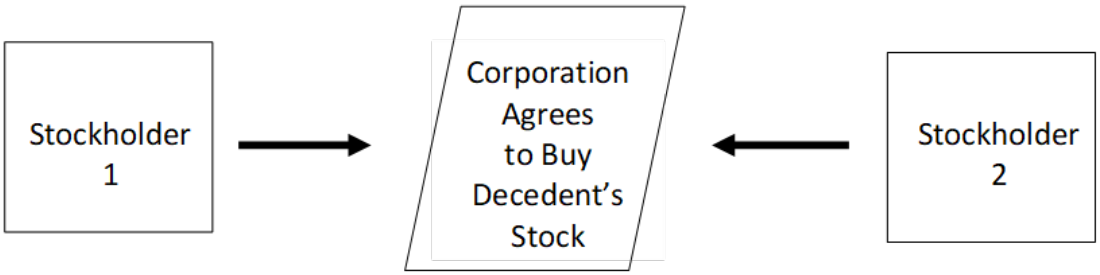


Execution or Outcome

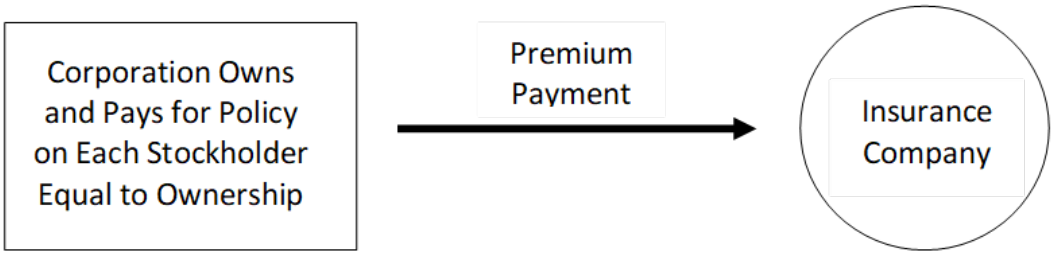


Entity Purchase – Partnership
Stock-Redemption – Corporation
(Same process for both entities)

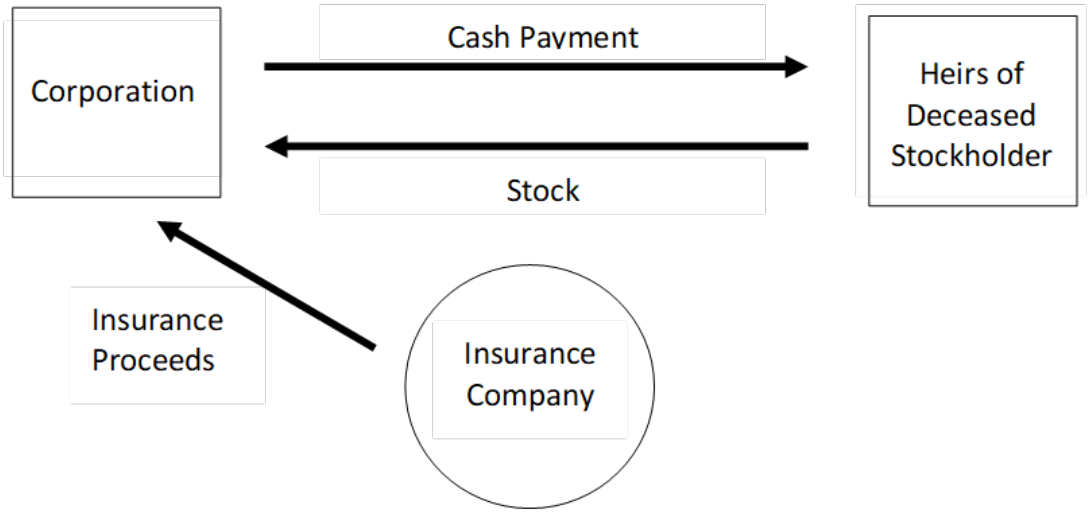
Agreement Structure



Insurance Structure



Execution or Outcome



Knowledge Check

Use your knowledge of buy-sell agreements, their funding methods, and the structure of life insurance/disability policy ownership to provide advice and counsel as a member of the client's succession planning team.

Your client has informed you that five years ago, her company had a buy-sell agreement drafted, and the consensus was that they did not need to purchase life insurance because their banker would loan them the money to fund the agreement.

Their banker just left the bank under suspicion of embezzlement, and the shareholders are now concerned that they will not be able to get a loan.

How would you advise the client on available funding options and the advantages of each?

Review of Learning Objectives

1. Explain the steps an agent should take when placing Employer-Owned Life Insurance (EOLI) on an employee.

2. Evaluate the features of a key person's life insurance policy in relation to client needs.

3. Explain how an employer can use a Section 162 Executive Bonus Plan as a means of providing an employee benefit.

4. Describe the important elements of a business succession plan, including the issues created by the death of a partner or shareholder, methods of funding buy-sell agreements, and the structures of insurance policy ownership.

Knowledge Check – ANSWERS

While visiting a commercial account during an annual review of their business insurance, your client asks if it is possible for the business to have a life insurance policy written on their sales director.

What concerns would you address with your client regarding the business's life insurance on an employee?

Answer:

Establish that the sales director is in fact a major contributor to the success of the company. If so, discuss what impact their untimely death would have on the business, and possibly continue the discussion by offering one of the four methods of establishing a key person's value. Describe to the owner the issues involved with EOLI and suggest a course of action with an application for life insurance to determine if an employee is insurable.

Knowledge Check – ANSWERS

Explain how an employer can use an Section 162 Executive Bonus as a means of providing an employee benefit.

Answer:

A Section 162 Executive Bonus provides employer-paid life insurance, tax-free benefits to the heirs in the event of untimely death, and cash value accumulation for the insured employee (aka "golden handcuffs").

You have a commercial client who owns a C-corporation and is considering purchasing additional personal life insurance. Your client has asked if it is possible for them to deduct their personal life insurance premiums as a company business expense.

What counsel would you provide?

Answer:

First, remind them that <u>usually</u> life insurance premiums are not tax-deductible. However, as a C-corporation, the company can increase compensation/bonus in an amount equal to the desired premium paid for a policy and, therefore, deduct that amount as W-2 compensation or bonus.

Knowledge Check – ANSWERS

Ralph owns a very successful fast-food franchise and has recently taken on a partner in the business. Ralph is 55 and a widower with two grown sons. His new partner who bought into the business is Jason, age 35, and married with three young children. Jason's wife is an attorney currently serving as counsel for a group of local physicians.

Use knowledge of the various issues created by the death or disability of a partner/shareholder to help develop a process of business succession. Consider the issues you would discuss with Ralph and Jason.

What is your counsel?

Answer:

A buy-sell agreement needs to be drafted between Ralph and Jason. Ralph does not want Jason's wife to be a new partner in the event of his death, and Jason, likewise, does not want Ralph's two sons in the business to be heirs to Ralph's estate. Determining the business's value and the appropriate amount necessary to buy out is the first order of business. Then suggest life insurance as the best method to create necessary cash. The issue of the difference in age between Ralph and Jason regarding life policies and premium payment needs to be addressed as well.

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Section 3

HEALTH INSURANCE AND EMPLOYEE BENEFITS CONCEPTS

RISK & INSURANCE
EDUCATION ALLIANCE

Resources

Available at:
riskeducation.org/LHresources

Glossary

Health Care Comparison Chart

IRA to HSA Rollovers

2023 IRS Publication 502

Genworth Cost of Care Survey

Health Insurance and Employee Benefits Concepts

Section Goal

The Health Insurance and Employee Benefits Concepts section provides participants with the core knowledge and tools necessary to deliver information and counsel to their clients regarding health insurance concepts and products.

Learning Objectives

1. Use knowledge of health insurance contracts to evaluate their appropriateness for various client needs.

2. Use knowledge of the Affordable Care Act (ACA) and ACA-compliant and noncompliant medical plans to offer advice regarding client needs.

3. Apply knowledge of tax-favored health plans to meet a variety of prospect and client needs.

4. Apply knowledge of federal laws when providing counsel to clients and prospects.

5. Apply knowledge of Medicare, Medicare Supplements, and Medicaid to determine the best product to meet client needs.

6. Use understanding of long-term care insurance (LTCI) to evaluate client needs and provide appropriate counsel in contract selection.

7. Use knowledge of LTCI policy provisions, benefit triggers, qualified and non-qualified contracts, state-endorsed programs, and medical underwriting issues to determine the possibilities for payout in given scenarios.

8. Use knowledge of other products available to insure long-term care needs to determine the best products to meet a particular client's needs.

9. Use knowledge of the definitions of disability, the statistical risk of becoming disabled, and potential sources of income after disability to evaluate client needs and provide appropriate counsel.

10. Use knowledge of types of disability policy provisions, optional riders, and underwriting considerations to determine the appropriate product to meet client needs in a variety of situations.

11. Use knowledge of Business Overhead Expense (BOE) disability income policies and their tax considerations to advise clients about contract options for reimbursement of qualifying expenses if an owner becomes disabled.

Essentials of Health and Medical Contracts

Learning Objective 1:
Use knowledge of health insurance contracts to evaluate their appropriateness for various client needs.

Coverages and Policy Provisions

Types of Coverage

"Health insurance" is a broadly defined term that includes coverages for medical, dental, vision, disability income, accident, and critical illness insurance. Health insurance can provide individual or family coverage (two or more individuals) written either on an individual or employer-sponsored (group insurance) basis. Specific policy language will vary from state-to-state due to state-specific mandates.

The following are broad categories of health insurance:

Medical Insurance (designed for catastrophic coverage)	Dental Insurance	Vision Care
Supplemental Health (critical illness, cancer, etc.)	Travel Accident or Occupational Accident Insurance	Medicare/Medicare Supplements/ Medicare Advantage
Prescription Drug Plans	Short-Term Medical	Employee Assistance Programs (EAPs)
Wellness Programs	Disability Insurance*	Long-Term Care Insurance*

*Note:
Disability Insurance and Long-Term Care Insurance (LTCI) will be covered in depth later in this section.

Health Insurance Policy Provisions

1. **Deductible:** A deductible is expressed as a fixed dollar amount. It refers to the cumulative amounts allowed for covered health care services the insured is responsible for paying before the health insurance plan begins to pay. It is designed as a "financial incentive" for the insured to assume the cost of small claims in exchange for a lower premium. After the plan deductible is satisfied, the insured is responsible for the coinsurance and/or copay cost-sharing provisions up to the out-of-pocket maximum.

Types of Health Insurance Deductibles

Calendar Year Deductible:

The insured has the entire year (1/1–12/31) to accumulate amounts allowed for covered medical expenses before the insurance company starts paying. This is the most common deductible found in medical plans.

Plan Year Deductible:

This type of deductible is virtually the same as the *calendar year* deductible, but for a different 12-month time frame. The most common usage is in plans incorporating a Health Reimbursement Account (HRA), also called a Section 105 plan.

Per Occurrence:

Similar to deductibles found on property or auto policies, these deductibles apply to each covered incident or occurrence. They differ from copays in that they are applied to the whole incident (heart attack or flu, for example) as opposed to a specific coverage (such as an office visit). They are not often encountered; they tend to be found in travel/visitor medical, short-term medical, or limited benefit plans. Generally, there is also a time limitation (policy period) to the incident accumulation period.

Types of Health Insurance Deductibles (continued)

Individual Deductible vs Family Deductible:

An individual deductible is found in a health insurance plan that provides coverage to a single insured. A family deductible is commonly found in a health insurance policy that covers two or more insureds (e.g., a married couple and their children). An individual deductible is generally smaller than a family deductible.

Aggregate Deductible:

This applies to family deductibles only. It represents the dollar amount of allowable covered medical expenses the family must pay (accumulate) before the health insurance plan will begin sharing in the cost (with exception of preventive medical services). It is most commonly found in a high deductible health plan (HDHP). The amount of out-of-pocket costs the family pays for covered medical services is credited toward the aggregate deductible. The aggregate deductible is satisfied after the combined total of these expenses during the calendar or plan year reaches the dollar amount of the aggregate deductible. The health plan then begins to pay for the covered medical expenses of the family either in full or in combination with a coinsurance provision. One member of the family can satisfy the aggregate deductible if his or her out-of-pocket expenses are large enough to meet the aggregate deductible. Under new ACA rules that begin in 2016, a health plan can't require any individual covered by a family plan to pay a deductible that is higher than the ACA out-of-pocket maximum (OOPM) for individual coverage ($9,450 for 2024)—see below.

Embedded Deductible:

This applies to family deductibles only. It combines two deductibles in family coverage: an individual deductible and a family deductible. The individual deductible applies to each family member and is lower than the family deductible. The family deductible applies to all family members. The family deductible is usually twice the size of the individual deductible (e.g., $2,000 individual deductible embedded into a $4,000 family deductible). Any covered health care expenses incurred by an individual family member is credited toward both the individual deductible and the family deductible. Once a family member meets the individual deductible, they will usually only be required to pay a copayment or coinsurance for covered medical services in excess of the individual deductible, regardless of whether the family deductible is met. The payments after the deductible for this individual will not be applied toward the family deductible. The family deductible will only be met once more than one family member has paid enough towards the individual deductible that the overall family deductible has been met. An embedded deductible is not required for family coverage but may help ensure that there is coverage for individual family members once they meet their individual deductible, regardless of whether the family deductible has been met.

In-network vs. Out-of-Network Deductibles:

An in-network deductible applies when you visit an in-network provider. An out-of-network deductible applies when you visit a provider that is not in-network. Generally, the out-of-network deductible is twice as large as the in-network deductible. Any covered medical expenses that apply to the out-of-network deductible do not apply to the in-network deductible.

2. **Accumulation period:** The time frame in which incurred charges can be applied against the deductible; it is most frequently stated on a calendar year (or plan year basis)

3. **Deductible credit provision**: This benefit provides whatever portion of the insured's deductible had been met on their old policy to be given as a credit against the new policy's deductible. This provision allows companies and insureds to change insurance plans or carriers mid-year without having the covered individuals (the employees) meet the deductible again. The new insurance carrier gives credit for the amount (dollars, not %) of the deductible met with the prior carrier. This is also referred to as "no loss/no gain."

4. **Deductible carry-over provision**: This provision allows a plan participant(s) to apply medical expenses from the last quarter of the current year to next year's deductible. It only applies if the medical expenses incurred in the previous quarter apply toward the deductible. For example, if a plan participant satisfied $750 of the $2,000 annual deductible in the fourth quarter of 2023, the $750 would carry over to the 2024 calendar year deductible. The plan participant would start the next year needing only to satisfy the remaining $1,250 annual deductible.

5. **Copayment:** This is the **fixed dollar amount** incurred by the insured each time a specified service is utilized. It is most commonly used for physician office visits, prescriptions, and emergency room care.

6. **Coinsurance**: This is the percentage of covered medical expenses the insured pays after the deductible has been paid. Typical coinsurance percentages range from 20% to 50% and are most commonly seen as percentages of *90/10, 80/20, 70/30, 60/40, and 50/50*. The insured pays the small coinsurance rate, while the health plan pays the larger one. Coinsurance is applied to most covered medical claims during the applicable phase after the deductible has been satisfied. Coinsurance percentages are generally different when applied to in-network vs. out-of-network charges.

7. **Out-of-Pocket Maximums (OOPMs):** The Affordable Care Act (ACA) imposes annual OOPMs on the amounts that participants can be required to pay for covered Essential Health Benefits (EHBs) through cost sharing in non-grandfathered health plans. The OOPM includes the annual deductible, copayments, and coinsurance. It does not include premiums or out-of-network cost sharing. The U.S. Department of Health and Human Services (HHS) establishes the annual OOPMs. The 2024 OOPM limits are $9,450 for self-only coverage and $18,900 for family coverage (2x self-only and applies to other than self-only coverage). Beginning in 2016, an embedded OOPM is required for family coverage only and applies to each individual enrolled in family coverage if the plan's family OOPM exceeds the ACA's OOPM for self-only coverage ($9,450 for 2024). An embedded OOPM is an individual OOPM inside a family OOPM; the plan's individual OOPM applies to each covered individual, whether the individual has self-only coverage or family coverage.

   For example, if a plan has an OOPM of $4,000 for self-only and $8,000 for a family, an individual who is part of a family plan won't pay more than $4,000 (the OOPM for self-only under the plan) during the year. Other members of the family plan would be subject to the same $4,000 OOPM until combined cost-sharing expenses for the entire family reach the $8,000 family OOPM.

   The Internal Revenue Service (IRS) annually issues separate OOPMs specific to HDHPs that can be linked to Health Savings Accounts (HSAs).

   The OOPMs for HDHPs will be covered later in this section.

PRACTICE EXERCISE

- $27,000 in-network covered medical expenses (first claim of the calendar year and not preventative)
- Individual coverage
- Deductible – $2,000 in-network deductible/$4,000 out-of-network
- Coinsurance – 80/20 in-network/out-of-network 50/50
- Out-of-pocket maximum (OOPM) – $5,000 in-network/unlimited out-of-network

Total payable by the insured and insurer?

Description		Insured's Responsibility	Insurer's Responsibility
Total hospital and surgical bill	$27,000		
Deductible applies first	2,000	(2,000)	
Amount subject to coinsurance after deductible	25,000		
Amount paid by insured and insurer subject to 80/20 *coinsurance*		(5,000)	(20,000)
Amount paid by insured and insurer before applying *$5,000 OOPM*		(7,000)	(20,000)
OOPM credited to insured		2,000	
OOPM debited from insurance company			(2,000)
Total bill	27,000		
Total paid by insured		5,000	
Total paid by insurance company			22,000

8. **Cost Containment Provision**: This provision requires the insured to receive permission from a company-approved medical review service before proceeding with most non-emergency medical services or hospital confinements. It can also include a post-service medical review. Incentives may be provided for utilization. A premium reduction incentive of 5% to 15% over standard plans is common. Penalties, such as a reduction in benefits by 25% to 50%, are imposed if permission is not received before proceeding. The following are examples of typical cost containment requirements:

   - Pre-admission certification
   - Securing second surgical opinions
   - Notification within 24 hours of an emergency admission
   - Discharge from the hospital by a pre-set schedule date
   - Preapprovals for hospital stay extensions
   - Concurrent review
   - Retrospective review
   - Outpatient (ambulatory) surgery units

9. **Pre-existing conditions:** The Affordable Care Act (ACA) prohibits medical insurance plans from refusing to cover or charge individuals more just because they have a pre-existing condition. The ACA does not apply to health insurance contracts that are not ACA-compliant (e.g., limited medical plans, long-term care insurance, dental insurance, vision insurance, and disability plans).

10. **General exclusions:** Normally found in medical policies (including group policies)

□ *Occupational disease and injury	□ Eyeglasses and vision care
□ Suicide or intentional self-inflicted injury	□ Cosmetic surgery (*exception*—caused by an accident)
□ War	□ U. S. government hospitals
□ Service while in the armed forces	
□ Dental, unless an accident	

**Agents (both P/C and health) need to be aware there is a possibility of E&O action if a person—usually a self-employed individual—rejects workers compensation, has an on-the-job injury, and then learns that their health insurance excludes Occupational Disease and Injury. This exclusion varies from state to state and carrier to carrier.*

Group Coverage vs. Individual Coverage

Insurance carriers can issue group and/or individual insurance plans. Individual plans can be offered on and/or off a health insurance marketplace (discussed later in the material).

Group Coverage: This is an insurance plan where the unit is a group, NOT an individual. This is what we typically think of when describing employer-sponsored health insurance programs. Group plans can also be offered by associations (e.g., Chamber of Commerce, union, or co-op).

- The employer (association, union, co-op, etc.) receives the master contract.
- Each participant (employee, association member, union member, etc.) receives, or has access to, a certificate that describes the coverage, cost-sharing provisions (deductible, copayments, coinsurance, and out-of-pocket maximums), and any additional coverages, such as dental or vision.

Individual Coverage: This contract is between the individual and the insurer.

- Consumers can purchase coverage during an annual Open Enrollment Period (OEP), although some states offer deadline extensions.
- Outside of the yearly OEP, you must have a Special Enrollment Period (SEP) to enroll. Eligibility to enroll during the SEP occurs if an individual has certain life events, including losing employer-sponsored health insurance, moving, getting married, having the birth of a baby, or adopting a child.

Underwriting Considerations

1. Guaranteed Issue Basis – Under the ACA, any individual and/or fully insured group plan that is provided must be made available on a guaranteed issue basis, with no preexisting condition limitations, and the coverage cannot have any restrictions on annual or lifetime limits.

2. Community Rating Standards – Individual and fully insured small group plans with up to 100 employees will be required to abide by strict, modified community rating standards; experience rating will be prohibited. Experience rating may be used with "stop-loss" insurance in partially self-funded plans.

3. Valid Group – Insurance is incidental to group formation, meaning the group cannot be formed for the express purpose of purchasing insurance; it must be a valid group, such as employer-employee, association, union, etc.

4. Flow of Lives – Eligibility to participate in the plan is clearly defined, and there is a flow of lives through the group.

5. Participation – Minimum participation may be required; for example, 75% of eligible employees.

6. Automatic benefit determination – everyone has access to at least some nondiscriminatory coverage. The ACA has four plan options: Platinum, Gold, Silver, and Bronze. Health Savings Accounts (HSAs) are also approved coverage plans; thus, some employees may have HSAs while others have Gold Plans.

7. Third-party cost-sharing – employers are required to pay a minimum of 50% of the employee premium; for example, more favorable benefits and rates may be given to "non-contributory" or employer-pay-all contracts in group life and disability plans, but this is not the case in group health under the ACA.

8. Efficient administration – most forms are now online and paperless; typically, premiums are paid via EFT, with no paper billing sent to the plan administrator.

9. The power to make contract changes belongs to the group administrator; an individual's decision is limited to whether to participate, and coverage is automatic.

Renewability Provisions

Medical contracts are guaranteed renewable, as ACA now dictates. The health insurance company cannot cancel the contract. However, the insurer can raise the premium as long as it does so in a nondiscriminatory manner. Each state's insurance department must approve rates and rate increases. Generally, premiums for individual and group plans will be guaranteed for 12 months.

Taxation of Group Insurance

Are insurance premiums tax deductible by the employer?

Generally, **YES**

1. Insurance premiums are classified as ordinary business expenses if total compensation is reasonable.

2. Premiums for both individual and group health, disability, dental, and vision insurance are usually deductible if paid on behalf of employees. Premiums for group life insurance are also deductible if paid for employees. These deductions do not apply personally to owners of sole proprietorships or partnerships and do not apply to owners of S corporations. For these individuals, a portion of their individual and/or group health, dental, and vision insurance premiums are deductible on their personal income tax returns as long as the amount exceeds the percentage of income guidelines in the IRS rules. Individual life insurance premiums are generally not deductible for employers or employees.

Table I: Are Premiums Tax Deductible by the EmployER?

EmployEE Class	Life	Medical	DI	Other
Employ**EE**s	YES[1]	YES[5]	YES[5]	YES[5]
Owner/**EE** of a "C" Corporation	YES[1]	YES[5]	YES[5]	YES[5]
Owner/**EE** of an "S" Corporation	NO[2]	NO[6]	NO[6]	NO[6]
Owners of a Partnership	NO[3]	NO[7]	NO[7]	NO[7]
Owner of a Sole Proprietorship	NO[3]	NO[7]	NO[7]	NO[7]
Retired Employ**EE**s and Dependents	YES[1]	YES[5]	YES[5]	YES[5]
Dependents of Deceased Employ**EE**s	YES[1]	YES[5]	YES[5]	YES[5]
Non-Employ**EE**s (Contractors)	YES[4]	YES[4]	YES[4]	YES[4]

Are the premiums paid by the employer reported as income to the employee?

Generally, **NO**

Table II: Are Premiums Reported as Income to the EmployEE?

EmployEE Class	Life	Medical	DI	Other
Employ**EE**s	NO[8]	NO[13]	NO[13]	NO[13]
Owner/**EE** of a "C" Corporation	NO[8]	NO[13]	NO[13]	NO[13]
Owner/**EE** of an "S" Corporation	NO[9]	NO[14]	NO[14]	NO[14]
Owners of a Partnership	NO[10]	NO[15]	NO[15]	NO[15]
Owner of a Sole Proprietorship	NO[10]	NO[15]	NO[15]	NO[15]
Retired Employ**EE**s and Dependents	NO[8]	NO[16]	NO[16]	NO[16]
Dependents of Deceased Employ**EE**s	NO[11]	NO[13]	NO[13]	NO[13]
Non-Employ**EE**s (Contractors)	YES[12]	YES[12]	YES[12]	YES[12]

Are the benefits that are received by employees and beneficiaries taxable?

Generally, benefits are tax-free to employees and/or their beneficiaries.

An exception exists for employer-paid disability insurance.

Table III: Are Benefits Taxable to the EmployEE or Beneficiaries?

EmployEE Class	Life	Medical	DI	Other
Employ**EE**s	NO[17]	NO[18]	YES[22]	NO[18]
Owner/**EE** of a "C" Corporation	NO[17]	NO[18]	YES[22]	NO[18]
Owner/**EE** of a "S" Corporation	NO[17]	NO[19]	NO[23]	NO[19]
Owners of a Partnership	NO[17]	NO[20]	NO[24]	NO[20]
Owner of a Sole Proprietorship	NO[17]	NO[20]	NO[24]	NO[20]
Retired Employ**EE**s and Dependents	NO[17]	NO[18]	YES[22]	NO[18]
Dependents of Deceased Employ**EE**s	NO[17]	NO[18]	YES[22]	NO[18]
Non-Employ**EE**s (Contractors)	NO[17]	NO[21]	NO[24]	NO[21]

Definitions relating to TABLES I, II, and III: The group heading for "Medical" includes those contracts paid by an employer for dental and vision care. Group headings for "Other" include policies for, but are not limited to, accidental death and dismemberment and travel accident insurance. Pension laws are not considered.

Notice:
This information is a general statement of current law and should not be construed as tax advice.
Please consult a competent tax attorney/advisor regarding questions on taxation of group insurance.

[1] Employer may deduct full and unlimited actual premium. (IRC 162 (a) (1) Rev. Rul. 56-400) No deduction is allowable if the employer is directly or indirectly a beneficiary.

[2] Shareholder employees (2% or less stock-ownership) of an "S" corporation will be treated the same as #1. If more than 2% ownership, they will be treated as #3.

[3] Not deductible. IRC 264 (a); Reg. 1.264-1.

[4] To be deductible, the expense of coverage provided must relate directly to a business relationship between the corporation and independent contractor. (IRC sect. 79)

[5] Deductible as per Reg. 1.162-10 (a). This includes those forms known as Business Overhead Expense.

[6] Shareholder employees (2% or less stock-ownership) of an S corporation will be treated the same as #5. If more than 2% ownership, they will be treated as #7.

[7] Since this classification is not an "employee," they are under the personal health insurance tax rules. IRC 162 (2).

[8] The actual employer-paid premium cost of term life up to $50,000 is <u>not</u> reportable to the employee. The "cost" (not actual premium, but Uniform Government Table of Premium) in excess of $50,000 coverage is reportable to the employee for both withholding and FICA (IRC Section 79). Coverage can be provided through either a "group term contract" or an individual policy(s).

[9] Shareholder-employees (2% or less stock-ownership) of an "S" corporation will be treated the same as #8 above. If more than 2% ownership, they will be treated as #10.

[10] Not reportable. Not classified as an "employee".

[11] Not reported as long as coverage does not exceed $2,000 per dependent/spouse of employee. Premiums on any amount that exceeds $2000 are reportable. "Cost" is from the Uniform Government Table of Premiums.

[12] All employer-paid premiums are reported as income to a non-employee.

[13] IRC Sec. 106

[14] Shareholder-employees (2% or less stock-owner) of an S Corporation will be treated the same as #13. More than 2% owners will be treated as #15.

[15] Not classified as an "employee."

[16] IRC 106. Rev. Rul. 62-199, 1962-2 CB 38.

[17] Benefits must meet "life insurance" definition. IRC 7702.

[18] Benefits received are excluded from gross income whether paid through health insurance policy or cash reimbursement paid by the employer. If reimbursement exceeds actual expenses, the excess must be included in gross income. (IRC 105 (b), Reg. 1.105-2)

[19] Shareholder-employees (2% or less stock-ownership) of an "S" corporation will be treated the same as #18. If more than 2% ownership, they will be treated as #20.

[20] Benefits are not taxable (unlimited) if premiums are personally paid. {IRC Sec. 104 (a) (3)}.

[21] Benefits are not taxable (unlimited) since employer reported full premium to non-employee.

[22] Wage continuation benefits, including sick pay plans, will be included in gross income and taxable to the employee. If the plan is a Business Overhead Expense contract, the benefits are taxable to the owner, which is usually the corporation.

[23] Shareholder-employees (2% or less stock-ownership) of an "S" corporation will be treated the same as #22. More than 2% ownership will be treated as #24.

[24] Benefits from personally owned disability income policies are received income tax-free. {IRC Sec. 104 (a) (3}). Disability premiums will not be tax deductible since the insured was not an "employee."

IRS Tax Implications for:	
Group Health	Employer contributions are tax-deductible; tax-free to employee
Group Dental	Employer contributions are tax-deductible; tax-free to employee
Group Vision	Employer contributions are tax-deductible; tax-free to employee
Group Rx	Employer contributions are tax-deductible; tax-free to employee
Group Term Life	Employer contributions are tax-deductible; tax-free to beneficiaries up to $50,000
Group Disability	Employer contributions are tax-deductible, and benefits are taxable to employee.
Voluntary Products	No employer contributions. Employee contributions are best as post-tax–let's discuss!
Wellness	Employers can provide incentives for the employee to participate.

Knowledge Check

Your client has a medical plan with the following cost-sharing provisions:

- Deductible: $3,000 in-network/$6,000 out-of-network
- Coinsurance: 80/20 in-network/out-of-network 50/50
- Out-of-pocket maximum: $6,000 in-network/unlimited out-of-network

She incurs allowable in-network medical expenses in the amount of $15,000. How much of this amount will your client pay out-of-pocket, and how much will her insurance company pay?

How much of this amount will your client pay out-of-pocket, and how much will her insurance company pay if this is an out-of-network claim?

Affordable Care Act

Learning Objective 2:

Use knowledge of the Affordable Care Act (ACA) and ACA-compliant and noncompliant medical plans to offer advice regarding client needs.

The Affordable Care Act (ACA), also known as the Patient Protection and Affordable Care Act (PPACA) or "Obamacare," is a comprehensive healthcare reform law enacted in March 2010 that sets essential health benefits for health insurance.

Two primary goals of the ACA were to (1) make affordable health insurance available to more people by providing consumers with federal subsidies (premium tax credits and reduced cost-sharing provisions) and (2) expand the Medicaid program to adults under age 65 with incomes below 138% of the federal poverty level (FPL).

The law provides premium tax credits for households with incomes between 100% and 400% of the FPL and cost-sharing reductions to reduce the out-of-pocket expenses (e.g., deductibles, copayments, and maximum out-of-pocket limits) for eligible individuals and families with incomes under 250% of the FPL to purchase insurance through the Health Insurance Marketplace. Both income and citizenship status verification are required. Employees offered coverage by an employer are not eligible for premium tax credits or cost-sharing reductions unless the employer's plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 8.39% of income (2024).

On June 28, 2012, the U.S. Supreme Court upheld the ACA individual mandate and the Medicaid expansion but struck down the penalty on individual states that did not expand Medicaid, thereby making the decision to expand Medicaid optional for states.

Essential Health Benefits (EHBs)

The "10 Essential Health Benefits" of the ACA are services that all qualified health insurance plans must provide to comply with the ACA.

The ten broad categories are:

1. Ambulatory patient services
2. Emergency care
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse care
6. Rehabilitative services and devices
7. Laboratory services
8. Preventive and wellness services/chronic disease management
9. Prescription drugs
10. Pediatric services (children under age 19), including oral and vision care

Notable Health Care Reform Provisions of the ACA

Elimination of annual and lifetime maximum benefits

Elimination of preexisting conditions exclusion

Addition of a "Summary of Benefits and Coverage"

Dependent coverage for children up to age 26

Guaranteed issue and renewability: this allows premium variation based only on age (limited to a 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to a 1.5 to 1 ratio)

Minimum Medical Loss Ratios (MLRs – 85% group, 80% individual) and requires consumer rebate rules for insurance companies

Maximum waiting periods for new employees cannot exceed 90 days

Health insurance marketplaces

Health Insurance Marketplace

The Health Insurance Marketplace provides a way for consumers to purchase affordable health coverage independently. Premium tax credits are available to some individuals and families to make health insurance more affordable. These tax credits can only be used to purchase health insurance for marketplace plans. In addition to the tax credits, cost-sharing reductions may also be available to help them pay their cost-sharing charges. Individuals and families with incomes up to 250 percent of FPL are eligible for cost-sharing reductions. Cost-sharing reductions include lower deductibles, out-of-pocket maximums, and copayments.

Health insurance plans offered in the Marketplace (and the individual market outside the marketplace) fall under four "metal" categories: Bronze, Silver, Gold, and Platinum. These categories are distinguished by how healthcare costs are shared between the insured(s) and the insurer. Each metal level plan is categorized by how much, on average, a typical population's medical spending a health insurance plan would cover (indicated in parentheses below next to each plan category). Cost-sharing reductions increase the actuarial value (AV) of the Silver Plan. In addition to metal plans, Catastrophic plans are also available to certain individuals.

1. Bronze (60%)

   - Lowest monthly premium
   - Highest costs when you need care
   - Bronze Deductibles—the amount of medical costs you pay yourself before your insurance plan starts to pay—can be thousands of dollars a year
   - Good choice if you want a low-cost way to protect yourself from worst-case medical scenarios, like serious sickness or injury; your monthly premium will be low, but you'll have to pay for most routine care yourself

2. Silver (70%)

- Moderate monthly premium
- Moderate costs when you need care
- Silver Deductibles–usually lower than those of Bronze plans
- **IMPORTANT:** If you qualify for cost-sharing reductions, you must pick a Silver plan to get the extra savings; you can save hundreds or even thousands of dollars per year if you use a lot of care
- Good choice if: You qualify for "extra savings" — or, if you don't, you're willing to pay a slightly higher monthly premium than Bronze to have more of your routine care covered

3. Gold (80%)

- High monthly premium
- Low costs when you need care
- Gold Deductibles–are usually low
- Good choice if you are willing to pay more each month to have more costs covered when you get medical treatment; if you use a lot of care, a Gold plan could be a good value

4. Platinum (90%)

- Highest monthly premium
- Lowest costs when you need care
- Platinum Deductibles are very low, meaning your plan starts paying its share earlier than for other categories of plans
- Good choice if you usually use a lot of care and are willing to pay a high monthly premium, knowing nearly all other costs will be covered

ACA Employer Shared Responsibility Penalties

The employer-shared responsibility provisions under the ACA apply only to certain employers called Applicable Large Employers (ALEs). In general, an ALE is any employer who, on average, during the preceding calendar year, employed at least 50 full-time employees, including full-time equivalent employees (FTEs). The vast majority of employers will fall below the ALE threshold. The ACA requires ALEs to offer coverage to full-time employees and their dependents that offers minimum essential coverage that is "affordable" and provides "minimum value," or potentially make an Employer Shared Responsibility payment to the IRS. Penalties may be imposed on ALEs that either:

1. Fail to offer minimum essential coverage to 95 percent of its full-time employees and their dependents, and any full-time employee receives coverage on the marketplace; or,

2. Offer coverage that is not affordable or does not provide minimum value.

Employers with fewer than 50 full-time employees (including full-time equivalent employees) are not subject to the Employer Shared Responsibility Provisions of the ACA.

Affordable

Coverage is affordable if the plan's cost for self-only coverage is no more than 8.39% (2024) of the employee's household income. An employee's Form W-2 wages are typically used to determine affordability. Other affordability safe harbors to determine affordability also available to employers include (1) the employee's rate of pay or (2) the Federal Poverty Level (FPL) for a household of one.

Minimum Value (MV)

The employer-provided health plan must satisfy the minimum value requirement under the ACA. Minimum value means the health care plan's share of the total allowed cost of benefits provided under the plan is at least 60% of the actuarial costs.

Employer Shared Responsibility Provisions Under the ACA 2024

Failure to Offer Coverage to at least 95% of full-time employees and dependents. The penalty is $2,970 (for 2024) per full-time employee minus the first thirty. Applies to each month the Applicable Large Employer (ALE) (1) failed to offer MEC to at least 95% of its full-time employees and their dependents under age 26 AND (2) at least one full-time employee received Premium Tax Credits (PTC) for purchasing coverage through the Marketplace for that month. The annualized penalty for the 2024 tax year is the sum of $2,970/12 X (number of full-time employees – 30 full-time employees) X each month that at least one full-time employee received PTCs.

Failure to Offer Affordable Coverage and of Minimum Value (MV). Applies each month for every full-time employee that (1) did not receive an offer of coverage from the ALE or received such an offer, but the offer was either unaffordable or did not provide MV (or both) AND (2) the employee received a Premium Tax Credit (PTC) for that month. The annualized penalty for the 2024 tax year is the sum of $4,460/12 X (number of full-time employees receiving PTCs each month).

ACA Individual Mandate

The individual mandate is a provision within the Affordable Care Act that required individuals to purchase minimum essential coverage or face a tax penalty unless they were eligible for an exemption. Technically, the individual mandate itself is still in effect. However, there is no longer a penalty to enforce it. The tax penalty was eliminated after the end of 2018 under the terms of the Tax Cuts and Jobs Act of 2017.

Compliant and Noncompliant Plans

The ACA mandates that an employer group plan will fail to meet the minimum value test if its coverage pays less than 60% of medical costs. Basically, this (and other rules) means a plan of insurance provided by an employer must have certain coverage components and meet all the rules and regulations mandated by the ACA. For example, an employer's accidental medical plan, or "mini-med" plan, would not be considered ACA-compliant coverage since it violates numerous "minimum value" test provisions. Should an employee have such a plan, the ACA would view this as NOT having met the provisions of the law, and the employer would be subject to the individual or family penalty.

Knowledge Check

Your good friend, Jennifer, is about to open a bagel and sandwich shop. You are discussing property and casualty options. She states: “I plan to have five to six full-time employees (30+ hours per week) and about the same number of part-time employees (less than 30 hours per week). I have heard I will be required to provide my employees with health insurance, as per the Affordable Care Act. Is that true?”

You handle a small manufacturing risk, owned by Bob. They employ 65 full-time employees. Bob has just received the renewal notice from their health insurance carrier, which provides an ACA-compliant coverage plan. All full-time employees are afforded coverage. The premium has increased dramatically. Bob currently pays 90% of the employee’s self-only premium. He is thinking of dropping that to 50%. He asks, “Do you see any potential problems with that plan?”

Tax-Advantaged Accounts

Learning Objective: 3

Apply knowledge of tax-favored health plans to meet a variety of prospect and client needs.

Consumer-Driven Health Plans

Flexible Spending Accounts (FSAs)

Also known as Cafeteria Plans or 125 Plans, healthcare FSAs are employer-established benefit plans that pay or reimburse participating employees for **Qualified Medical Expenses (QMEs) as defined by IRS Publication 502**. The Coronavirus Aid, Relief and Economic Security Act (CARES ACT) permanently reinstated over-the-counter (OTC) products as qualified medical expenses (QMEs) for HSA, FSA, and HRA accounts, reversing the ACA law, which stated that (OTC) drugs were only eligible with a prescription. Menstrual care products were also added to the eligible list. These changes are retroactive to January 1, 2020.

The employee contributes funds to the account through a salary reduction agreement and is able to withdraw the funds to pay for QMEs. The salary reduction agreement means that any funds set aside in a flexible spending account escape both income tax and Social Security tax. Employers may contribute to these accounts as well.

- The ACA limits the maximum contribution by an employee to a medical FSA to $3,200 during the 2024 plan year; no statutory limit is placed on an employer's contribution, but employer contributions may not discriminate.

- The maximum annual contribution, or annual election, limit for a dependent care FSA is $5,000 (2024).

- An open enrollment period occurs once a year when an employee can sign up, stop contributions, or amend the amount of the contributions to a medical FSA or dependent care FSA. Once the annual election has been made, the employee is not allowed to change the amount or drop out of the plan during the year unless they experience a change of family status; by law, the employee forfeits any unspent funds ("use it or lose it") in the account at the end of the plan year.

In November of 2013, the IRS issued a ruling (effective in 2014) that allows employers to amend their FSA plans so employees can carry over a portion of these funds from one year to the next, thus changing the "use it or lose it" rule. In 2024, this amount is $640. The ruling goes on to clarify as follows:

- The carryover amount does not count against the annual contribution limit
- FSA plan document cannot offer both a grace period AND a carryover
- Carryover only applies to health FSAs and does not apply to the dependent care benefit

Limited Purpose FSA

A limited purpose FSA is much like a health FSA. The main difference is that the limited purpose FSA may only be used to cover qualifying dental and vision expenses, such as:

- Vision exams, LASIK surgery, contact lenses, and eyeglasses
- Dental cleanings, X-rays, fillings, crowns, and orthodontia

Many employers offer limited purpose FSAs for their employees who have health savings accounts. That's because IRS rules state that you cannot have an HSA and a health FSA since both apply funds toward your medical expenses. A limited purpose FSA allows you to continue to contribute to an HSA. You maximize your savings and tax benefits by restricting your FSA reimbursement to only vision and dental expenses.

Your entire annual election ($3,200 during the 2024 plan year) is available on the first day of the plan year, but your total FSA annual election amount is deducted from your paycheck in equal amounts throughout the year

Example:
Your limited purpose health FSA election is $1,200, and your plan year begins on January 1. Assuming you are paid once a month, $100 will be deducted from your paycheck each month throughout the year. On the first day of the FSA plan year, which would be January 1, you can use $1,200 immediately to pay for eligible FSA expenses.

Health Reimbursement Arrangements (HRAs)

HRAs, also known as Section 105 plans, are not insurance plans. They are a tax-advantaged way for an employer to pay medical expenses on behalf of an employee. An HRA allows the employer to consider any benefits payments as an ordinary business expense, and the employee does not have to declare any plan reimbursement for a QME as income.

- HRAs consist of funds set aside by employers for their employees on a nondiscriminatory basis; they are used to pay or reimburse employees for QMEs
- Can be used for any QMEs, such as deductibles, copays, dental, vision, etc.
- If an insurance contract pays for the QME, the HRA cannot duplicate it; it can only be used for what the insurance plan (or no plan) fails to pay or reimburse
- HRA funds are not subject to the "use it or lose it" rule as seen with the FSA; employees do not contribute to the HRA–only the employer

Note:
Should an employee terminate from an employer that funded an HRA, the funds remain with the employer. They do not follow the employee.

There are three additional options for HRAs:

1. An Individual Coverage HRA (ICHRA) that allows an employee to pay for individual health coverage and reimburse other eligible expenses. It cannot be offered to employees who are eligible for group coverage.
2. An Excepted Benefit HRA (EBHRA) that is a stand-alone HRA with an annual maximum benefit limit that can reimburse medical expenses for employees and their dependents. It can only be offered to employees who are eligible for a group health plan sponsored by their employer.
3. Small employers with fewer than 50 full-time employees can offer a Qualified Small Employer HRA (QSEHRA). Funds can be used for approved medical expenses and healthcare insurance premiums.

Health Savings Accounts (HSAs)

Health Savings Accounts are arrangements used to pay for unreimbursed healthcare expenses. These accounts can accumulate tax-deferred interest similar to Individual Retirement Accounts (IRAs).

Funds are controlled and owned by the account holder. Anyone can make a contribution to the account on behalf of the account holder. To qualify, the insured taxpayer must be covered by a High-Deductible Health Plan (HDHP). For 2024, the annual deductible limitations for qualifying HDHPs are:

- INDIVIDUAL – minimum deductible is $1,600 with a $8,050 maximum out-of-pocket amount

- FAMILY – minimum deductible is $3,200 with a $16,100 maximum out-of-pocket amount

Savings are rolled over every year and are portable since the account is "owned" by the insured/account holder, regardless of employment status. Funds can be used on a pretax basis to pay for long-term care insurance premiums, health insurance premiums paid while unemployed, and COBRA premiums.

Funds can accumulate earnings, which are not taxed unless funds are used for non-qualified-medical expenses. Such use may trigger ordinary income taxes in addition to a 20 percent penalty if under age 65. If the account holder becomes disabled or reaches Medicare eligibility age, distributions for non-qualified medical expenses from the account are subject only to ordinary income tax, not the penalty.

Purpose and Flow of an HSA

- To allow the account holder (the insured under the HSA) the flexibility of choosing their own medical providers

- A High Deductible Health Plan is required ***(The Insurance Part)***

- Sets aside a tax-deductible contribution that can be used to pay the deductible and other allowable QMEs
  (The Cash Account Part – optional but a key component of an HSA)

Requirements for Establishing an HSA

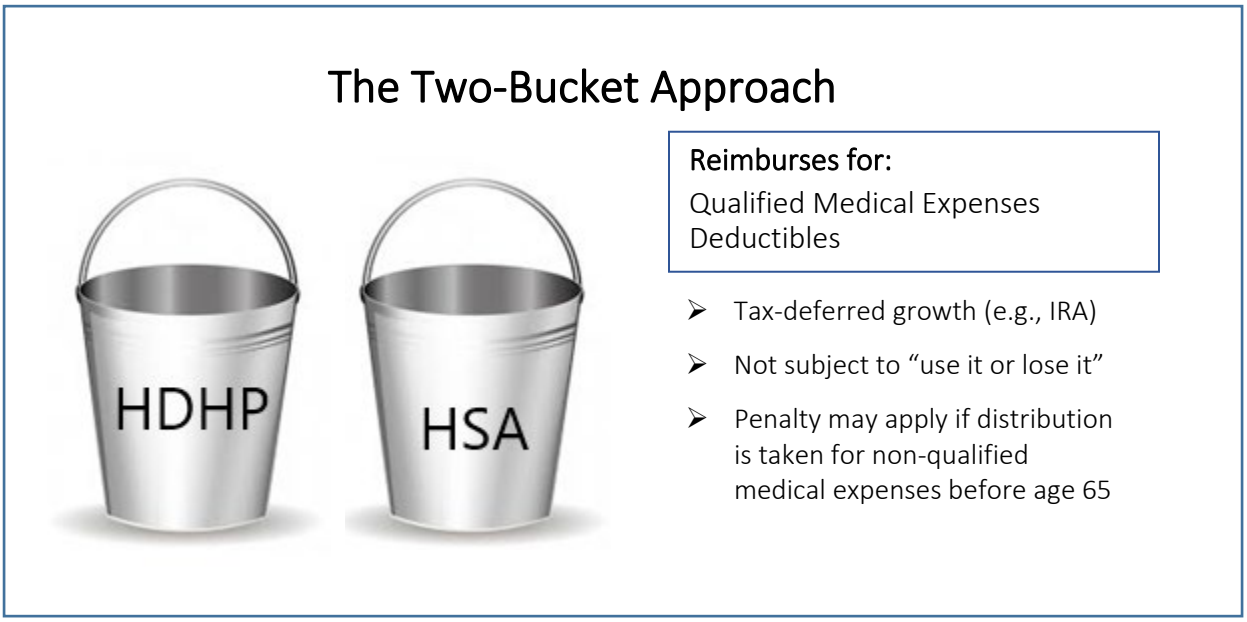
- Purchase a qualified HDHP
- Have **a written document** from an **approved HSA trustee** (life insurance company, mutual fund company, bank, or other approved administrator for the contributed funds)
- Fund with cash contributions to cover unreimbursed claims (optional)

1. The maximum annual contribution to an HSA is $4,150 (2024) for self-only coverage and $8,300 (2024) for a family plan.

2. HSA account holders age 55 or older by the end of the calendar year can make an additional $1,000 catch-up contribution to their HSA. If both spouses are age 55 or older, they must have an HSA account in separate names in order to make the $1,000 catch-up contribution.

3. Contributions can be made by the account holder or anyone on behalf of the account holder, including the employer–but total deposits from ALL sources cannot exceed the annual maximum contribution limits.

4. If the employer is the contributor, there must be "comparable" contributions for all participating employees for each period.



2024 HSA Contribution Limits

Contribution Limits for Health Savings Accounts Under HDHPs

(*Individual means self-only coverage.)

	2024	2023	Change
HSA Contribution Limit	Individual: $4,150	Individual: $3,850	Individual: +$300
	Family: $8,300	Family: $7,750	Family: +$550
HSA Catch-Up Contribution	$1,000	$1,000	No Change
HDHP Minimum Deductible	Individual: $1,600	Individual: $1,500	Individual +$100
	Family: $3,200	Family: $3,000	Family: +$200
HDHP Max Out-of-Pocket	Individual: $8,050	Individual: $7,500	Individual: $+550
	Family: $16,100	Family: $15,000	Family: $+1,100

https://www.kiplinger.com/taxes/hsa-contribution-limit-2024

Tax Treatment of Contributions and Distributions

1. Contributions to an HSA:

   - Account-holder contributions may be made by anyone
   - Employer contributions are tax-deductible to the employer and excludable from income to the individual
   - Individual contributions are deductible "above the line." That is, a taxpayer does not have to itemize deductions in order to take the contribution as a deduction
   - Those contributions made by someone other than the individual or their employer are deductible to the account holder

Note:
Contributions can be made via pre-tax payroll deduction, in which case they are NOT deductible on the account holder's federal income tax return.

2. Tax-free distributions from an HSA:

   - Distributions for "qualified medical expenses" incurred by the account holder, their spouse, and all dependents claimed on the account holder's tax return
   - Insurance premiums for:
     1. Long-term care insurance
     2. Healthcare continuation coverage (e.g., COBRA)
     3. Health care coverage while receiving unemployment compensation under federal or state law
     4. Medicare and other health care coverage if you were 65 or older (other than premiums for Medicare supplemental policy, such as Medigap)

Form IRS Publication 969 (Cat. No. 24216S)

Health Savings Accounts and Other Tax-Favored Health Plans

"Qualified medical expenses. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses."

https://www.irs.gov/pub/irs-pdf/p969.pdf

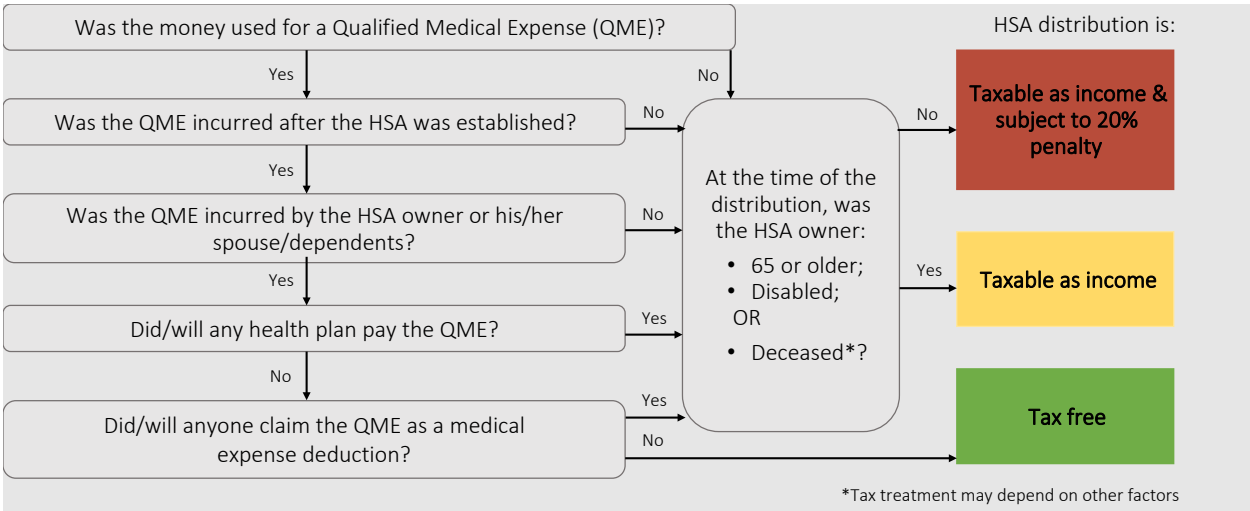
3. Other distributions from an HSA:

- If the beneficiary of an HSA is the spouse of the account holder, the HSA account and all tax benefits transfer to the spouse after the death of the account holder. The spouse may leave the account open or transfer the funds to their own HSA account. If someone other than the account holder's spouse is named as the beneficiary, they are required to take a full distribution from the HSA which is a taxable event. The non-spouse beneficiary may reduce the account balance for tax purposes by the amount of any payments made from the HSA for QME's incurred by the deceased account holder before death.

- Non-medical before age 65 – income tax plus 20% penalty

- Non-medical after age 65 – income tax only

- Amounts not used by year-end are not forfeited (they accumulate year-to-year)



Knowledge Check

Your client is familiar with FSA plans but wants their employees to have more of their own money involved in their health care programs.

What plans, if any, are available for the employer to offer?

Federal Legislation

Learning Objective 4:
Apply knowledge of federal laws when providing counsel to clients and prospects.

Federal Employer Laws

Many think federal legislation is where group insurance administration is involved in insurance law. It is not. It is "employer law," and the employee benefit plan is 100% responsible for compliance.

Federal Employer Laws	
ERISA	DOMA
NMHPA	GINA
WHCRA	USERRA
MHPA	CHIP
COBRA	MICHELLE'S LAW
HIPAA	
FMLA	
QMCSO	
ACA	

Explanations of Select Federal Employer Laws

COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA allows for the temporary continuation of group medical insurance (including any FSA or HRA plans), dental and vision coverage for certain former employees, retirees not eligible for Medicare, spouses, former spouses, and dependent children. It began in 1986 and is only for groups of a minimum size and only for certain covered events. COBRA does not apply to Group Life, Disability, or Accidental Death & Dismemberment plans.

Some states have their own versions, which can be more liberal, but not more restrictive, than federal COBRA. For more information, see http://www.COBRAinsurance.com.

Note:
Should an employer discontinue a group health insurance plan, COBRA would not apply (exception for asset purchases where the purchaser takes on the seller's employees and has a group medical plan in force on their current employees).

Features of COBRA

- For groups of 20 or more employee equivalents, as defined by COBRA
- Allows for a continuation of health insurance coverage at the covered person's expense
- 36 months for spouse/family due to death or divorce (or legal separation) of employee
- 29 months (in some situations) if Social Security disability applies
- 18 months for separation of service–additional time may be available to spouse and/or dependents

> "When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the employee's spouse and dependents can last until 36 months after the date the employee becomes entitled to Medicare.
>
> For example, if a covered employee becomes entitled to Medicare 8 months before the date his/her employment ends (termination of employment is the COBRA qualifying event), COBRA coverage for his/her spouse and children would last 28 months (36 months minus 8 months)," according to the Department of Labor.

- Employer or administrator may collect 102% of the cost of coverage
- Employer has 30 days to notify COBRA administrator of any terminations

COBRA FAQ can be found at:
FAQs on COBRA Continuation Health Coverage for Employers and Advisers (dol.gov)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a broad federal law passed in the 1990s that addresses certain health insurance issues, including the guaranteed issue of certain health coverage plans, preexisting condition issues, Certificates of Creditable Coverage, and others. It also mandated numerous new rules specific to the medical care community. Most of the laws relating to health insurance have been replaced by the ACA.

There is still one key area of HIPAA that is a major concern for health insurance agents and companies–**PRIVACY**

- The law is very specific that anyone who has or obtains Private Health Information (PHI) needs to protect the access to and release of such data; this can include medical history and information obtained during the application process with the following: life insurance, health insurance, disability insurance, and long-term care insurance

- Agents, insurance companies, MGAs, and others must make sure that safeguards are in place to protect the information from unauthorized individuals

- Employers need to discuss the issue with their employees so they understand the potential dangers to themselves and the employer should there be a breach

- An insured's medical data on an application of insurance (health history, medications, alcohol, and drug usage, etc.) is PHI and is NEVER to be discussed or released to unauthorized individuals; the following site can offer helpful information: ▷ HIPAA Compliance: Regulations, Standards, Certification, Training for 2023 (hipaa-101.com)

Creditable Coverage

A Certificate of Creditable Coverage was necessary before the ACA was implemented. This allowed a covered person (and those covered under the plan, such as the spouse and dependents) to move from one plan or coverage to another without preexisting condition restrictions. Because preexisting condition limitations on health insurance plans were not permitted after the start of the 2014 plan year, **Certificates of Creditable Coverage are no longer necessary.** However, entities whose policies include prescription drug coverage must notify Medicare eligible active working individuals and their spouses and dependents, Medicare eligible COBRA individuals and their spouses and dependents, Medicare eligible disabled individuals, and any retirees and their spouses and dependents a Certificate of Credible Coverage for Medicare Part D (to be covered later in the presentation).

Mental Health Parity Act of 1996 (MHPA)

The MHPA provides coverage for either mental health or substance use disorders and medical/surgical benefits; it generally applies to group health plans and health insurance issuers.

- Requires mental illness benefits to be provided under the same terms and conditions as other medical conditions IF mental illness benefits are part of the current plan (and the group has 51 or more employees)
- Must provide equal lifetime and annual maximums
- Cannot impose dollar limits on hospital stays but can impose day limits
- Excludes substance abuse and chemical dependency for equal maximums

Note:
The ACA has overridden numerous provisions noted above in HIPAA and MHPA

Family and Medical Leave Act of 1993 (FMLA)

Under the FMLA, covered employers (generally groups with 50 or more employees within 75 miles) must grant an eligible employee up to a total of 12 work weeks of **unpaid** leave during any 12-month period for one or more job-protected leave for qualifying family and medical reasons. Employees are eligible for FMLA leave if they work for a covered employer for at least 12 months and have at least 1,250 hours of service with the employer during the 12 months before the FMLA leave begins. Qualifying family and medical reasons include:

- For the birth and care of a newborn child of the employee;
- For placement with the employee of a child for adoption or foster care;
- To care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- To take medical leave when the employee is unable to work because of a serious health condition.

The military family leave provisions of the FMLA entitle eligible employees of covered employers to take FMLA leave for any:

- "Qualifying exigency" arising from the foreign deployment of the employee's spouse, son, daughter, or parent with the Armed Forces; or
- To care for a servicemember with a serious injury or illness if the employee is the service member's spouse, son, daughter, parent, or next of kin.

Employee Retirement Income Security Act of 1974 (ERISA)

ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans offered by private sector employers to provide protection for individuals in these plans. The following provisions are required:

- Participants must be provided with plan information, including important information about plan features and funding
- Fiduciary responsibilities for those who manage and control plan assets are outlined
- Plans for a participant grievance and appeals process must be established
- Participants have the right to sue for benefits and breaches of fiduciary duty
- Does not apply to governmental entities or churches

Newborns and Mothers Health Protection Act of 1996 (NMHPA)

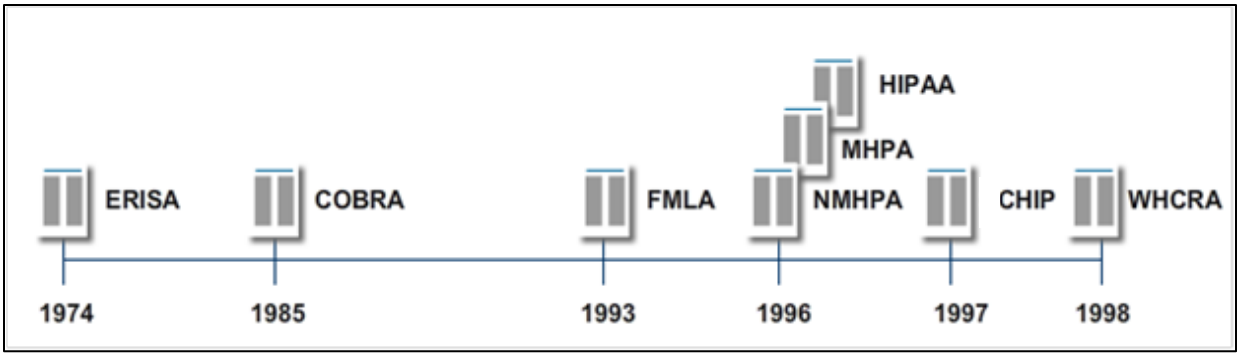
The NMHPA provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth:

- Mandates health benefits for post-childbirth hospital stays
- No less than 48 hours for both mother and child
- Up to 96 hours for cesarean section birth
- Can be adjusted based on circumstances

Women's Health Cancer Rights Act of 1998 (WHCRA)

This act provides protections for individuals who elect breast reconstruction after a mastectomy:

- Mandates coverage for mastectomy patients
- Requires coverage for reconstruction of breast
- Requires coverage for other breast for symmetrical appearance
- Coverage for prostheses, if necessary



Medicare and Medicaid

Learning Objective: 5

Apply knowledge of Medicare, Medicare supplements, and Medicaid to determine the best product to meet client needs.

Medicare

DISCLAIMER

The following information covers the basic rules, regulations, eligibility, and coverage available under Medicare plans. This material is intended as a general information guideline and is not intended as legal advice. This material is not intended to market any of the plans within this section.

Medicare has strict rules regarding the marketing of Medicare health plans. For a complete overview of Medicare's marketing guidelines, please visit: https://tinyurl.com/pd247wj

Purpose

- Enacted in 1965 to provide insurance for medical, surgical, and related services to eligible participants

- For coverage to apply, costs must be ***reasonable and necessary*** and approved by Medicare

Eligibility

1. Persons aged 65 and older:

    - Automatically entitled if one already gets benefits from Social Security
    - Voluntarily, if NOT eligible for Social Security; must pay a monthly premium

2. Persons of any age who:

    - Have received Social Security disability for 24 months, or
    - Have end-stage renal disease or Amyotrophic Lateral Sclerosis (ALS)

Initial Enrollment Period

- A seven-month enrollment period that begins three months before one's 65th birthday, includes one's birth month, and ends three months later. If you miss your seven-month initial Enrollment Period, you may have to wait to sign up and pay a monthly late enrollment penalty for as long as you have Medicare Part B coverage. The penalty increases the longer you wait. The date Medicare coverage starts depends on the month you sign up during the initial Enrollment Period. Coverage always starts on the first of the month. If you sign up before the month you turn 65, or during the three months after, coverage starts the next month.

Coverage Trigger

- Medically necessary and showing signs of improvement

Medicare Coverage Parts

- Part A – Hospital Insurance
- Part B – Medical Insurance
- Part C – Medicare Advantage
- Part D – Prescription Drug Benefit

Medicare Benefits (2024)

Part A – Hospital insurance
Premium-free Part A for eligible beneficiaries. Premium-Part A if not an eligible beneficiary is $505 a month (2024).

1. **Inpatient Hospital Care**

   In 2024, after a $1,632 deductible, Medicare pays all "reasonable and approved expenses" of a hospital stay for the first 60 days of each benefit period. A ***benefit period*** begins the day one is admitted as an inpatient to a hospital or skilled nursing facility. The benefit period ends when one has not received any inpatient care for 60 days in a row. A new admission as an inpatient begins a new benefit period. There is no limit to the number of benefit periods.

   The following applies per benefit period (2024):

   - Days 1–60 insured pays $0 coinsurance
   - Days 61–90, $408 daily copayment paid by the insured
   - Day 91 and beyond, daily copay of $816 for each *lifetime reserve day* (lifetime reserve days are additional days that Medicare will pay beyond 90 days, with a maximum of 60 reserve days per lifetime)

     The patient is financially responsible for all in-patient medical costs.

2. **Skilled Nursing Facility (SNF) Care**

   To qualify, one must satisfy a three-day inpatient hospital stay requirement. In-hospital observation days do not count as inpatient days. One must then enter a Medicare-approved SNF facility within 30 days of being discharged from the hospital.

   - Medicare pays 100% of approved charges for days 1–20 in a benefit period
   - Days 21–100, the patient pays $204 per day in a benefit period as a copayment (2024)
   - Days 101 and beyond are the patient's responsibility

Part B – Medical Insurance

1. **What Part B costs**

   Part B is optional. The standard Part B monthly premium amount in 2024 is $174.70. Premiums for high-income beneficiaries may be higher depending on tax-filing status and modified adjusted gross income. The maximum income-related monthly adjusted Medicare Part B premium is $594.00 (2024). Persons who fail to qualify for Part A can still receive Part B benefits.

2. **Part B covers:**

   - Medical expenses (doctor's services)
   - Home health care
   - Outpatient care

Part C – Advantage plans

Provide all your Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) coverage. Additional benefits such as vision, hearing, dental, and health and wellness programs are generally offered. Most include Medicare Part D prescription drug coverage. The cost varies by plan.

Part D – Prescription drug benefit

1. The Medicare Prescription Drug, Improvement, and Modernization Act was passed on December 8, 2003. Also known as the Medicare Modernization Act, it established a *voluntary drug benefit* for Medicare beneficiaries and created Medicare Part D.

2. Medicare Part D plans are government-sponsored insurance policies issued by commercial insurance companies designed to help protect Medicare beneficiaries against the ever-rising cost of prescription drugs. Anyone with Medicare Part A or Part B can purchase a prescription drug benefit plan through private insurance companies as of January 1, 2006.

3. The premium will vary by the prescription drug plan purchased and the beneficiaries' tax filing status and modified adjusted gross income. Your Medicare premiums for a given year are calculated using your tax return from two years prior. For example, your 2024 Part D premiums are based on your 2022 tax return. The 2024 Part D income-related monthly adjusted premiums range from $0.00 to $81.00.

4. Part D – Prescription drug coverage description (2024)

- **Beneficiary pays a monthly plan premium** – generally, $32.74 per month, but higher premiums (surcharges) will apply if income exceeds certain limits, as shown in the table. The average monthly premium for Medicare Part D in 2024 is $55.50. A surcharge applies to Medicare Part D monthly premiums for high-income earners ranging from $12.90 to $81.00.

The Four Phases/Stages of Medicare Part D Plans

- **Annual deductible** – beneficiary pays the first $545 (2024) of plan-covered drugs.

- **Initial coverage period** – begins after beneficiary satisfies the $545 (2024) annual deductible. The beneficiary is required to pay either a flat copayment amount or coinsurance of up to 25% of the actual retail costs of the prescription drugs covered by the plan. The Part D plan pays 75% of the costs. When the sum of both member and plan costs reaches $5,030 (2024), the member moves into the coverage gap. The amount of time it takes a member to exhaust this limit will vary widely based on the cost of their particular medications.

- **Coverage gap** (aka the "donut hole") – begins once the initial coverage period ends. Once you reach the coverage gap, you'll pay 25% of the cost for your plan's covered prescription drugs The Plan D plan will pay 5%, and the drug manufacturers will provide a discount of 70%. Once the true out-of-pocket costs plus what the Part D plan pays and the discount from the manufacturers equals $8,000 (2024), you'll move to the Catastrophic Phase. The beneficiary pays only 37% of the plan's cost for covered generic/25% for brand name while in the coverage gap due to the plan discount for covered drugs.

- **Catastrophic benefit period** – once the $8,000 (2024) out-of-pocket has been reached in the coverage gap, the catastrophic benefit period begins. Starting in 2024, Medicare Part D beneficiaries will pay $0 for covered Part D drugs during the Catastrophic Coverage stage. The Part D plans will pay 20% and Medicare will pay 80%.

Note:
The deductibles, gap coverage, surcharges, and discounts are extremely complex. A Medicare Part D beneficiary needs to consult a knowledgeable, certified agent for assistance. These numbers reflect the 2024 limits.

Medicare Supplement (Medigap)

A Medigap policy helps pay some of the health care costs that Original Medicare (Part A and Part B) doesn't cover, like:

1. Copayments
2. Coinsurance
3. Deductibles

Some Medigap policies also cover services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, here's what happens:

- Medicare pays its share of the Medicare-approved amount for covered health care costs; then your Medigap policy pays its share
- A Medigap policy is different from a Medicare Advantage Plan, which is a way to get all Medicare benefits; a Medigap policy only supplements your Original Medicare benefits
- In some situations, an insurance company cannot deny Medigap coverage because of guaranteed issue rights

Excerpt from the ***2020 Social Security and Medicare Facts*** book from the National Underwriter Company:

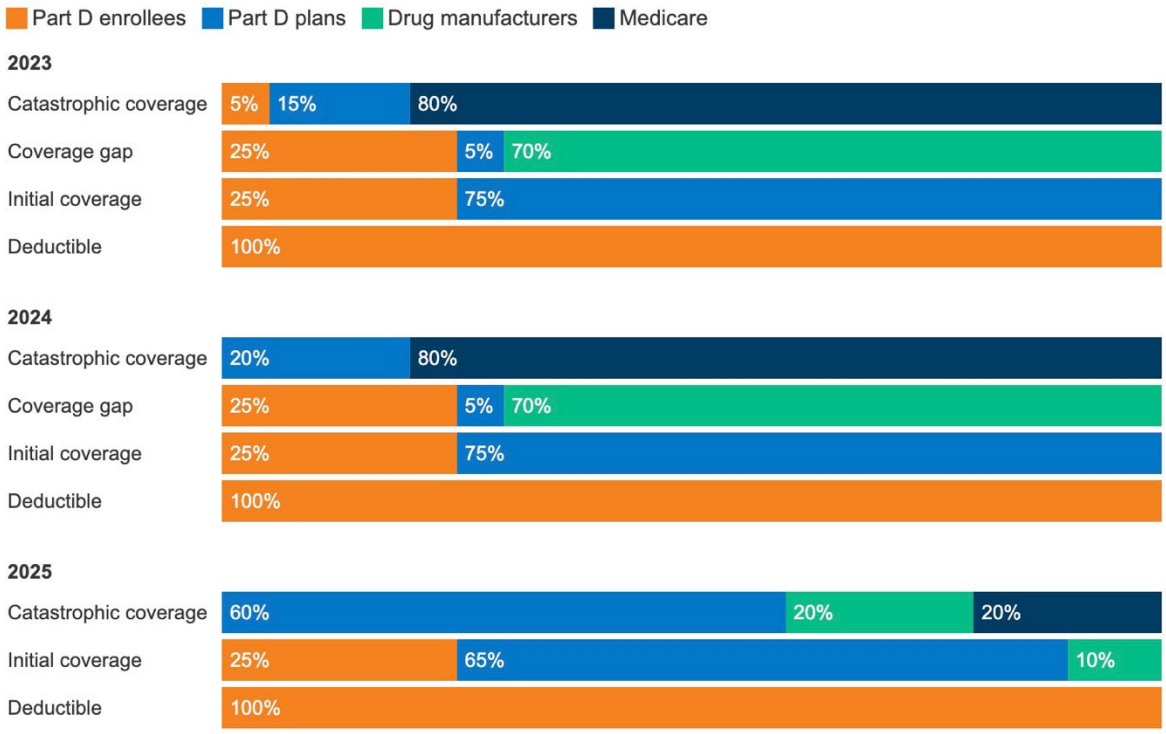
1202. Is Medicare Supplement Plan F being Eliminated?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), passed by Congress and signed into law on April 16, 2015, changed the law on various aspects of health care, including some Medicare Supplement plans. The new law states that on or after January 1, 2020, a Medicare Supplement policy that provides coverage of the Part B deductible may not be sold or issued to a newly eligible Medicare beneficiary. Anyone whose birthday is December 31, 1954 (turning sixty-five on December 31, 2019) may be the last group able to enroll in Medicare Supplement Plan F. **After January 1, 2020, individuals will not be able to enroll in Medicare Supplement Plan C, one of the closest alternatives to Plan F, either, since it also covers the Part B deductible**. Those who already have Plan F can keep it. The law only affects new enrollees.

Figure 4

The Share of Medicare Part D Drug Costs Paid by Enrollees, Plans, Drug Manufacturers, and Medicare Will Change in 2024 and 2025

Share of total drug costs paid by:



NOTE: The manufacturer discount applies to brand-name drug costs only. For generic drug costs, plans pay 75% in the coverage gap phase in 2023 and 2024, and 75% in the initial coverage phase in 2025, and Medicare will pay 40% in the catastrophic coverage phase in 2025.
SOURCE: KFF, based on Medicare Part D benefit design changes in the Inflation Reduction Act. • PNG

KFF

The chart below shows basic information about the different benefits Medigap policies cover.

Benefits Offered by Each Medigap Plan										
Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No

Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	$7,060 (2024)	$3,530 (2024)	N/A	N/A

* Plans F and G also offer high-deductible plans. If you choose this option, you must pay for Medicare-covered costs up to the deductible amount of $2,800 in 2024 before your Medigap plan pays anything.
** For plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.
***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to $50 for emergency room visits that don't result in inpatient admission.

Note:
If you live in Massachusetts, Minnesota, or Wisconsin, Medigap policies are standardized differently.
https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies

Medicare Advantage Plan

Medicare Advantage Plans are not always available in every location.

1. **Preferred Provider Organization (PPO) plans**

   - A Medicare PPO Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company; in a PPO plan, you pay less if you use doctors, hospitals, and other healthcare providers that belong to the plan's network, and you pay more if you use doctors, hospitals and providers outside of the network
   - A PPO plan isn't the same as Original Medicare or a Medicare Supplement Insurance (Medigap) policy
   - PPO plans usually offer more benefits than Original Medicare, but you may have to pay extra for these benefits

2. **Health Maintenance Organization (HMO) plans**

   - In HMO plans, you generally must get your care and services from doctors, other healthcare providers, and hospitals in your plan's network; you may also need to get a referral from your primary care doctor to see other providers
   - If your doctor or other health care provider leaves the plan, your plan will notify you; you can then choose another doctor in the plan
   - If you get health care outside the plan's network, you may have to pay the full cost
   - Insureds must follow the plan's rules, like getting prior approval for certain services

Private Fee-For-Service (PFFS) plans

1. A PFFS plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company; PFFS plans aren't the same as Original Medicare or Medigap.

2. The plan determines how much it will pay doctors, other health care providers, and hospitals and copayments or coinsurance you must pay when you get care; Original Medicare won't pay for your health care while you're in the Medicare PFFS Plan.

3. Some PFFS plans contract with a network of providers who agree to always treat you even if you've never seen them before.

4. Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before (a provider can choose at every visit whether to accept your plan's terms and conditions of payment).

5. For **each service** you get, you need to make sure the doctors, hospitals, and other providers agree to treat you under the plan and accept the plan's payment terms.

6. In an emergency, doctors, hospitals, and other providers must treat you.

Qualifying events that allow a change from Medicare Advantage to Original Medicare

1. Anyone enrolling in an Advantage plan has a 12-month trial period

2. Moving to an area that has no network

3. Your network becomes insolvent
    - **Networks** – Most MAs have either an HMO or PPO.
    - **Precertification** – Not all procedures have to be pre-certified, but many procedures do. For example, an MA plan may say you would need physical rehabilitation before approving and Doctor recommended hip replacement.
    - **Switching** – After 12 months, if one decides to leave the MA plan and purchase a Medicare Supplement, that Carrier will underwrite that applicant.

Medicaid

Medicaid (Medi-Cal in California) provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. States administer Medicaid according to federal requirements. The program is funded jointly by states and the federal government.

Qualifications for Medicaid

State Application Form

Limits of assets and income vary by state, but there are two tests that must be passed

1. Income rules test:
    - What is and is not income under Medicaid's rules?
    - How is Social Security income viewed under Medicaid?
2. Level of care eligibility test:
    - Assisted living
    - Nursing home

Rules for Singles and Married Couples

1. Income/assets

2. "Spend down"

3. "Community spouse resource allowance"

4. "Institutionalized spouse"

Deficit Reduction Act of 2005, effective February 8, 2006

1. Look-back period for all transfers is 60 months

   - Begins at time of application
   - If penalized for a violation of the transfer of assets rule, the qualification time frame begins at the date of application, not the date of violation

2. The penalty period created by a transfer will not begin until the transferor:

   - Has moved to a nursing home,
   - Has spent down to the asset limit for Medicaid eligibility,
   - Has applied for Medicaid coverage, **and**
   - Has been approved for coverage, but for the transfer

Permitted Asset Transfers

1. Your spouse (but this may not help you become eligible since the same asset limit on both spouses' assets will apply)

2. Your child who is blind or permanently disabled or into a trust for the sole benefit of anyone under age 65 and permanently disabled

3. In addition, you may transfer your home to those listed above, as well as to the following individuals:

    - Your child who is under age 21 (unusual for nursing home residents)

    - Your child who has lived in your home for at least two years prior to your moving to a nursing home and who provided you with care that allowed you to stay at home during that time (often referred to as the "caretaker child")

    - A sibling who already has an equity interest in the house and who lived there for at least a year before you moved to a nursing home

Mandatory Benefits

Mandatory Medicaid Benefits				
Facilities	Inpatient hospital services	Outpatient hospital services	Nursing facility services, including skilled nursing, rehabilitation, and long-term care	
Services	Home health services	Physician services	Certified pediatric and family nurse practitioner services	Transportation to medical care
Clinics	Rural health clinic services	Federally qualified health center services		
Diagnostic	Laboratory and X-ray services	Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) for children		
Pregnancy	Nurse-midwife services	Family planning	Freestanding birth center services (when licensed or otherwise recognized by the state)	Tobacco cessation counseling for pregnant women

Optional Benefits

Optional Medicaid Benefits			
Facilities	**Services**	**Other**	**Therapy**
Services for individuals age 65 or older in an Institution for Mental Disease (IMD)	Clinic, optometry, and dental services	Prescription drugs	Physical therapy
Services in an intermediate care facility for individuals with intellectual disability	Chiropractic, respiratory care, and podiatry services	Dentures, prosthetics, and eyeglasses	Occupation therapy
Inpatient psychiatric services for individuals under age 21	Private duty nursing, personal care, hospice, case management, and TB-related services	State plan home and community-based services – 1915(i) and Community First Choice Option 1915(k)	Speech, hearing, and language disorder services
Health homes for enrollees with chronic conditions – Section 1945	Other diagnostic, screening, preventative, and rehabilitative services	Other services approved by the Secretary of HHS	

Knowledge Check

The prospect is turning sixty-five in three months and is receiving a lot of mail regarding Medigap.

He wants to know if Medigap is mandatory and the difference between the AARP Plan G and the Blue Cross Blue Shield Plan G.

Essentials of Long-Term Care Insurance (LTCI)

Learning Objective 6:
Use understanding of long-term care insurance to evaluate client needs and provide appropriate counsel in contract selection.

Life Expectancy Trends

Much longer life expectancy than our great-grandparents

Quality of life at older ages is a real question mark!

Family dynamics:

- Smaller families with fewer siblings to care for parents
- Families spread out geographically across the country or even the world

Individuals in the workforce and unable to care for a family member

Baby boomers coming of age into long-term care needs

U.S. Life Expectancy

Year	Male	Female
1900	48	51
1920	56	58
1940	63	67
1960	68	74
1980	71	78
2000	75	80
2040	84	87
* Age rounded to nearest whole number		

Reasons for LTCI

1. Preserve independence

2. Guarantee choice of care and caregivers (allowing one to stay at home as long as possible)

3. Protect assets and standard of living

4. Avoid being a burden on family

5. Leave more assets to family, church, school, or worthy cause

6. Peace of mind

Genworth Cost of Care Survey 2023

Genworth Cost of Care Survey 2023 | Summary

HOME

Homemaker Services: Services providing help with household tasks that cannot be managed alone. Homemaker services includes "hands-off" care such as cooking, cleaning and running errands.

NATIONAL MEDIAN HOURLY RATE 2023	NATIONAL MEDIAN HOURLY RATE 2022	YEAR-OVER-YEAR PERCENT CHANGE
$30	$28	7.14%

Home Health Aide Services: Home health aides offer services to people who need more extensive care. It is "hands-on" personal care, but not medical care. The rate listed here is the rate charged by a non-Medicare certified, licensed agency.

NATIONAL MEDIAN HOURLY RATE 2023	NATIONAL MEDIAN HOURLY RATE 2022	YEAR-OVER-YEAR PERCENT CHANGE
$33	$30	10%

COMMUNITY

Adult Day Health Care (ADC): Provides social and support services in a community-based, protective setting. Various models are designed to offer socialization, supervision and structured activities. Some programs may provide personal care, transportation, medication management and meals.

NATIONAL MEDIAN DAILY RATE 2023	NATIONAL MEDIAN DAILY RATE 2022	YEAR-OVER-YEAR PERCENT CHANGE
$95	$90	5.56%

FACILITY

Assisted Living Facility (ALF): Residential arrangements providing personal care and health services. The level of care may not be as extensive as that of a nursing home. Assisted living is often an alternative to a nursing home, or an intermediate level of long term care.

NATIONAL MEDIAN MONTHLY RATE 2023	NATIONAL MEDIAN MONTHLY RATE 2022	YEAR-OVER-YEAR PERCENT CHANGE
$5,350	$5,278	1.36%

Nursing Home Care: These facilities often provide a higher level of supervision and care than Assisted Living Facilities. They offer residents personal care assistance, room and board, supervision, medication, therapies and rehabilitation, and on-site nursing care 24 hours a day.

Semi-Private Room

NATIONAL MEDIAN DAILY RATE 2023	NATIONAL MEDIAN DAILY RATE 2022	YEAR-OVER-YEAR PERCENT CHANGE
$285	$273	4.40%

Private Room

NATIONAL MEDIAN DAILY RATE 2023	NATIONAL MEDIAN DAILY RATE 2022	YEAR-OVER-YEAR PERCENT CHANGE
$320	$305	4.92%

Source: https://pro.genworth.com/riiproweb/productinfo/pdf/131168.pdf

Out-of-Pocket

These family-funded sources include cash, savings, retirement plans, reverse mortgages, senior life settlements, etc.

The Government

1. **Veterans Administration (VA)**

   Veterans of foreign wars may be eligible for in-home care or nursing home benefits provided by subsidized VA programs. The Department of Veterans Affairs handles such inquiries.

2. **Medicare**

   - Website: http://www.medicare.gov/

   - Medicare primarily provides short-term and rehab care

   - Medicare does have long-term care coverage, BUT it provides coverage only if several requirements are met:

     – A consecutive three-day hospital stay must precede entry into a skilled nursing facility and for the same medical condition

     – Care needed by the patient must be skilled nursing

     – Facility must be certified by Medicare

     – Physician must certify the need

     – Patient's condition must be improving

- Medicare's response to LTC need
  - Medicare nursing home requirement rules
  - Medicare at-home requirement rules
  - Various degrees of therapy are provided
  - Certain necessary equipment

- There is a sliding scale of coverage payments from Medicare that will likely result in significant monetary outlay by the patient; in addition to copayments, Medicare *only provides 100 days of coverage per admission:* it is NOT long-term coverage
  - First 20 days in a facility – Medicare pays in full
  - Days 21–100 – Patient pays $204 (2024) per day as a copayment
  - Days 101 and beyond – Medicare pays nothing

- Medicare Supplement Insurance – fills in the coverage "gaps" from Medicare (Part A or B)

3. **Medicaid**

- Certainly, the method of last resort, but it does pay for LTC services for those at or below poverty level

- Anyone who still has assets and applies for Medicaid will be required to divest many of those assets to their state's Medicaid program

- Amount of assets and income that one can keep when applying for Medicaid is minimal and varies by state

Benefits Provided by LTCI

In-Home Coverage

- Home health care – medically necessary skilled care performed by trained medical personnel
- Home care – more custodial in nature

Assisted Living Facility/Group Home

- Coverage form and benefits can vary significantly among insurance companies

Nursing Home Coverage

- Skilled care – requires trained medical personnel authorized by a physician
- Intermediate care – similar to skilled care but on a less frequent basis

Adult Day Care Coverage

- Not usually every day, but sufficient to give regular caregiver a break and to give the patient welcome interaction outside the home

Hospice Care

- Not location-specific but pays benefits for symptom control for terminally ill patients

Types of LTCI Policies

Most long-term care insurance policies today are "**reimbursement**" type contracts where benefits are paid only for expenses incurred, up to a predetermined amount. "**Indemnity**" contracts typically pay the entire predetermined daily or monthly benefit amount.

Comprehensive: provides for nursing home facilities, assisted living facilities, home health care, adult day care, respite care, and care coordination

Nursing home only: may include assisted living facilities

Home care only: may include adult daycare

Note:
Not all carriers offer all three. In the last few years, the marketing trend has been for companies to offer a Comprehensive policy only.

LTCI Policy Provisions and Coverage Options (Riders)

Learning Objective 7:

Use knowledge of policy provisions, benefit triggers, qualified and non-qualified contracts, state-endorsed programs, and medical underwriting issues to determine the possibilities for payout in given scenarios.

Bed Reservation

A policy provision that provides 30 to 50 days of annual coverage for daily room expense in an assisted living facility or nursing home should the covered person require a stay at a hospital. This ensures the facility will not rent the room to someone else should a medical emergency arise.

Daily/Weekly/Monthly Benefit Amount

Most contracts are issued as a *daily benefit*. This type of policy would pay covered expenses but no more than a daily maximum limit. A broader contract would be one issued as a weekly benefit or even a monthly benefit (many carriers accomplished this via a rider). The extra premium for a broader contract is usually no more than 7% to 12% annually.

Reimbursement vs. Indemnity

Most contracts are sold as *reimbursement*. These policies pay the lesser of the covered expense, not to exceed the daily (or weekly/monthly) benefit purchased. An indemnity contract pays the daily (or weekly/monthly) benefit purchased regardless of actual claims expense. The *claim trigger* number of ADLs (activities of daily living) and *elimination period* would have to be satisfied.

Guaranteed Benefit Increase (Inflation Rider)

A rider which increases the daily (or weekly/monthly) benefit on a systematic basis (usually annually). Available on either a simple or compounded basis.

Joint Waiver of Premium Rider

Also referred to as a *dual waiver of premium,* this rider is available only when coverage has been purchased by a couple (married or partner). A standard policy provision with some carriers, this rider waives the premium on both contracts when one spouse or partner satisfies the ADL coverage trigger and the elimination period and begins collecting benefits.

Policy Sharing Benefit

This is a benefit added via a rider. It is only available when contracts have been purchased by a couple (married or partner) ***and*** has a benefit period that is *less* than lifetime. Allows you to access up to half of your spouse or partner's benefits when your own policy benefits have been exhausted.

Elimination Period

The time frame the insured must wait before collecting benefits from the contract. This is represented in the number of days after the ADLs (or severe cognitive impairment) are satisfied. The longer the elimination period, the lower the premium.

Benefit Period

The number of years the benefit is payable once the claim trigger and elimination period are met. Years such as 2, 3, 5, and 10 are the usual options available.

Premium Discounts and Options

Carriers offer a wide variety of premium discounts. Some carriers make them available only for contracts covering both a husband and wife. Others make them available for partners with a common address. Some carriers will have a paid-up policy, such as a 10-pay or age 65.

Coverage Outside the United States

Many carriers allow some restricted coverage outside the United States or Canada. Carriers that provide coverage usually do so by limiting the maximum payout to a percentage of the daily benefit–such as 75%–and then further limiting the coverage to a maximum number of years–such as five or six.

Caregiver Training and Respite Care Service

Many carriers provide some benefit for caregiver training. This would be training a family member wishing to be the caregiver. Also, a benefit is usually available for another person to relieve the primary caregiver so they may have some time off. This is called respite care service.

Compensation for Family Member as the Caregiver

This is available through some carriers but generally only as a rider.

Nonforfeiture Benefit

This benefit is different than the nonforfeiture benefit in whole life. A standard policy provision with some carriers (but a rider with most) that allows coverage to continue in force for some period of time or may allow a reduced paid-up contract should the premiums be terminated by the insured.

Benefit Triggers in a Qualified LTCI Policy

Six Activities of Daily Living

Benefits are triggered by the inability to perform any **two** of these ADLs:

1. Eating: Feeding yourself by getting food into your body from a receptacle such as a plate, cup, or table, or from a feeding tube or intravenously

2. Dressing: Putting on and taking off all items of clothing and necessary braces, fasteners, or artificial limbs

3. Bathing: Washing yourself by sponge bath or in either a tub or shower, including the task of getting in or out of the tub or shower

4. Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene

5. Transferring: Moving into or out of a bed, chair, or wheelchair

6. Maintaining continence: Ability to maintain control of bowel or bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag

OR

Severe Cognitive Impairment

"Severe cognitive impairment" means a loss or deterioration in intellectual capacity that is: (1) comparable to Alzheimer's disease and similar forms of irreversible dementia and (2) determined by clinical evidence and standardized tests that reliably measure impairment in the individual's (1) short-term or long-term memory; (2) orientation to people, places, or time; and (3) deductive or abstract reasoning

State-Endorsed LTCI Partnership Programs

- Most states are instituting Long-Term Care Insurance Partnership Programs, which are designed to mitigate significant drains on Medicaid funds in the individual states

- Insurance companies agree to participate by offering LTCI policies that meet state and federal requirements

- Policyholders who own these contracts could be entitled to *asset disregard*, meaning the amount of a policyholder's assets equal to the amount of insurance benefits received under the qualified partnership policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid

- Asset disregard encourages people to purchase long-term care coverage, which could minimize the number of applicants who would otherwise apply for Medicaid to fund their long-term care

- See the HHS LTCI website at https://longtermcare.gov for state-specific information

Factors Affecting Cost

The cost of a long-term care policy depends on the following factors:

1. Health
2. Age–the average purchaser's age is 59
3. Marital status
4. Benefits chosen
5. Eligible discounts

Medical Underwriting Issues

Questions on a typical application that are answered "yes" will most often preclude the issuance of a policy to the applicant. Certainly, this depends on an individual company's policy, but the following are examples of conditions or situations that tend to be deal breakers.

Does the applicant currently have, or have they ever been diagnosed with:

- Alzheimer's
- ALS
- Dementia
- Huntington's chorea
- Memory loss
- Multiple sclerosis
- Parkinson's disease

Does the applicant require assistance in any of the ADLs?

Does the applicant require any assistance in walking, such as using a cane, walker, wheelchair, or other device?

Tax Legislation

Individual Purchase

Tax-qualified LTCI premiums are considered a medical expense. For an individual who itemizes tax deductions, medical expenses are deductible to the extent that they exceed 7.5% of the taxpayer's adjusted gross income (AGI). The amount of the LTCI premium treated as a medical expense is limited to the eligible LTCI premium, as defined by IRC 213(d). Any portion of the LTCI premium that exceeds the eligible LTCI premium is not a deductible medical expense.

Individual taxpayers can treat premiums paid for tax-qualified long-term care insurance for themselves, their spouse, or any tax dependents (such as parents) as a personal medical expense.

The yearly maximum deductible amount for each individual depends on the insured's attained age at the close of the taxable year (see **Table 1** for current limits). These deductible maximums are indexed and increase each year for inflation.

2024 Long-Term Care Insurance Federal Tax-Deductible Limits (Table 1)

Taxpayer's Age at End of Tax Year – Deductible Limit	
40 or less	$ 470
More than 40 but not more than 50	$ 880
More than 50 but not more than 60	$1,760
More than 60 but not more than 70	$4,710
More than 70	$5,880

Self-Employed

Self-employed individuals can deduct 100% of their out-of-pocket LTCI premiums up to the eligible premium amounts listed in Table 1. The portion of LTCI premiums that exceeds the eligible premium amount is not deductible as a medical expense. The deductible amount includes eligible premiums paid for spouses and dependents per IRC 162(l). It is not necessary to meet Adjusted Gross Income (AGI) thresholds to take this deduction.

However, self-employed individuals may not deduct LTCI premiums during any calendar month in which they or their spouse are eligible to participate in a subsidized LTCI plan (where the employer pays all or part of the premiums for LTCI).

Partnerships, LLCs, and Subchapter S Corporations

Partners in a partnership, members of a Limited Liability Company (LLC) taxed as a partnership, and shareholders/employees of Subchapter S corporations who own more than 2% of the corporation are taxed as self-employed individuals. The partnership, LLC, or Subchapter S corporation pays the premium.

The partner, member, or shareholder/employee includes the LTCI premium in their adjusted gross income but may deduct up to 100% of the age-based eligible premium, as listed in Table 1. It is not necessary to meet an AGI threshold.

C Corporations

When a business purchases a tax-qualified LTCI policy on behalf of any of its employees or their spouses and dependents, the C corporation is entitled to take a 100% deduction as a business expense on the total premiums paid. The deduction is not limited to the aged-based eligible premiums.

The purchase of a tax-qualified LTCI policy is not subject to any nondiscrimination rules, allowing an employer to be selective in classifying employees it elects to cover.

The premium paid by the business is excluded from the employee's AGI (not reported) even if the premium exceeds the eligible premium amount listed in Table 1.

Employer-Pay Contributory Arrangement on Behalf of an Employee

If an employer pays all or a portion of a tax-qualified LTCI premium on behalf of an employee, the amount paid is deductible by the employer as a business expense. The age-based limits do not limit the deduction. The entire employer contribution is also excluded from the employee's AGI.

If the employer only pays a portion of the premium, employees are able to apply the balance that they pay towards their medical expenses up to the eligible premium amount and are entitled to a deduction for medical expenses that exceed 7.5% of AGI in 2023.

Learning Objective 8:
Use knowledge of other products available to insure long-term care needs to determine the best products to meet a particular client's needs.

Life Insurance Policy With an LTC Rider

- Normally allows the insured to receive an advance on the death benefit
- Inflation adjustment riders may be available
- Some contracts include automatic waiver of premium triggered by insured qualifying for LTC benefits
- Long-term care benefit periods may range from a few years to a lifetime

Additional Insurance Products for Funding Long-Term Needs

Linked Benefit Life Insurance

- A linked-benefit life insurance policy provides assets, combining life insurance with LTC benefits; if the insured needs long-term care, the policy helps pay those expenses; if the insured does not need LTC, the policy provides a death benefit (almost always free of income tax)
- Most are written on a single-premium basis (can be flexible premium), which leverages the premium into a higher benefit, e.g., a $50,000 single premium purchases $125,000 of benefit that can be used for LTC or passed to heirs at death (if no LTC benefit is used, the full amount is passed on to heirs; if LTC benefit is used, unused amount is passed to heirs)
- Optional riders may increase LTC benefits
- Some companies also offer second-to-die (survivorship) life policies that provide insureds with both LTC benefits and a death benefit on the unused amount

Long-Term Care Summary Proposal for

Jon Hill (2/3/1960) & Sara Hill (3/10/1955)

Purpose: To provide Long-Term Care if needed and a death benefit if not needed.

Company: OneAmerican/State Life

Product: Asset Care (Whole Life with LTC Rider)

Death: $166.667 at second death

Benefit Period: 33 Months

LTC Benefit: $5,000/Monthly

Total Benefit Period: Lifetime for both

Elimination Period: 90 Days in Facility/0 Days at Home

Premium:	Annual for Life	Annual for 20 Years	Single Premium
Base Policy	$8,683.35	$9,763.35	$118,205
Add COB (continuation of benefits)	$10,150	$18,168	$138,704
Add Inflation Rider 3% Lifetime	$18,450	$24,757	$164,765

Linked Benefit Annuity

- A linked benefit annuity works much the same way as a linked benefit life insurance policy and might be a choice if the applicant cannot qualify for life insurance

- Most are written on a single-deposit basis with a percentage of the annuity's value available for LTC; if the annuitant does not need LTC, any taxable death benefit passes to the named beneficiary

Short-Term Care Insurance Products

Some companies are offering this product as a pre-long-term care benefit. It generally provides 100 to 360 days of benefits, has a limited benefit amount of up to $300 per day, short elimination periods, such as 0, 15, 30, or 60 days, and minimal underwriting requirements. It is NOT, however, approved for sale in all 50 states.

Long-Term Care Funding Options		
Client's Top Priority	**Solution**	**Considerations**
Protecting assets from an extended healthcare event	Traditional LTCI	PRO: Maximizes LTC leverage while minimizing premium commitment. Potentially tax deductible for businesses. CON: Premiums not guaranteed, lack of flexibility
Protecting assets from an extended healthcare event while retaining maximum flexibility	Asset-Based LTCI	PRO: Maximized flexibility while still retaining the primary objective of providing for an LTC event. Provides Return of Premium Death benefit, and LTCI. Guaranteed level premiums. CON: Reduced death benefit compared to Life with rider option. Reduced LTC poll compared to traditional LTCI.
Maximizing death benefits while retaining some flexibility	Traditional Life Insurance with an Accelerated Benefit Rider	PRO: Provides largest death benefit while retaining flexibility to pay for LTC costs. Better suited to pay on a monthly basis if needed. CON: Reduced LTC benefit compared to Traditional LTC and Asset-based LTC. Typically, it does not offer 110% ROP.
Long-term care options late in life with potential health concerns	Fixed on Indexed Annuity with LTC Rider	PRO: Provides streamlined underwriting for clients with health concerns while turning tax-deferred to potentially tax-free growth CON: No immediate leverage of the base asset and limited growth opportunities compared to alternative annuity options
Access to money	Self-Fund	PRO: Zero upfront cost while retaining liquidity CON: Pay dollar for dollar for any care needed. Estate serves as the primary funding source.

Knowledge Check

A personal lines client you have worked with for many years has just called you to inquire about the cost of LTCI. His mother passed away six months ago and was in a Medicaid-certified nursing facility for two and a half years prior to her death.

Now, the state is telling your client they will be liquidating his mother's assets to recover Medicaid expenses for the last two years.

The client wants your help in conserving his family assets to prevent this from happening to him and his children and is concerned about adding LTCI to his budget because his youngest child is getting ready to go to college.

How would you counsel him?

Essentials of Disability Insurance

Learning Objective 9:
Use knowledge of the definitions of disability, the statistical risk of becoming disabled, and potential sources of income after disability to evaluate client needs and provide appropriate counsel.

The Nature and Risk of Becoming Disabled

- **56 million Americans, or 1 in 5, live with a disability**
  Social Security Administration Fact Sheet, January 2017

- **38 million disabled Americans, or 1 in 10, live with a severe disability**
  Social Security Administration Fact Sheet, January 2017

- **More than 1-in-4 20-year-olds become disabled before reaching retirement age**
  Social Security Administration Fact Sheet, January 2017

- **Nearly half of adults (48%) indicate they have set aside an emergency fund that would cover three months of expenses**
  Report on the Economic Well-Being of U.S. Households in 2016 – May 2017, Federal Reserve Board

- **Approximately 30% of all people ages 35 to 65 will suffer a disability that lasts at least 90 days**
  www.doctordisability.com/disability-statistics/

Your Age	Chances of suffering a long-term disability	Average length of disability
30	51%	4.7 years
35	48%	5.1 years
45	40%	5.8 years
50	34%	6.2 years

Source: Commissioners Individual Disability Tables, CSO/Society of Actuaries, the National Safety Council, and/or The Million Dollar Round Table.

If my disability has lasted one year, what is the probability the disability will last:

Your Age	1 More Year	2 More Years	5 More Years
25	67%	57%	47%
35	76%	67%	57%
45	79%	72%	62%
55	81%	73%	62%

Source: *Commissioners Individual Disability Tables, CSO/Society of Actuaries*

Potential Sources of Income After a Disability

1. Savings account
2. Loan from relatives
3. Loan from the bank or other lending institution
4. Liquidation of assets (retirement accounts, investments, home, cars, etc.)
5. Disability insurance policy
6. Social Security

Social Security's Definition of Disability

The inability to engage in any gainful activity by reason of any medically determinable physical or mental impairment which has lasted or could be expected to last for a continuous period of 12 months or result in death. The impairment must be so severe that the individual is unable to engage in substantial gainful work that exists in the national economy regardless of whether or not such work exists in the immediate area in which the applicant lives.

Program Description:

"The Social Security Administration (SSA) administers two programs that provide benefits based on disability: The Social Security disability insurance program (title II of the Social Security Act) and the Supplemental Security Income (SSI) program (title XVI of the Act).

"Title II provides for payment of disability benefits to disabled individuals who are 'insured' under the Act by virtue of their contributions to the Social Security trust fund through the Social Security tax on their earnings, as well as to certain disabled dependents of insured individuals. Title XVI provides SSI payments to disabled individuals (including children under age 18) who have limited income and resources."

"The Act and SSA's implementing regulations prescribe rules for deciding if an individual is 'disabled.' SSA's criteria for deciding disability may differ from those applied in other government and private disability programs."

Disabilities covered fall under the following categories:

Musculoskeletal System	Skin Disorders
Special Senses and Speech	Endocrine Disorders
Respiratory Disorders	Congenital Disorders Affecting Multiple Body Systems
Cardiovascular System	Neurological Disorders
Digestive System	Mental Disorders
Genitourinary Disorders	Cancer (Malignant Neoplastic Diseases)
Hematological Disorders	Immune System Disorders

Total Disability Definitions

Any Occupation

- If, because of accident or sickness, the main duties of **any occupation** cannot be done; requires physician's care

Own Occupation

- If, because of accident or sickness, the main duties of one's **own occupation** cannot be done

Insuring Agreement of a Disability Contract

Claim trigger:

1. **Accident** – an accidental bodily injury that happens on or after the effective date of the contract

2. **Sickness** – a sickness or disease that first appears on or after the effective date of the contract; includes a disability from a transplant surgery

Recurrent Disability

If a sickness or injury qualifies as a recurrent disability, it will actually be a continuation of a prior claim. No new waiting period will be required. The same related condition must cause the recurrent disability. Most contracts require less than six months to lapse between the claims.

Presumptive Disability

Total disability will be presumed, and no waiting period required, if the insured suffers the total and complete loss of any of the following:

1. Speech
2. Hearing in both ears
3. Sight in both eyes
4. Use of both hands
5. Use of both feet
6. Use of one hand and one foot
7. Sight in one eye and the total loss of one foot or hand

Example of the restrictive nature that one (or two) word(s) can have in determining the payment of a claim:

"We will pay the monthly benefit if the named insured suffers the total loss of any one, or a combination of the following: speech, hearing in both ears, etc."

"We will pay the monthly benefit if the named insured suffers the total, and irrecoverable, loss of any one, or a combination of the following: speech, hearing in both ears, etc."

Partial Disability

Some insurers offer a partial disability option for their disability income insurance policies intended to help cover reduced income. If the insured is working on a part-time basis, they are eligible to receive 50% of the otherwise payable benefit for a specified period of time. If the monthly benefit in the policy is $4,000 and the actual covered expenses in a month total $3,000, the partial benefit is 50% of the covered expenses, or $1,500.

Partial vs. Residual Disability – This may be a policy provision in some contracts. It allows benefits to be paid even though the insured is not totally disabled.

1. Partial disability – based on occupational performance
2. Residual disability – based on the lost percentage of income

Disability Policy Provisions

Learning Objective 10:

Use knowledge of types of disability policy provisions, optional riders, and underwriting considerations to determine the appropriate product to meet client needs in a variety of situations.

Elimination Period

This is similar to a deductible. The longer one waits to receive benefits, the lower the premium, all other coverage being equal. The elimination period is generally defined as the number of days immediately following the start of a disability in which no benefits are payable. In individual plans, the typical wait is 30, 60, 90, 180, or 365 days. The waiting period will always be shown on the policy's coverage page.

Benefit Period

This is the length of time the carrier will pay benefits as per the schedule selected by the insured. Two- and five-year benefits are common with all companies. The lower hazard occupations (attorneys, physicians, etc.) are eligible for coverage to age 65 or even a lifetime. The longer the benefit period, the higher the premium. Benefits can be payable for either total disability or residual disability. The benefit period should be the same for both an accident and sickness.

Grace Period

A grace period of 30 or 31 days is found in all contracts.

Waiver of Premium

After 90 days of total disability, no further premiums are payable. Some carriers refund the three months of premium back to the insured.

Benefit Amount

This is the total amount of benefit payable. Most carriers will insure up to 60% or 70% of pretax income. Benefits received from personally paid, individual contracts are income-tax-free. Some carriers will insure up to a $20,000 monthly benefit.

Refund After Death

All companies refund any unearned premium. Some pay an additional three to six months of benefit as a lump sum to a named beneficiary, but only if the named insured is not currently on an active claim.

Misstatement of Age or Sex

The company will adjust the benefits to what the true and accurate age (or sex) would have purchased.

Named Exclusions in a Disability Contract

The fewer, the better–some companies have no named exclusions (or only War). Most companies, however, have some or all of the following:

- War
- Normal pregnancy
- Normal childbirth
- Self-inflicted injuries
- Alcoholism
- Drug addiction

Continuing Coverage Past Age 65

Most DI contracts end at age 65. Some have a provision that allows the insured to continue coverage past age 65, usually to age 72 or 75. The language requires a certain number of hours at work each week. No additional riders are typically allowed.

Incontestability Clause

This policy provision is similar to the language found in life contracts of two years.

Cancellation or Renewability Provisions

1. **Cancellable**:

   - Once issued and until the end of the policy period, no restrictive riders can be added;
   - the premium may be increased on renewal if increased for all in that class;

     AND

   - the contract can be canceled if withdrawn from an entire class, such as a state

2. **Guaranteed renewable**:

   - Once issued, no restrictive riders may be added by the company;
   - the premium may be increased on renewal if increased for all in that class;

     AND

   - the company cannot cancel the contract

3. **Noncancellable** (non-can):

   - The insurance company cannot cancel the contract;
   - after issuance, no restrictive riders may be attached;

     AND

   - the rates cannot be increased

Renewability

Renewability is the policy provision that details the conditions for which the insurance company agrees to continue to insure the disability income policy, e.g., *noncancelable*, *guaranteed renewable,* or *conditionally renewable*.

Proof of Loss

Also known as proof of claim, proof of loss requirements vary from policy to policy but are usually contained in the policy's definitions section or in a section explaining how to submit a claim. It consists of the information you must provide to support a claim.

Other Insurance

Coordination of benefits: Some policies offset Disability Income (DI) payments dollar-for-dollar, while others have a maximum dollar limit. Many will offset against the following types of income sources:

1. Workers compensation

2. State disability income (CA, HI, NJ, RI, and PR)

3. Social Security disability benefits

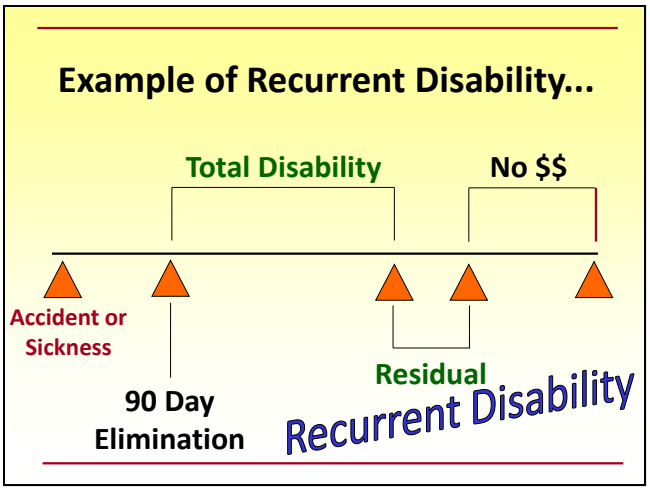
4. State no-fault auto wage laws

Profit restrictions

Some carriers have a provision that contractually prevents an insured from making a profit (too much DI in relation to income).

Recurrent disability

If a sickness or injury qualifies as a recurrent disability, it will actually be a continuation of a prior claim. No new waiting period will be required. The same or related condition must occur again to qualify as a recurrent disability. Most contracts require less than six months (12 months with some) to lapse between the two claims.



Disability Income Policy Riders

Cost of Living Rider

An excellent but reasonably expensive rider that increases the coverage based on the Cost Of Living Adjustment (COLA) or another inflation rate *after* the disability begins. There is usually a wait of one or two years until benefits increase.

Guaranteed Issue Rider (GIR)

A reasonably inexpensive rider (a policy provision with some carriers) that allows the insured to purchase additional coverage at certain ages; a GIR is usually in one- to three-year increments that cease at age 50. No medical or occupational underwriting is performed. However, a major difference between this GIR and the one found in the life policies is financial underwriting. The carrier will only insure for about 60% to 70% of coverage to gross income. All forms of in-force individual and group coverage are considered for this percentage.

Social Insurance Substitute Rider

This provides additional benefits when the insured is disabled and receiving no social insurance benefits, such as workers compensation, no-fault, state DI, and/or Social Security DI benefits.

Return of Premium

This provision returns all or a portion of the paid premium to the owner. The amount returned depends on the number of years the policy was in force and the number of claims paid.

Occupational Rehabilitation

This rider helps pay for vocational training after a disability, which can be helpful if you have an own-occupation policy that allows collection of benefits while working another job.

Catastrophic Disability Benefit

A rider that pays an additional benefit amount if you have a catastrophic disability, typically defined as one where you are unable to perform two activities of daily living.

Unemployment Premium Suspension

This rider suspends premiums while unemployed, allowing the policyholder to stop paying premiums but to continue to own the policy. Coverage is suspended during unemployment. If the policyholder becomes disabled during this time, they won't receive a benefit.

Underwriting Considerations

Considerations Other Than Medical

Underwriting will take into account the following: age, sex, nicotine use, hobbies, pretax income (earned and passive), and occupation.

Occupation

Because the duties of a job may contain more risk than the job title indicates, it is important to get a thorough job description.

Medical History

A healthy insured who qualifies for standard life may be rejected for disability. For preexisting conditions, the underwriting options are to endorse, rate up, or reject entirely.

Knowledge Check

You have a friend in your Rotary Club who is a pediatric hand surgeon and associate professor at a large university medical school hospital. She has been concerned about disability income issues since a colleague of hers was involved in a boating accident, resulting in a recovery period of several years.

She has requested your counsel with the following question:

What is the best disability coverage for her to purchase that will not require her to take another job to pay the premium?

Essentials of Business Overhead Expense (BOE) Disability Income

Learning Objective 11:

Use knowledge of Business Overhead Expense disability income policies and their tax considerations to advise clients about contract options for reimbursement of qualifying expenses if an owner becomes disabled.

BOE DI Contracts

Primary Purposes

A BOE policy provides for reimbursement of eligible expenses in the event of disability of the person named in the policy (the owner and primary revenue earner in the business).

- Allows the business to receive income while the insured person is disabled
- Qualifying expenses include:
    1. Payroll (employees)
    2. Rent
    3. Utilities
    4. Professional licenses and dues
    5. Accounting and legal fees
    6. Forms and supplies
    7. Business insurance premiums
    8. Miscellaneous (see the *Sample BOE Worksheet*)

- Allows the business to hire capable replacements
- Keeps the business open
- If the disability will be long-term, a BOE policy can be a mechanism to allow the business to be sold as a “going concern.”

Characteristics of BOE DI Contracts

- Waiting periods are short: usually 30, 60, or 90 days
- Benefit periods are short: 12, 18, or 24 months
- Benefit amounts: up to $20,000 per month is available with many major companies

Sample Business Overhead Expense Worksheet

Prepared For:	Jan Jones, DVM	**By:**	Joe Agent
Name of Business:	Northeast Animal Hospital	**Date:**	01/12/24

Eligible Business Expense	Monthly Expense
Salaries of non-income producing employees	$5,000.00
Rent or interest on your business mortgage	1,500.00
Utilities (telephone, electricity, heat, and water)	500.00
Business depreciation	500.00
Business related taxes	200.00
Leasing or installment payment on equipment, furniture, and business auto	1,000.00
Professional licenses and dues	200.00
Laundry and maintenance	100.00
Accounting, legal fees, billing, and collection services	100.00
Business forms and supplies (not inventory stock)	50.00
Business insurance premiums (including malpractice)	200.00
Telephone answering service and/or paging system	30.00
Other expenses (itemize)	
Veterinary Assistant	2,000.00
Monthly Total	$11,380.00
Your Share of Total	$11,380.00

General Tax Guidelines: [IRS ruling 55-264, C.B. 1955-1, 11] 1) The premiums are tax deductible regardless of whether your business is a sole proprietorship, partnership, or corporation. 2) The benefits from this policy are taxable as income, but when these benefits are used to pay for deductible business expenses, the tax liability is offset by the business deduction.

Note: This information is a general statement of current law and should not be construed as tax advice. Please consult your attorney or tax advisor about the particulars of your own situation.

Knowledge Check

Your accountant has a client who is a dentist and just lost his dental practice because of an illness that took him away from work for nine months.

Your accountant, a sole practitioner, has asked you if any type of insurance will pay her expenses if she becomes disabled.

What recommendations would you present to your accountant?

Review of Learning Objectives

1. Use knowledge of health insurance contracts to evaluate their appropriateness for various client needs.

2. Use knowledge of the Affordable Care Act (ACA) and ACA-compliant and noncompliant medical plans to offer advice regarding client needs.

3. Apply knowledge of tax-favored health plans to meet a variety of prospect and client needs.

4. Apply knowledge of federal laws to provide appropriate counsel to clients and prospects.

5. Apply knowledge of Medicare, Medicare supplements, and Medicaid to determine the best product to meet client needs.

6. Use understanding of long-term care insurance (LTCI) to evaluate client needs and provide appropriate counsel in contract selection.

7. Use knowledge of LTCI policy provisions, benefit triggers, qualified and non-qualified contracts, state-endorsed programs, and medical underwriting issues to determine the possibilities for payout in given scenarios.

8. Use knowledge of other products available to insure long-term care needs to determine the best products to meet a particular client's needs.

9. Use knowledge of disability definitions, the statistical risk of becoming disabled, and potential sources of income after disability to evaluate client needs and provide appropriate counsel.

10. Use knowledge of types of disability policy provisions, optional riders, and underwriting considerations to determine the appropriate product to meet client needs in a variety of situations.

11. Use knowledge of Business Overhead Expense (BOE) disability income policies and their tax considerations to advise clients about contract options for reimbursement of qualifying expenses if an owner becomes disabled.

Knowledge Check – ANSWERS

Your client has a medical plan with the following cost-sharing provisions:

- Deductible: $3,000 in-network/$6,000 out-of-network
- Coinsurance: 80/20 in-network/out-of-network 50/50
- Out-of-pocket maximum: $6,000 in-network/unlimited out-of-network

She incurs allowable in-network medical expenses in the amount of $15,000. How much of this amount will your client pay out-of-pocket, and how much will her insurance company pay?

Answer:

Description	Insured's Responsibility	Insurer's Responsibility
Allowable in-network medical expenses $15,000		
Deductible applies first *$3*,000	(3,000)	
Amount subject to coinsurance after deductible $12,000		
Amount paid by insured and insurer subject to 80/20 *Coinsurance*	(2,400)	(9,600)
Amount paid by insured and insurer before applying *$6,000 OOPM*	(5,400)	(9,600)
OOPM credited to insured	0	
OOPM debited from insurance company		0
Total bill $15,000		
Total paid by insured	$5,400	
Total paid by insurance company		$9,600

How much of this amount will your client pay out-of-pocket, and how much will her insurance company pay if this is an out-of-network claim?

Description	Insured's Responsibility	Insurer's Responsibility
Allowable out-of-network medical expenses $15,000		
Deductible applies first *$6*,000	(6,000)	
Amount subject to coinsurance after deductible $9,000		
Amount paid by insured and insurer subject to 50/50 *Coinsurance*	(4,500)	(4,500)
Amount paid by insured and insurer before applying *Unlimited OOPM*	(10,500)	(4,500)
OOPM credited to insured	0	
OOPM debited from insurance company		0
Total bill $15,000		
Total paid by insured	$10,500	
Total paid by insurance company		$4,500

Knowledge Check – ANSWERS

Your good friend, Jennifer, is about to open a bagel and sandwich shop. You are discussing property and casualty options. She states: "I plan to have 5-6 full-time employees (30+ hours per week) and about the same number of part-time employees (less than 30 hours per week). I have heard I will be required to provide my employees with health insurance, as per the Affordable Care Act. Is that true?"

Answer:

No, that is not true. Since you will be under 50 full-time employees, you will not have any potential penalty under the ACA for not offering coverage.

You handle a small manufacturing risk, owned by Bob. They employ 65 full-time employees. Bob has just received the renewal notice from their health insurance carrier, which provides an ACA-compliant coverage plan. All full-time employees are afforded coverage. The premium has increased dramatically. Bob currently pays 90% of the employee's self-only premium. He is thinking of dropping that to 50%. He asks, "Do you see any potential problems with that plan?"

Answer:

There are at least two potential problems with this Large Employer: 1) Should a full-time employee that is covered under the plan have to pay greater than 9.12% (2023) of their income for their self-only coverage, it will be deemed as "unaffordable." If their income is below 400% of the Federal Poverty Level, they are then eligible for a federal subsidy for their health insurance. Should they come off your plan and get a subsidy for an individual policy, you (the business) will be looking at a healthy penalty – exceeding $2,880 (2023) every month for every full-time employee who obtains coverage and receives a subsidy. 2) Employee Benefits – such as health insurance – are a major factor in hiring and retaining good employees. Should an employee's contribution to health insurance premiums become very high, it may seriously affect hiring and retention.

Knowledge Check – ANSWERS

Your client is familiar with FSA plans but wants their employees to have more of their own money involved in their healthcare programs

What plans, if any, are available for the employer to offer?

Answer:

Health Savings Accounts (HSA) allow for payment of unreimbursed healthcare expenses with a tax-qualified fund controlled and owned by the account holder (employee). Offer an HDHP high deductible health plan to provide insurance coverage. Also, offer a limited purpose FSA to offer vision and dental coverage. IRS does not allow a general-purpose FSA offered with an HSA.

Knowledge Check – ANSWERS

The prospect is turning sixty-five in three months and is receiving a lot of mail regarding Medigap.

The prospect wants to know if Medigap is mandatory.

Answer:

Medigap is not mandatory but necessary due to the deductibles and coinsurance in Medicare plans.

What is the difference between the AARP Plan G and the Blue Cross Blue Shield Plan G?

Answer:

Benefits are the same, but the premiums could be different.

Knowledge Check – ANSWERS

A personal lines client you have worked with for many years has just called you to inquire about the cost of long-term care. His mother passed away six months ago, and was in a Medicaid-certified nursing facility for two and a half years prior to her death.

Now, the state is telling your client they will be liquidating his mother's assets to recover Medicaid expenses for the last two years.

The client wants your help in conserving his family assets to prevent this from happening to him and his children. He is concerned about adding long-term care insurance to his budget because his youngest child is getting ready to go to college.

How would you counsel him?

Answer:

Look into adding a life insurance policy that allows for LTC payments. Also, look into annuities with LTC options. Advise on setting up trusts that allow for sheltering assets. He will need advice from a trust attorney.

Knowledge Check – ANSWERS

You have a friend in your Rotary Club who is a pediatric hand surgeon and associate professor at a large university medical school hospital. She has been concerned about disability income issues since a colleague of hers was involved in a boating accident, resulting in a recovery period of several years.

She has requested your counsel on the following question:

What is the best disability coverage for her to purchase that will not require her to take another job to pay the premium?

Answer:

Review the current disability income policy through her university group program. Consider adding to it to cover any uncovered exposure. Look at the "own occupation" definition, which is non-cancellable, with an extended elimination period.

Knowledge Check – ANSWERS

Your accountant has a client who is a dentist and just lost his dental practice because of an illness that took him away from work for nine months.

Your accountant, a sole practitioner, has asked you if any type of insurance will pay her expenses if she becomes disabled.

What recommendations would you present to your accountant?

Answer:

Discuss business overhead expense coverage. Recognizing that it is designed to pay only qualifying expenses (not lost profits) and that benefit periods are short-term, usually two years at most.


Thank
You !