Addendum: for use with Maryland Life & Health online ExamFX courses and study guide version 20891en/20895en, per exam content outline updates effective 1/1/2020.

***Please note that Maryland is changing testing providers. Effective 10/1/2020, state insurance exams will be administered by Prometric**. For additional information about exam requirements and complete exam content outlines, please review the Licensing Information Bulletin at https://www.prometric.com*

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*The following are **additions** to supplement your existing text:*

LIFE & HEALTH

General Insurance

A. Concepts

2. Risk Management Key Terms

Exposure

Exposure is a unit of measure used to determine rates charged for insurance coverage. In life insurance, all of the following factors are considered in determining rates:

- The age of the insured;
- Medical history;
- Occupation; and
- Sex.

A large number of units having the same or similar exposure to loss is known as **homogeneous**. The basis of insurance is sharing risk among the members of a large homogeneous group with similar exposure to loss.

B. Insurers

Mutual Assessment Insurers

A **mutual assessment insurer** is a mutual insurance company with the right to assess policyholders' additional amounts of premium to meet operational needs. Like a regular Mutual Insurer, profits are distributed to the policyholders. Unlike Stock or regular Mutual Insurers, if an Assessment Insurer loses money in a given year, all policyholders can be assessed their fair share of the losses.

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C. Producers and General Rules of Agency

Captive vs. Independent Producers

Exclusive or **captive agents** represent only one company and are compensated by commissions.
Independent agents sell the insurance products of several companies and work for themselves or other agents. The independent agent owns the expirations of the policies he/she sells, meaning they may place that business with another insurer upon renewal if in the best interest of the client.

D. Contracts

2. Distinct Characteristics of an Insurance Contract

Personal Contract

In general, an insurance contract is a **personal contract** because it is between the insurance company and an individual. Because the company has a right to decide with whom it will and will not do business, the insured cannot be changed to someone else without the written consent of the insurer, nor can the owner transfer the contract to another person without the insurer's approval. Life insurance is an exception to this rule: A policyowner can transfer (or assign) ownership to another person. However, the insurer must still be notified in writing.

Insurance Regulation

A. Licensing

3. Types of Licensees

Consultants

Insurance consultants offer advice to the public about the benefits, advantages and disadvantages of insurance policies for a fee.

Exemptions/Exceptions

An insurance producer license is not required of any officer, director or employee of an insurer or organizations employed by insurers, provided they are not directly or indirectly involved with the actual sale of an insurance contract and **do not receive any commission**.

Furthermore, the following individuals are NOT required to hold an insurance producer license:

- A director or employee of an insurer whose activities are limited to executive, administrative, managerial, or clerical;
- The director or employee of a special agent assisting insurance producers by providing technical advice and assistance to licensed insurance producers;

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- A person who secures and furnishes information for group insurance or performs administrative services related to mass-marketed property and casualty insurance;
- An employer or association engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees;
- Employees of insurers or organizations engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale of insurance;
- A person whose activities are limited to advertising without the intent to solicit insurance;
- A nonresident who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; or
- A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or subsidiaries.

4. Renewal and Maintenance

Requirement to Report Other States Actions

An insurance producer must report to the Commissioner any administrative action taken against him/her in another jurisdiction or by another governmental agency in Maryland within **30 days** of the final disposition of the matter.

5. Appointment Procedures

Producer's Contract with Insurer vs. Producer's Appointment with Insurer – *new section on the outline*

A producer's contract with the insurer is a signed agreement between the insurer and the producer that outlines what each party is expected to do. Producer's express authority will be spelled out in the contract. Contractually, only those actions that the agent is authorized to perform will be binding to the principal (insurer). The contract will usually also specify the percent of commission the insurer will pay and the amount of insurance the licensee is expected to sell.

As defined by the Insurance Code, a **producer appointment** means an agreement between an insurance producer and insurer under which the insurance producer, for compensation, may sell, solicit, or negotiate policies issued by the insurer.

Appointment and Notice of Appointment – *addition to the existing text*

An **appointment is not required** for an insurance producer to perform the following duties:

1. Submit to an insurer an informal inquiry for any kind of life insurance, health insurance, or annuity for which the insurance producer has a license if the insurer has a certificate of authority for that kind of insurance; and

2. Solicit an application for any kind of life insurance, health insurance, or annuity for which the insurance producer has a license if the insurer has a certificate of authority for that kind of insurance.

Termination of Appointment/Notice to Agent – *section has been modified as follows:*

Typically, an appointment is valid until terminated. There are several reasons an insurer's appointment of a producer may be terminated. If the agent's license is terminated, all appointments are terminated. When an appointment is terminated, a producer must cease all solicitations on behalf of the insurer.

The insurer is required to update its producer register within **30 days** of the termination of a producer appointment. If the insurer is terminating an appointment because of a belief that the producer has engaged in misconduct, the insurer must send written notification of the termination to the Commissioner and **notify the producer within 15 days** of the date that a notice of termination is sent to the Commissioner. The insurer must also update the insurer's producer register by entering the effective date of the termination.

The insurer must provide any additional documents or information concerning the termination when requested by the Commissioner of Insurance.

If the appointment of an insurance producer is terminated because the producer failed to renew his or her license, once the license is reinstated, the insurer may **reappoint the insurance producer retroactively**, with the appointment effective on the date that the license expired.

Within 15 days after providing the required notice of producer termination to the Commissioner, an insurer must mail a copy of the notice to the insurance producer at the last known address and by certified mail (return receipt requested, postage prepaid) or by overnight delivery using a nationally recognized carrier. Within **30 days** after an insurance producer receives original or additional notice, the insurance producer may file with the Commissioner written comments concerning the substance of the notice. The producer must also simultaneously send a copy of the comments to the insurer. Producer's comments will be made part of the Commissioner's file on the producer.

B. State Regulation

3. Producer Regulation

Acting for an Unauthorized Insurer

A producer cannot transact insurance (except with regard to his own property or person) with or by any insurance company that does not hold a valid certificate of authority. If a producer makes any contract of insurance on behalf of an insurance company that is not licensed to do business in this state, the producer will be **personally liable** to the insured for the benefits and other aspects of the contract, including the payment of claims.

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4. Unfair Trade Practices

Rebating – *the dollar amount has been updated*

Promotional or educational materials, as well as articles of merchandise with a value that does **not exceed $50** are allowed as long as they are not an inducement for purchasing a policy.

LIFE

Life Insurance Basics

G. Producer Responsibilities

2. Field Underwriting

Application

Consequences of Incomplete Application

Before a policy is issued, all of the questions on the application must be answered. If the insurer receives an incomplete application, the insurer must return it to the applicant for completion. If a policy is issued with questions left unanswered, the contract will be interpreted as if the insurer waived its right to have an answer to the question. The insurer will not have the right to deny coverage based on any information that the unanswered question might have contained.

Disclosures at the Point of Sale – HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that protects health information. HIPAA regulations provide protection for the privacy of certain *individually identifiable health information (such as demographic data that relates to physical or mental health condition, or payment information that can identify the individual), referred to as **protected health information**.* Under the **Privacy Rule**, patients have the right to view their own medical records, as well as the right to know who has accessed those records over the previous 6 years. The Privacy Rule, however, allows **disclosures without individual authorization to public health authorities** authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

USA PATRIOT Act/Anti-Money Laundering

The Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act, also known as the **USA PATRIOT Act** was enacted on October 26, 2001. The purpose of the Act is to address social, economic, and global initiatives to fight and prevent terrorist activities. The Act enabled the Financial Crime Enforcement Network (FinCEN) to require banks, broker-dealers, and other financial institutions to establish new **anti-money laundering (AML)** standards. With new rules in place, FinCEN incorporated the insurance industry into this group.

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To secure the goals of the Act, FinCEN has implemented an AML Program that requires the monitoring of all financial transactions and reporting of any suspicious activity to the government, along with prohibiting correspondent accounts with foreign shell banks. A comprehensive customer identification and verification procedure is also to be set in place. The AML program consists of the following minimum requirements:

- Assimilate policies, procedures and internal controls based on an in-house risk assessment, including:
  - Instituting AML programs similar to banks and securities lenders; and
  - File suspicious activity reports (SAR) with Federal authorities;
- Appointing a qualified compliance officer responsible for administering the AML program;
- Continual training for applicable employees, producers and other; and
- Allow for independent testing of the program on a regular basis.

Suspicious Activity Report (SAR) Rules

Any company that is subject to the AML Program is also subject to SAR rules. SAR rules state that procedures and plans must be in place and designed to identify activity that one would deem suspicious of money laundering, terrorist financing and/or other illegal activities. Deposits, withdrawals, transfers or any other business deals involving $5,000 or more are required to be reported if the financial company or insurer “knows, suspects or has reason to suspect” that the transaction:

- Has no business or lawful purpose;
- Is designed to deliberately misstate other reporting constraints;
- Uses the financial institution or insurer to assist in criminal activity;
- Is obtained using fraudulent funds from illegal activities; or
- Is intended to mask funds from other illegal activities.

Some "red flags" to look for in suspicious activity:

- Customer uses fake ID or changes a transaction after learning that he or she must show ID;
- Two or more customers use similar IDs;
- Customer conducts transactions so that they fall just below amounts that require reporting or recordkeeping;
- Two or more customers seem to be working together to break one transaction into two or more (trying to evade the Bank Secrecy Act (BSA) requirements); or
- Customer uses two or more money service business (MSB) locations or cashiers on the same day to break one transaction into smaller transactions (trying to evade BSA requirements).

Relevant SAR reports must be filed with FinCEN within 30 days of initial discovery. Reporting takes place on FinCEN Form 108.

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Life Insurance Policies

A. Term Insurance

Return of Premium

Return of premium (ROP) life insurance is an *increasing term* insurance policy that pays an additional death benefit to the beneficiary equal to the amount of the premiums paid. The return of premium is paid if the death occurs within a specified period of time or if the insured outlives the policy term.

ROP policies are structured to consider the low risk factor of a term policy but at a significant increase in premium cost, sometimes as much as 25% to 50% more. Traditional term policies offer a low-cost, simple-death benefit for a specified term but have no investment component or cash value. When the term is over, the policy expires and the insured is without coverage. An ROP policy offers the pure protection of a term policy, but if the insured remains healthy and is still alive once the term limit expires, the insurance company guarantees a return of premium. However, since the amount returned equals the amount paid in, the returned premiums are not taxable.

F. Group Life Insurance

Trusts

A **Multiple-Employer Trust (MET)** is made up of two or more employers in *similar or related businesses* who do not qualify for group insurance on their own because they have a small number of employees. Several small companies band together to create a large pool of people so that the insurance company will provide coverage. This group of employers jointly purchase a single benefits plan to cover employees of each separate employer. METs may be sponsored by life insurance companies, independent administrators, or the employers that form a MET.

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

Covered Dependents

Participants of group insurance are usually allowed to cover dependents on their policies. **Dependent coverage** usually applies to the insured's spouse and children, but may also include dependent parents or anyone else on which dependency can be proven.

Benefit Payments

This provision is simply the payment of benefits to the beneficiary designated by the insured person. In the event there is no beneficiary living at the time of death of insured person, the maximum of $2,000 may be paid to any person showing evidence of

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incurred funeral or other expenses incident to the last illness or death of the insured person.

Contributory vs. Noncontributory

The employer or other group sponsor may pay all of the premiums or share premiums with the employees. When an employer pays all of the premiums, the plan is referred to as a **noncontributory plan**. Under a noncontributory plan, an insurer will require that 100% of the eligible employees be included in the plan. When the premiums for group insurance are shared between the employer and employees, the plan is referred to as a **contributory plan**. Under a contributory plan, an insurer will require that 75% of eligible employees be included in the plan.

Credit Life Insurance – *new topic on the outline*

Credit insurance is a special type of coverage written to insure the life of the debtor and pay off the balance of a loan in the event of the death of the debtor. Credit life is usually written as **decreasing term insurance**, and it may be written as an individual policy or as a group plan. When written as a group policy, the creditor is the owner of the master policy, and each debtor receives a certificate of insurance.

The creditor is the owner and the beneficiary of the policy although the premiums are generally paid by the borrower (or the debtor). **Credit life insurance cannot pay out more than the balance of the debt**, so that there is no financial incentive for the death of the insured. The creditors may require the debtor to have life insurance; they cannot, however, require that the debtor buys insurance from a specific insurer.

Life Insurance Policy Provisions, Options, and Riders

C. Policy Loans and Withdrawals

Education Loans

Educational loan provisions may be included as additional benefits, as part of the policy, or as a rider or as a separate agreement, subject to the following requirements:

- The loan applicant is a covered individual under the life policy.
- The purpose of the loan is to provide funds for a covered individual to attend an institution of higher learning, a trade school, or technical school.
- Age eligibility of the individual for whom the educational loan will be used may be limited to an age range no less restrictive than age 15 to age 25, subject to continued life insurance coverage of the covered individual during this duration.
- The individual for whose education the loan will be used must attend a qualifying institution at least half-time and must maintain an academic record sufficient to demonstrate reasonable progression or advancement.

The amount of funds available for an educational loan shall be specified in the policy, and shall be further limited to an amount not to exceed the actual cost of the school or institution during any given year of attendance.

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Annuities

E. Uses of Annuities

Charitable Gift Annuities

A charitable gift annuity is a type of planned giving, where a donor (individual annuitant or couple) makes an arrangement with a nonprofit organization (charity) that upon the donor's death, the balance of the assets in the annuity account will be retained by the organization as a gift. Charitable gift annuities provide a charitable donation, a partial income tax deduction for the donation, and a guaranteed lifetime income for the annuitant and sometimes a spouse or other beneficiaries.

Suitability in Annuity Transactions

It is a producer's responsibility to make sure that annuity transactions address consumers' needs and financial objectives. To ensure suitability, producers must make a reasonable effort to obtain relevant information from the consumer and evaluate the following factors:

- Age;
- Annual income;
- Tax status;
- Financial needs and timeline;
- Investment objectives;
- Liquidity needs and liquid net worth;
- Existing assets;
- Intended use of annuity;
- Financial experience; and
- Risk tolerance.

Qualified Plans – *new chapter on the outline*

A. General Requirements

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

Qualified plans have the following characteristics:

- Designed for the exclusive benefit of the employees and their beneficiaries;
- Are formally written and communicated to the employees;
- Use a benefit or contribution formula that does not discriminate in favor of the *prohibited group* — officers, stockholders, or highly paid employees;
- Are not geared exclusively to the prohibited group;
- Are permanent;
- Are approved by the IRS; and
- Have a vesting requirement.

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B. Plan Types, Characteristics, and Purchasers

1. Self-Employed Plans (HR-10 or Keogh Plans)

HR-10 or Keogh plans make it possible for **self-employed persons** to be covered under an IRS qualified retirement plan. These plans allow the self-employed individuals to fund their retirement programs with pre-tax dollars as if under a corporate retirement or pension plan. To be covered under a Keogh retirement plan, the person must be self-employed or a partner working part time or full time who owns at least 10% of the business.

Contribution limits are the lesser of an established dollar limit or 100% of their total earned income. The contribution is tax deductible, and it accumulates tax deferred until withdrawal.

Upon a participant's death, payouts can be available immediately. If a participant becomes disabled, he or she may collect benefits immediately or the funds can be left to accumulate. When a participant enters retirement, distribution of funds must occur no earlier than 59½ and no later than 70½. If withdrawn before 59½, there is a 10% penalty. At any time payments may be discontinued with no penalty, and funds can be left to accumulate.

Under eligibility requirements, any individual who is at least 21 years of age, has worked for a self-employed person for one year or more, and worked at least 1,000 hours per year (full time) must be included in the Keogh Plan. The employer must contribute the same percentage of funds into the employee’s retirement account as he/she contributes into his/her own account.

2. Simplified Employee Pensions (SEPs)

A Simplified Employee Pension (SEP) is a type of qualified plan suited for the small employer or for the self-employed. In a SEP, an employee establishes and maintains an individual retirement account to which the employer contributes. Employer contributions are not included in the employee’s gross income. The primary difference between a SEP and an IRA is the much larger amount that can be contributed each year to a SEP (an IRS established annual dollar limit or 25% of the employee’s compensation, whichever is less).

3. SIMPLE Plans

A SIMPLE *(Savings Incentive Match Plan for Employees)* plan is available to small businesses that employ **no more than 100 employees** who receive at least $5,000 in compensation from the employer during the previous year. To establish a SIMPLE plan, the employer must not have a qualified plan already in place. Employees who elect to participate may defer up to a specified amount each year, and the employer then makes a matching contribution, dollar for dollar, up to an amount equal to 3% of the employee's annual compensation. **Taxation is deferred** on both contributions and earnings until funds are withdrawn.

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C. Taxation

1. Tax Advantages for Employers and Employees

If the general requirements for qualified plans are met, the following tax advantages apply:

- Employer contributions are tax deductible to the employer, and are not taxed as income to the employee;
- The earnings in the plan accumulate tax deferred; and
- Lump-sum distributions to employees are eligible for favorable tax treatment.

2. Taxation of Distributions (Age Related)

Benefits in qualified plans are taxable to the plan participant when they are received during retirement, at a time when the retired person is likely to be in a much lower tax bracket. Distributions prior to age 59½ impose a 10% penalty, unless they fall under an exception to the 10% penalty.

The following types of distributions are considered **exceptions** to the early distribution rule and, therefore, are not subject to the 10% early withdrawal penalty:

- Death of the participant;
- The participant's disability;
- A divorce decree requiring a distribution to a spouse as part of the settlement;
- As a series of equal payments (at least annually) over the participant's life expectancy;
- A loan from the plan; or
- As part of a qualified rollover.

HEALTH

Health Insurance Basics

D. Limited Policies

3. Types of Limited Policies

Critical Illness

A **critical illness** policy covers multiple illnesses, such as heart attack, stroke, renal failure, and pays a lump-sum benefit to the insured upon the diagnosis (and survival) of any of the illnesses covered by the policy. The policy usually specified a minimum number of days the insured must survive after the illness was first diagnosed.

Short-Term Medical

Short-term medical insurance plans are designed to provide temporary coverage for people in transition (those between jobs or early retirees), and are available for terms from one month up to 11 months, depending on the state. Unlike regular individual major medical plans, short-term health insurance policies are not regulated by the Affordable Care Act and their enrollment is not limited to the open enrollment period;

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they also do not meet the requirements of the federally mandated health insurance coverage.

Like traditional health plans, short-term plans may have medical provider networks, and impose premiums, deductibles, coinsurance and benefit maximums. They also cover physician services, surgery, outpatient and inpatient care.

F. Producer Responsibilities in Individual Health Insurance

Notification of Medicare Eligibility

When a health insurance is terminated because the insured attains the maximum age stated in the policy, the insured must be notified of eligibility to apply for coverage under Medicare.

Disability Income and Related Insurance

A. Individual Disability Income Insurance

Annual Renewable Term Rider

This rider incorporates annual renewable term life insurance into the Disability Income policy. The policy now will provide a death benefit in addition to the disability benefits.

C. Individual Disability Underwriting

Policy Issuance Alternatives

If the underwriter feels that applicant is too great of a risk, the applicant could be declined. However, if the risk is more than standard but less than a decline, the underwriter could offer the policy on a rated-up basis or issue the contract with an exclusion rider. If the policy is rated up, the premium will be increased. If a policy contains an exclusion rider, then the loss related to that exclusion would not be covered.

Workers Compensation – *new section on the outline*

Workers Compensation is a benefit offered and regulated by the states, and will vary to some degree from state to state.

Eligibility: To be eligible for Workers Compensation benefits, the worker must work in an occupation covered by Workers Compensation and have had an accident or sickness that is work related. Workers Compensation benefits are payable when a worker is injured by a work-related injury, regardless of fault or negligence.

Benefits: Workers Compensation laws provide four types of benefits:

1. Medical benefits;
2. Income benefits;
3. Death benefits; and
4. Rehabilitation benefits.

Medical Plans

B. Types of Providers and Plans

3. Health Service Plans

Plans Offered

Health service providers may be formed to operate as:

- Fraternals;
- Health maintenance organizations;
- Preferred provider organizations;
- Medical service corporations; or
- Nonprofit medical service corporations.

Other Services

Health care service providers may provide other services such as dental care, vision care, hearing care, etc.

Qualified Providers

A medical service corporation cannot condition its willingness to allow any physician or other provider of health services to participate in a preferred provider arrangement on such physician's or provider's agreeing to enter into other contracts or arrangements with the medical service corporation or any other person that are not part of or related to the preferred provider arrangement.

Choice of Provider

Nothing in the regulations can prevent a health service plan from reimbursing a subscriber for services received in a non-participating hospital within or outside the Commonwealth in the event of accident, illness or maternity or, upon the written direction of the subscriber, from making payment to said hospital for such services, provided, however, that the amount of such reimbursement and payment to any such hospital can be based upon the charges of the hospital in effect on the date of services.

Disclosure of Benefits

No accident and health insurance policy or contract can be issued in this state unless the appropriate disclosure form is delivered to the policyholder. The specific form that must be used depends on the coverage provided in the policy. Generally, the disclosure form lists the major benefits and exclusions of the policy.

Should an insurer issue an insurance policy providing coverage different than that applied for, the outline of coverage describing the policy must advise the recipient to read the outline carefully, pointing out that the policy is not identical to the coverage requested.

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5. Preferred Provider Organizations (PPOs)

Open Panel or Closed Panel

When a medical caregiver contracts with a health organization to provide services to its members or subscribers, but retains the right to treat patients who are not members or subscribers, it is referred to as open panel. In an **open panel** arrangement, the doctors are not considered to be employees of the health organization.

When the medical caregiver provides services to only members or subscribers of a health organization, and contractually is not allowed to treat other patients, it is referred to as **closed panel**. In a closed panel arrangement, the doctors are considered employees of the health organization.

TRICARE

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE utilizes the resources of the Army, Navy and Air Force and supplements them with networks of civilian health care professionals to provide better access and high quality service while maintaining the capability to support uniformed services operation. TRICARE has been implemented to:

- Improve overall access to health care for members;
- Provide faster, more convenient access to civilian health care;
- Create a more efficient way to receive health care;
- Offer enhanced services, including preventive care;
- Provide choices for health care; and
- Control escalating costs.

TRICARE offers eligible members 3 choices for their health care:

1. TRICARE Prime
2. TRICARE Extra
3. TRICARE Standard

Under TRICARE Prime, the principal source of health care will be provided from a Military Treatment Facility (MTF). The TRICARE contractor's Preferred Provider Network (PPN) can then supplement the healthcare. The second choice, TRICARE Extra, is a preferred provider option where the member chooses a doctor, hospital or other medical provider listed in the TRICARE Provider Directory. TRICARE Standard is the new name for the traditional CHAMPUS. Under this plan, the members can see the authorized provider of their choice. However, this type of flexibility means that care generally cost more.

Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs)

Health Savings Account (HSA)

Health savings accounts (HSAs) are designed to help individuals save for qualified health expenses that they, their spouse, or their dependents incur. An individual who is covered by a high deductible health plan can make a tax-deductible contribution to an

HSA, and use it to pay for out-of-pocket medical expenses. Contributions by an employer are not included in the individual's taxable income.

Eligibility

To be eligible for a Health Savings Account, an individual must be covered by a high deductible health plan (HDHP), must not be covered by other health insurance (does not apply to specific injury insurance and accident, disability, dental care, vision care, long-term care), must not be eligible for Medicare, and can't be claimed as a dependent on someone else's tax return.

Contribution Limits

HSAs are linked to high deductible insurance. A person may obtain coverage under a qualified health insurance plan with established minimum deductibles ($1,400 for singles and $2,800 for families in 2020).

Each year eligible individuals (or their employers) are allowed to save up to certain limits, regardless of their plan's deductible (current contribution limits are $3,550 for singles and $7,100 for families). When opening an account, an individual must be under the age of Medicare eligibility. For taxpayers aged 55 and older, an additional contribution amount is allowed (up to $1,000).

An HSA holder who uses the money for a nonhealth expenditure pays tax on it, plus a 20% penalty. After age 65, a withdrawal used for a nonhealth purpose will be taxed, but not penalized.

Health Reimbursement Account (HRA)

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

The following are key characteristics of HRAs:

- They are contribution healthcare plans, not defined benefit plans;
- Not a taxable employee benefit;
- Employers' contributions are tax deductible;
- Employees can roll over unused balances at the end of the year;
- Employers do not need to advance claims payments to employees or healthcare providers during the early months of the plan year;
- Provided with employer dollars, not employee salary reductions;
- Permit the employer to reduce health plan costs by coupling the HRA with a high-deductible (and usually lower-cost) health plan; and
- Balance the group purchasing power of larger employers and smaller employers.

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Eligibility

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

Contribution Limits

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

Group Health Insurance

B. Defined Groups

Creditor Groups

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

Small Employer Medical Plans

As a condition of transacting business in this state with small employers, every small employer carrier is required to actively offer to small employers **at least 2 health benefit plans**:

1. Basic health benefit plan; and
2. Standard health benefit plan.

Basic Care is a managed plan developed in conjunction with the Health Benefit plan committee. The Basic Care is lower in cost than the Standard Benefit Plan. A Standard Benefit Plan is a managed care plan developed in conjunction with the Health Benefit plan committee that provides better benefits at a higher cost than the Basic Care Plan.

Small employer means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least **50%** of its working days during the preceding calendar year, employed no more than **50 eligible employees**, the majority of whom were employed within the state.

Availability of Coverage

As a condition of transacting business in this state with small employers, every small employer carrier is required to actively offer to small employers at least 2 health benefit

plans. One plan offered by each small employer carrier must be a basic health benefit plan and one plan must be a standard health benefit plan.

Disclosure of Coverage Provisions

When offering health insurance to small employer, insurance issuers must make a reasonable disclosure in their solicitation and sales material about:

- How premium rates are adjustable due to the claim experience and health status of the employees and their dependents;
- The provisions concerning the insurer's right to change premium rates;
- The provisions relating to pre-existing conditions; and
- The provisions relating to renewability of coverage.

Renewability

A small employer medical plan must be renewable with respect to all eligible employees and dependents, at the option of the small employer, **except** in any of the following cases:

- Nonpayment of required premiums;
- Fraud or misrepresentation;
- Noncompliance with the carrier's minimum participation or employer contribution requirements;
- Repeated misuse of a provider network provision;
- The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers; or if
- The Department of Insurance finds that the continuation of the coverage would not be in the best interests of the policyholders, or may impair the carrier's ability to meet its contractual obligations.

Dental Insurance

Employer Group Dental Expense

Integrated Deductible vs. Stand-Alone Plans

Dental plans attempt to minimize adverse selection by utilizing probationary periods, where insureds that had no prior dental coverage are likely to have a large number of untreated dental problems. There can also be a limitation on benefits for late enrollees where benefits may be reduced for the first year. Even though dental coverage is regulated by COBRA continuation rules, it is seldom convertible like individual health insurance.

Minimizing Adverse Selection

Adverse selection occurs when an unusually high percentage of people with high health care costs select a plan that is priced based upon the normal health cost of population average. When this occurs, it seems that the solution would be simply to increase the premium rate. However, this usually causes those in the plan with normal or lower than normal health care costs to leave the plan, leaving insured those with the high health care costs.

Some of the most effective ways of minimizing adverse selection in group insurance is

- Reducing or restricting the subscriber's choices of coverage;
- Providing benefits that all subscribers must accept, whether they will use the benefit or not; or
- Have waiting periods before coverage becomes effective.

Insurance for Senior Citizens and Special Needs Individuals

Medicaid

Medicaid is a federal and state funded program for those whose income and resources are insufficient to meet the cost of necessary medical care. Individual states design and administer the Medicaid programs (typically through the state's Department of Public Welfare) under broad guidelines established by the federal government.

Eligibility

To qualify for Medicaid, individuals must meet income and other eligibility requirements. Once a person is determined to qualify with low income and low assets, the person must meet other qualifiers, some of which are blindness, disability, pregnancy, age (over 65), or caring for children receiving welfare benefits. For many eligibility groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL).

After the implementation of the Affordable Care Act, new, modernized rules regarding verification of Medicaid eligibility will mean that state Medicaid agencies will rely primarily on information available through data sources (such as the Social Security Administration, the Departments of Homeland Security and Labor) rather than paper documentation from families. Each state has prepared a verification plan for Medicaid in order to comply with the new rules.

In addition to certain levels of income and assets, there are other nonfinancial eligibility criteria that are used in determining Medicaid eligibility. In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

Benefits

Medicaid mandates that the states provide at least the following services:

- Physician's services;
- Inpatient hospital care;
- Outpatient hospital care;
- Skilled nursing home services;
- Laboratory and x-ray services;
- Home health care services;
- Rural health clinic services;
- Periodic screening, diagnosis, and treatment;
- Family planning services; and
- Medicaid also pays for prescription drugs, dental services, private duty nursing services, eyeglasses, check-ups, and medical supplies and equipment.

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Federal Tax Considerations for Health Insurance

Medical Expense Coverage for Sole Proprietors and Partners

Sole proprietors and partners may deduct 100% of the cost of a medical expense plan provided to them and their families because they are considered self-employed individuals, not employees. The deduction may not exceed the taxpayer's earned income for the year.

D. HSAs, HRAs, and FSAs

Flexible Spending Accounts

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

Insurance Regulations for Accident and Health Policies

B. Medical Plans: State Requirements

4. Medicare Supplement Insurance

The Commissioner may order insurers violating any Medicare Supplement Insurance policy provision to cease marketing any Medicare supplement policy or take the necessary steps to comply with the provisions. The Commissioner may choose to apply both penalties to provision violations.

In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no individual Medicare supplement policy or certificate will be delivered or issued for delivery in this state unless the **outline of coverage** is delivered to the applicant at the time of application. The outline of coverage must follow the format and content prescribed by the Commissioner. The outline of coverage must include the following:

- A description of the principal benefits and coverage provided in the policy;
- A statement of the exceptions, reductions, and limitations contained in the policy;
- A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;
- A disclosure of the existence of automatic renewal premium increases based on the insured's age; and
- A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

Medicare supplement policies will have a notice prominently printed on the first page of the policy stating in substance that the policyholder will have the **right to return** the policy within **30 days** after delivery and to have any premium refunded if, after examination the policyholder is not satisfied for any reason. The insurer must pay any refund made directly to the policyholder in a timely manner.

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In addition to the outline of coverage, producers must also deliver a **buyer's guide**, prior to the application process. The guide covers differences between policies, coverage provided under policies, and steps taken to purchase coverage.

When soliciting Medicare supplement insurance in Maryland, producers must verify that an applicant is not currently enrolled in an existing Medicare supplement policy and is not currently receiving Medicaid benefits. The producer must obtain a written statement verifying the information provided by the applicant. Insurers and producers cannot solicit Medicare supplement policies to any individual who is not eligible for Medicare or are eligible for Medicaid benefits.

During the **advertisement** or solicitation of health insurance to an individual eligible for Medicare, insurers and producers are prohibited from:

- Stating or implying the insurer or producer represents a federal, state, or local government agency;
- Stating offered Medicare supplement coverage is approved or recommended by a federal, state, or location government agency;
- Using the terms "Medicare consultant," "Medicare adviser," "Medicare bureau," "disability insurance consultant," or similar wording;
- Making a misrepresentation or fraudulent comparison of a policy intended to induce the sale or replacement of a policy or take out a policy with another insurer; and
- Knowingly or negligently selling a Medicare supplement policy that duplicates existing coverage.

The purpose of the state policy and procedure regarding advertisements of Medicare Supplement insurance is to:

- Provide prospective purchasers with clear and unambiguous statements in the advertisement; and
- Ensure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance.

To this end, the Administration has established guidelines and standards of conduct in the advertising of Medicare supplement insurance to prevent unfair, deceptive and misleading advertising. Every insurer is required to establish and at all times maintain a system of control over the content, form and method of dissemination of all of its Medicare supplement insurance advertisements. All such advertisements, regardless of by whom written, created, designed or presented, are the **responsibility of the insurers** benefiting directly or indirectly from their dissemination. Insurers must provide the Commissioner with copies of intended advertisements no sooner than **5 days** before use.

The following **minimum coverages** must be provided by Medicare supplement policies:

- Coverage for Medicare Part A eligible expenses for the initial Medicare deductible for hospitalization in any Medicare benefit period;
- Coverage of Medicare Part A eligible expenses for hospitalization to the extent that they are not covered by Medicare for the 61st day through the 90th day in any Medicare benefit period;

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- Coverage for Medicare Part A eligible expenses incurred as daily hospital charges to the extent that they are not covered by Medicare during the use of Medicare's lifetime hospital inpatient reserve days;
- Upon exhaustion of all Medicare inpatient hospital coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days;
- Coverage for the coinsurance amount of Medicare eligible expenses under Medicare Part B, regardless of hospital confinement;
- Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood, or an equivalent, in any calendar year unless replaced in accordance with federal regulations or already paid for under Medicare Part B;
- Coverage under Medicare Part B for the reasonable cost of the first 3 pints of blood, or an equivalent, in any calendar year unless replaced by or already paid for under Part A; and
- An annual low-dose mammography screening.

Insurers are also required to offer Medicare supplement policy plan A to an individual younger than age 65 who is eligible for Medicare due to a disability during the 6-month period following notification of Medicare enrollment.

The following provisions apply to Medicare supplement policies sold in this state:

- Must provide minimum benefits required by federal law;
- Benefits regarding deductibles and coinsurance must coincide with changes applicable to Medicare provisions;
- Cannot exclude or limit benefits for losses involving pre-existing conditions incurred more than **6 months** after the effective date of coverage;
- Cannot define a pre-existing condition more restrictively than a condition for which an insured sought medical advice or treatment within 6 months before the effective date of coverage;
- Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to medical claims.
- Cannot contain any exclusion, limitation, or reduction that is inconsistent with those under Medicare;
- Must provide for suspension of policy benefits and premium for up to **24 months** if the covered person is receiving benefits under Medicaid;
- Waivers may not be included in or attached to a Medicare supplement policy if they exclude, limit, or reduce coverage or benefits for specifically-described diseases or physical conditions.

Medicare supplement policies **may only be cancelled** in response to nonpayment of premium or material misrepresentation.

During the **replacement** of an existing Medicare supplement policy, the replacing insurer must waive all waiting, elimination, and probationary periods associated with pre-existing conditions. In the event a group policyholder cancels a group Medicare

supplement policy, the issuing insurer must offer each insured an individual Medicare supplement policy.

If an insured's membership in a group is terminated, the insurer must offer a conversion option. At the option of the policyholder, the insurer may instead offer the insured continuation of coverage under the group policy.

If a group Medicare supplement policy is replaced, the replacing insurer must offer coverage to each individual covered under the replaced policy. Coverage may not be excluded for pre-existing conditions that would have been covered under the original policy.

Insurers may provide **commission** or other compensation to an insurance producer for the sale of Medicare supplement policies, only if the first-year commission is no more than 200% of the commissions paid in the second year. Insurers must maintain the same commission amount for at least 5 renewal years. During the replacement of a Medicare supplement policy, an insurer cannot pay a producer a commission in excess of that payable by the replacing insurer.

Medicare SELECT

A Medicare SELECT policy is a Medicare supplement policy that contains restricted network provisions — provisions that condition the payment of benefits, in whole or in part, on the use of **network providers**. SELECT plans negotiate with a provider network of doctors, hospitals and specialist to charge lower rates for medical services. It essentially operates like an HMO. These lower rates keep costs down for the SELECT plan provider, and plan members pay lower premiums.

Each Medicare SELECT policy must be approved by the head of a state's department of insurance. Currently, issuers are not allowed to sell new Medicare SELECT policies to individuals whose primary residence is located outside of the issuer’s service area.

Every Medicare SELECT policy must do the following:

- Provide payment for full coverage under the policy for covered services not available through network providers;
- Not restrict payment for covered services provided by non-network providers if the services are for symptoms requiring emergency care and it is not reasonable to obtain such services through a network provider;
- Make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare SELECT policy to each applicant;
- Make available upon request the opportunity to purchase a Medicare supplement policy offered by the issuer which has comparable benefits and does not contain a restricted network provision. These policies must be available without requiring evidence of insurability if the Medicare SELECT policy has been in force for 6 months; and
- Provide for continuation of coverage in the event that Medicare SELECT policies are discontinued due to the failure of the Medicare SELECT program.

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C. Long-Term Care

In Maryland, **Long-Term Care insurance** is any individual or group insurance policy or rider that is designed to provide coverage for at least 24 consecutive months for each covered person on an expense-incurred, indemnity, prepaid or other basis for necessary diagnostic, therapeutic, rehabilitative, maintenance, or personal care. This care is provided in a setting other than the acute care unit of a hospital. Long-Term Care does not include policies offered primarily to provide basic Medicare supplement, hospital confinement indemnity, basic hospital expense, income protection, accident-only, or skilled nursing coverage.

Individual long-term care insurance policies must contain a renewability provision, which appears on the first page of the policy. An individual policy may not be issued on any basis other than on a **noncancelable or guaranteed renewable** basis.

The premiums for a noncancelable policy must be level for the duration of the policy and may not vary by policy duration or by the attained age of the insured.

On guaranteed renewable policies, the insurer must establish initial and renewal premiums on the basis that the premium will be level for the remaining duration of the policies.

Long-term care policies cannot:

- Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured;
- Contain a provision establishing a new waiting period if existing coverage is converted to or replaced by another form of Long-Term Care coverage (except for an increase in benefits that the insured voluntarily selected); or
- Limit coverage to skilled nursing care only or provide a higher level of coverage in a facility for skilled care than coverage for lower levels of care.

A long-term care policy may not limit or exclude coverage by type of illness, treatment, medical condition, or accident, except under the following circumstances:

- Mental and nervous disorders; however, coverage for Alzheimer's Disease and senile dementia cannot be limited;
- Illness, treatment, or medical conditions arising out of war, participation in a felony, service in the armed forces, attempted suicide, or non-fare-paying aviation;
- Services provided by a member of the covered person's immediate family;
- Services provided or available under workers compensation, employer's liability, or occupational disease law; or
- Pre-existing conditions.

A long-term care policy may not exclude coverage for a loss or confinement that results from a pre-existing condition and begins more than 6 months following the effective date of the insured's coverage. A pre-existing condition may not be excluded beyond the 6-month waiting period or the period provided in the policy, if shorter.

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The following are provisions that are included in Long Term Care contracts:

- **Prior confinement** — A long-term care policy cannot condition eligibility for benefits on a requirement for earlier hospitalization or on the earlier receipt of a higher level of institutional care.
- **Free Look** — Except for an employer-employee group policy, a long-term care policy must allow the policyholder to return the policy within **30 days** after receiving it for a full refund of premium paid.
- **Inflation protection** — An insurer issuing a long-term care policy must offer the option to purchase a policy that provides for benefit levels to increase by at least 5% compounded annually or include another inflation protection option approved by the Commissioner.
- **Producer training** — An insurer may not authorize a producer to act as its agent to sell long-term care insurance unless the producer has initially received training in the needs for and purposes of the policies the producer is authorized to sell. After initial training, an insurer may not authorize the producer to sell long-term care insurance unless the producer receives at least 2 hours of continuing education devoted exclusively to long-term care during the preceding 24 months.

Health insurers offering LTC products in Maryland must adhere to the following advertising and marketing standards:

- Advertisements for LTC insurance must be submitted to the Commissioner for review, prior to dissemination;
- Insurer must maintain a record of advertisements for at least **3 years**;
- Insurers marketing LTC insurance must:
    - Create marketing procedures to ensure fair and accurate policy comparisons, prevention of excessive insurance, and adherence to regulatory compliance;
    - Provide senior citizen counseling program information;
    - Identify if applicants are or have been covered under a LTC policy in the past 12 months, are covered under a medical assistance program, or intend to replace existing health coverage with a LTC policy;
    - Disclose information and qualifications for the Qualified State Long-Term Care Insurance Partnership; and
    - Display the following statement on the first page of the outline of coverage:
        - "Notice to Buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

The Commissioner may refuse an insurer's marketing materials or advertisements if they do not comply with state requirements.

Insurers must provide LTC applicants with an outline of coverage and buyer's guide, prior to the presentation of an application or enrollment form.

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An **outline of coverage** must include the following:

- A description of benefits and coverage provided;
- Exclusions, reductions, and limitations;
- Renewal provisions, including the right to change the schedule of premiums;
- Expected premium increases in relation to benefit increases, especially for applicants over the age of 75; and
- A statement that the outline is a summary and the policy should be consulted to determine contractual provisions.

The **buyer's guide** must include information on the purchase of LTC insurance, along with a reference to the applicant's ability to return the policy within 30 days of delivery.

In addition to the outline of coverage and buyer's guide, an insurer must provide applicants with a graphic comparison of benefit levels over the course of **20 years.**

In the event a group LTC policy is replaced, the replacing insurer must provide coverage to those previously covered under the replaced policy. Replacing insurers may not exclude coverage due to pre-existing conditions. If a group LTC policy is terminated, the insurer must provide covered individuals with the ability to continue coverage or covert coverage to an individual LTC policy. Evidence of insurability is not required if the insured has been covered under the group policy for at least **6 months** prior to the date of termination.

An insurer may cancel or refuse to renew a LTC policy only for the nonpayment of premiums or material misrepresentation. An insurer must provide written notice to the insured and/or a designated individual. An extension of benefits may be limited to the duration of the benefit period or to the payment of maximum benefits and may be subject to a waiting period.

Questions in Applications

All long-term care insurance applications, except for the guaranteed issue LTC insurance, must contain clear and unambiguous questions to help determine an applicant's health condition.

If an application asks whether the applicant has had medication prescribed by a physician, the application also must ask the applicant to list the medication that has been prescribed.

A policy may not be rescinded if the insurer knew or should have known that a medication listed in an application was directly related to a medical condition which would normally result in the denial of coverage.

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