Addendum: for use with Wisconsin Life & Health online ExamFX courses and study guide version 25039en/25040en, per exam content outline updates effective 07/1/2020.

Please note that Wisconsin is changing testing providers. Effective 7/1/2020, state insurance exams will be administered by PSI*. For additional information about exam requirements and complete exam content outlines, please review the Licensing Information Bulletin* at https://candidate.psiexams.com/.

*The course chapters, content, and the Exam Breakdown will mostly remain the same. The following are **content additions** to supplement your existing text:*

LIFE

Annuities

C. Uses of Annuities

Long-Term Care Rider

A long-term care (LTC) rider can be added to an annuity as a supplement for an additional premium. With this rider, the policyowner receives both the income provided by the annuity, as well as the long-term care benefit, should that become necessary.

The application for the LTC rider is medically underwritten. In addition, the insurer will consider the applicant's current health condition, genetic factors, potential hazardous behaviors, and age in determining the amount of premium needed for the rider. Therefore, the cost of a long-term care rider would vary widely from one person to another. The premiums paid for the rider are not tax deductible, so the benefits will be received tax free.

In order for the benefit to begin, a physician must certify that the annuitant is unable to perform at least 2 of the 6 activities of daily living (as prescribed under federal law) for at least 90 days:

1. Bathing independently;
2. Dressing independently;
3. Eating (feeding yourself);
4. Transferring (being able to walk at least very short distances);
5. Toileting independently; and
6. Continence – the ability to control your bladder and bowel functions.

HEALTH

Accident and Health Basics

D. Limited Policies

3. Types of Limited Policies

Dental

Usually dental insurance distinguishes among several classes of dental expenses, and provides somewhat different treatment for each.

Routine and preventive maintenance is covered up to an annual maximum without a deductible or copayment. This coverage benefit usually includes routine examinations and teeth cleaning once a year, and perhaps full-mouth X-ray once every 3 years. (The absence of a deductible and copayment is intended to encourage preventive maintenance.)

Routine and major restorative care includes treatments for cavities, oral surgery, bridges and dentures. These procedures are covered up to a specific maximum, subject to an annual deductible per insured family member and a coinsurance.

Orthodontic care, if included, will have a separate maximum and a separate deductible, which may differ from the deductible for restorative care.

I. Required, Uniform and General Provisions

Coinsurance

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

Probationary Period

The **probationary period** provision states that a period of time must lapse before coverage for specified conditions goes into effect. This provision is most commonly found in disability income policies. The probationary period also applies to new employees who must wait a certain period of time before they can enroll in the group plan. The purpose of this provision is to avoid unnecessary administrative expenses in cases of employee turnover.

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Elimination Period

The **elimination period** is a type of deductible that is commonly found in disability income policies. It is a period of days which must expire after the onset of an illness or occurrence of an accident before benefits will be payable. The longer the elimination period, the lower the cost of coverage.

Medical Plans

C. Cost Containment in Health Care Delivery

Preauthorization

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

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

G. Health Insurance Exchange

Each state is required to set up and maintain **Affordable Insurance Exchanges, referred to as Marketplaces**. These exchanges either serve individuals and small businesses separately, or have a combined exchange to serve both individual and small business clients under one organization. In states that have chosen not to build their own Marketplace, a **Federally-Facilitated Marketplace** (healthcare.gov) is available that helps with comparison shopping tools, eligibility, enrollment, plan management, and consumer support. Coverage may be purchased through the Marketplace's call center, website, or by postal mail.

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

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

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

Qualified Plans

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

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

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

Trained and certified professionals who help on exchanges are called **navigators**. Navigators help educate consumers seeking coverage under the Affordable Care Act. Their duties include

- Conducting public awareness campaigns regarding the availability of qualified health plans;
- Distributing impartial information about the enrollment process and the availability of tax credits;
- Helping consumers enroll in qualified health plans;
- Referring consumers who have questions, grievances or complaints to the proper agencies; and
- Providing information in a manner appropriate to the consumer.

While navigators assist consumers in the enrollment process, they do NOT enroll consumers in a qualified health plan, nor do they select a plan for the consumer. They are also not responsible for determining a consumer’s eligibility.

Before aiding consumers, navigators complete comprehensive federal training and undergo criminal background checks, and state training and registration (when applicable).

Premium Tax Credit

Advance payments of the premium tax credit, or **APTC**, is a tax credit that can help individuals afford coverage bought through the Marketplace. These tax credits can be used right away to lower the monthly premium costs for insurance. If the insured qualifies, he or she may choose how much advance credit payments to apply the premiums each month, up to a maximum amount. If the amount of advance credit payments for the year is less than the tax credit due, the insured will get the difference as a refundable credit when the insured files the federal income tax return. If the advance payments for the year are more than the amount of the credit, the insured must repay the excess advance payments with the tax return.

APTC is paid on a sliding scale, from 100% of FPL to 400% of FPL. It is generally calculated based on attested projected annual income for the upcoming coverage year. Maximum APTC is calculated with reference to income and applicable second lowest cost silver plan.

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Cost-Sharing Reduction

A **cost-sharing reduction (CSR)**, also called extra savings, provides a discount to the amount an insured will pay for deductibles, copayments and coinsurance. Once the Marketplace application has been filled out, an applicant is able to determine their eligibility for tax credits or a CSR. A CSR is only applicable to insureds that have selected a Silver plan.

Included in CSRs is a lower out-of-pocket maximum. After the out-of-pocket maximum has been reached, the insurance plan will cover 100% of covered services.

Members of a federally recognized tribe or shareholders of an Alaska Claims Settlement Act (ANCSA) Corporation may be eligible for additional cost-sharing reductions.

Federal Tax Considerations for A&H Insurance

Consumer Driven Plans

Flexible Spending Accounts (FSAs)

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

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

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

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

- A dependent who was under age 13 when the care was provided and who can be claimed as an exemption on the employee's Federal Income Tax return;
- A spouse who was physically or mentally not able to care for himself or herself; or
- A dependent who was physically or mentally not able to care for himself or herself and who can be claimed as an exemption (as long as the person is earning gross income less than an IRS-specified amount).

Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have

constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.

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

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

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

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

High-Deductible Health Plans (HDHPs)

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

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

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Wisconsin Health Insurance Law

Step Therapy Protocols

Prior authorization means approval from a Medicare drug plan before insureds may fill their prescription in order for the prescription to be covered by the plan. Medicare drug plan may require prior authorization for certain drugs.

Step therapy is a type of prior authorization. In most cases, Medicare requires the insured to first try a certain, less expensive drug on the plan's Formulary that has been proven effective for most people with the same condition before the insured can move up a "step" to a more expensive drug. *For example*, some plans may require to first try a generic drug (if available), then a less expensive brand-name drug on their drug list before the insured can get a similar, more expensive, brand-name drug covered.

Quantity limits: for safety and cost reasons, plans may limit the amount of drugs they cover over a certain period of time. *For example*, most people prescribed heartburn medication take one tablet per day for 4 weeks. Therefore, a plan may cover only an initial 30-day supply of heartburn medication.

If the prescriber believes that it is medically necessary for the insured to be on a particular drug even though the insured doesn't meet the prior authorization criteria, the insured and the prescriber can contact the plan to request an **exception**. The prescriber must give a statement supporting the request. If the request is approved, the plan will cover the particular drug, even without prior authorization for the drug, or without trying a less expensive drug first.

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