POLICY INSIGHT

A Policy Newsletter on Life and Health Insurance and Financial Security Issues

April 2010

Timeline of Major Components of Federal Health Care Reforms

2010

- Lifetime benefit limits prohibited
- Cancellation of policies is prohibited except for fraud or intentional misrepresentation
- Dependent coverage is extended to age 26
- Pre-existing condition exclusions for dependents under the age of 19 is prohibited
- Allows restricted annual limits for essential benefits
- Small business tax credit is established
- National risk-pool is created
- Cost-sharing obligations (co-pays) for preventive services are prohibited
- Internet portal to facilitate consumer and small employer purchasing is created
- New health plan disclosure and transparency requirements are created
- Coverage for emergency services at in-network cost-sharing levels with no prior authorization is mandated
- Discrimination based on salary is prohibited
- New federal rate review process is established
- State grants to establish or expand consumer assistance/ombudsman programs are awarded
- Temporary retiree reinsurance program is established

2011

- Uniform coverage documents and standard definitions are developed by the US HHS
- Medical loss ratio minimums take effect

2014

- Pre-existing condition exclusions are prohibited
- Annual benefit limits are prohibited
- Guarantee issue is required
- Rating restrictions are imposed limiting the use of rating factors (i.e. geographic, age, tobacco…)
- Individual and employer mandates are established
- Individual and small business tax credits are expanded
- "Essential health benefit plans" are created
- Lifetime and annual dollar limits on essential benefits are prohibited
- Health Insurance Exchanges are created
- Coverage for clinical trials is mandated
- Multi-state health plans are created and offered through the Exchange

Texas Leads in Consumer Protections for Annuity Sales

In recent years, Texas has played a leading role in national reform efforts to guard against unscrupulous practices in the sale and marketing of annuities. In the past two legislative sessions, the Texas Legislature and Texas Department of Insurance have enacted stringent laws and tough new rules to prevent abuses of seniors and other consumers. These safeguards provide assurance for all Texans who wish to provide for their financial security during retirement.

Confidence and stability in insurance markets are essential and must be sustained. No one knows this better than the insurance industry. That's why the Texas Association of Life and Health Insurers and the American Council of Life Insurers have worked as partners with state leaders to pass national model reform acts and give the Texas Insurance Commissioner new powers to curb fraud and the potential for abuse in the sale of annuity products.

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TALHI
Texas Association of Life & Health Insurers

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The result is an impressive package of consumer protections (outlined below) covering every step in annuity transactions. These include:

- When the agent meets the consumer
- When the agent recommends a product
- When the agent provides important disclosures at the point of sale
- When insurers provide the ability to track ongoing sales trends
- When annual financial reports are provided after a sale

2007 – Lawmakers passed House Bill 2762, a model law to ensure that annuity products marketed and sold to consumers are suitable. The law sets standards and procedures so that insurers or agents will recommend annuity products that meet the insurance and financial needs of consumers at the time of purchase. The same year, lawmakers passed House Bill 2761. It established minimum standards for conduct of insurers and agents for transactions involving replacement of a life insurance or annuity product, including giving consumers appropriate information on which to base their decisions.

In cases of violations, both laws gave the Insurance Commissioner the authority to order full restitution for Texas residents harmed or to revoke or cancel the insurer's certificate of authority or the agent's license.

2009 – With the passage of House Bill 1294, lawmakers scrutinized and took action to stop agents from using misleading credentials. The law protects consumers from Texas agents who use designations and certifications that are not earned, are self-conferred or that imply a level of professional qualifications the agent does not possess. As part of the same law, the Department of Insurance adopted permanent rules requiring four hours of initial training and four hours of annual continuing education requirements for agents who sell, solicit, or negotiate an annuity contract or represent an insurer in relation to annuity products. The training sessions begin April 1, 2010.

Lawmakers also passed House Bill 1293 to require detailed disclosure of annuity rates, including key information explaining how they change and a summary of options and restrictions. The governor supported consumer provisions in this bill, but he vetoed it based on his belief that it would create a new private cause of action. The governor directed the Texas Insurance Commissioner to adopt the consumer protections in the form of new rules.

Once adopted, annuity disclosure regulations will outline the types of information about an annuity contract that must be disclosed to Texas consumers and the method for disclosing it. Disclosure requirements are expected to include explanation of rates and how or if they change, a summary of the options and restrictions for accessing money and an outline of fees. Timely disclosure and an Annuity Buyer's Guide are required to be provided to annuity applicants.

Compliance with provisions of this reform package began between January 1, 2008 and April 1, 2010. Industry experts encourage state leaders to give the Department of Insurance sufficient time to use the recent reforms in their investigation and enforcement of consumer complaints. As the reforms take effect, the Department of Insurance can assess the effectiveness of current laws and, if needed, recommend any additional consumer protections to close potential gaps.

Note to Insurance Company:

You responded to our claims quickly, and the initial payment really helped us to adjust to the immediate loss of income due to my illness. I have called the claims department for advice and information throughout the year. Every agent I spoke with was kind, patient, and helpful.

Edryce N. Tucker
Policyholder-National Teachers Associates Life Insurance Company

Wellness Programs: Reaping the Benefits

The Centers for Disease Control and Prevention notes that "more than 75% of all health care dollars are spent on chronic diseases, most of which are preventable."

One of the best ways employers can take a bite out of these costs is to implement workplace wellness programs, and they are doing just that. In 2003, according to the Society for Human Resource Management, 57% of employers offered wellness programs. By 2007, that had risen to 68%.

Fidelity Investments and the National Business Group on Health (NBGH) released data in 2010 noting that employers are still willing to make substantial investments to these programs, even in a tight economy. For example, 51% of respondents plan to institute at least one additional wellness-related program in 2010, and 89% plan to continue the current programs they provide.

According to the Business Roundtable, almost 40% of large companies in the U.S. spend over $200,000 a year on wellness programs, and 20% spend at least $1 million.

Just how effective are such initiatives? The Wellness Council of America (WELCOA) found in a study of 32 wellness programs that health care claims were reduced about 28%, physician visits were reduced by almost 17%, hospital admissions declined almost 63%, and disability costs were reduced 34%.

These days, the NBGH reports that, on average, employers can achieve a 3-to-1 ROI - a three dollar savings for every one dollar invested in wellness programs. Numbers vary, though. A study appearing in the *Journal of Health Promotion*, which reviewed 72 studies on wellness programs, found an average ROI of 3.5-to-1 for health care costs alone, 5.8-to-1 for absenteeism alone, and 4.3-to-1 for both.

And according to a recent article *CFO Magazine*, about half of companies that measure wellness program ROI see a 2-to-1 ROI, 25% see greater returns, and 25% say they are just breaking even or are actually even losing money.

One reason for the differences in ROI may be the fact that there are different types of wellness programs, each of which can provide a different ROI. WELCOA divides wellness programs into three categories, from least to most structured. The least structured (called Quality of WorkLife programs) reap an average ROI from 0-to-1 to 1.5-to-1. The middle group (called Traditional Wellness programs), reaps an average ROI from 1.5-to-1 to 3.5-to-1. The most structured (called Health and Productivity Management Wellness programs), reap an average ROI from 3.5-to-1 to 7.0-to-1.

Research reported in the 4th Annual Survey of Corporate Wellness Programs found that, while wellness programs in general average about 2-to-1 ROI, disease management programs in specific can save between 1.25-to-1 and 4.50-to-1.

Timing can be important in determining ROI, too. An article in the April 21, 2008 issue of Business Insurance notes that ROI for wellness programs is almost always forthcoming, but companies may need to wait five to 10 years before seeing savings.

But savings can accrue earlier. For example, Johnson & Johnson saved an average of $225 per staff member per year over four years, with the bulk of the savings showing up in third and fourth years.

However, the reverse can also be true. From 2001 to 2003, St. Luke's Health System avoided spending $8.50 in medical costs for every one dollar it spent on wellness for its employees. From 2003 to 2005, the cost avoidance was $3.50 for every one dollar spent.

In sum, the preponderance of evidence shows that, one way or another, employers save money by implementing wellness programs. In fact, as employers continue to see these savings, they are looking for ways to expand their programs and achieve even greater savings. For example, many are now encouraging employee spouses to participate. The reason: According to the University of Michigan, healthcare costs for spouses tend to be 9.7% higher than they are for employees. By opening wellness programs to spouses, employers have an opportunity to reduce these costs as well.

Note to Insurance Company:

I don't know what was more scary: surgery and diagnosis, or bills. The expediency and friendliness of working with you was absolutely miraculous.

Jo Ann Rufo

Policyholder-National Teachers Associates Life Insurance Company

Supplemental Policies: What They Cover

Supplemental insurance policies are insurance products designed to provide coverage in addition to what an individual's basic health policy might cover in certain circumstances. Supplemental policies are particularly attractive to individuals who are self-employed, families with children, and those who are financially unprepared to cover large medical expenses or lost wages due to a disability. Some of the more popular supplemental policies are outlined below.

Accidental death and dismemberment	Provides payment for the insured amount to the insured's beneficiaries in the event of death due to an accident. Also provides benefits, often a percentage of the death benefit, for the loss of limbs or vision due to a covered accident.
Accident health insurance	Reimburses the insured for medical expenses such as emergency care, hospitalization and outpatient surgery incurred as the result of accidents such as car accidents or accidents that occur at home or at work.
Disability	Provides a cash benefit to the insured for wages lost due to their inability to work. The amount of benefits paid are typically a percentage of the lost wages. Individuals are often able to obtain short-term and long-term policies from their employers. The policies may also be purchased in the private market on an individual basis.
Hospital indemnity insurance	Provides daily, weekly or monthly cash payments directly to the insured for each day they are hospitalized. The benefits are paid in addition to payments made by the insured's basic health policy.
Long-Term Care	Provides coverage for ongoing medical and non-medical care in nursing homes, assisted living settings and home medical care for individuals with either chronic illnesses or disabilities.
Medicare Supplemental (Medigap)	These are standardized policies that work with original Medicare to provide a range of coverage including payment for out-of-pocket costs like copayments, coinsurance, the yearly Medicare deductible and expenses after all hospital benefits are exhausted.
Specific disease	Provides cash benefits directly to the insured for medical expenses associated with the treatment of a specific disease such as cancer, heart disease or stroke. The amount of the benefits is typically not related to the amounts paid by an individual's basic health policy.

ABOUT TALHI: Texas Association of Life and Health Insurers

TALHI is the trade association for life and health insurers doing business in Texas. It was formed when Texas Life Insurance Association and the Texas Legal Reserve Officials Association merged in 1997.

Now representing the majority of insurers doing business in the state, TALHI has emerged as a leading voice for life and health insurers on legislative and regulatory matters.

TALHI is an open-door trade association boasting some of the most progressive life and health insurance company officials throughout the country. We are united for the mutual benefit and development of a healthy and competitive insurance market.

The work that TALHI does in the public policy arena is intended to strengthen the insurance market by enhancing insurers' ability to provide Texans financial security for their future.

We welcome the opportunity to work with you.

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