

Life & Health Insurance Advisor



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Indemnity Insurance

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Benefits of Hospital Indemnity Insurance

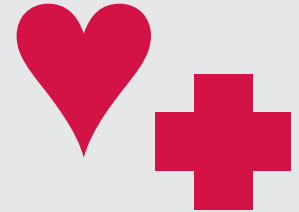
Hospital indemnity insurance is gaining in popularity as a way to deal with increasingly higher out-of-pocket expenses.

It's not health insurance, but it provides a cash benefit you can use to pay for expenses health insurance doesn't cover.

The Centers for Disease Control and Prevention estimated that the average hospital stay in 2017 was five days and cost more than \$30,000. Few families are prepared for such costs. According to a 2016 Kaiser Family Foundation and New York Times survey, 20 percent of Americans found that they had serious financial challenges when trying to pay their medical bills, even with health insurance.



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Pressure to End the Affordable Care Act Mounts

The U.S. Department of Justice (DOJ) recently submitted a legal brief to the 5th U.S. Circuit Court of Appeals outlining the Trump administration's arguments for invalidating the Affordable Care Act (ACA).

President Obama signed the ACA into law in 2010 and implemented the individual mandate, which requires all individuals to purchase health insurance or pay a tax penalty.

In 2017 the Republican-led Senate approved a tax bill that repealed the individual mandate (and the tax penalty associated with it) — effective in 2019.

The DOJ filed the brief on behalf of 20 Republican attorneys general who are challenging the

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One reason medical expenses are a challenge for many people is that health insurance companies limit what they will pay for many services. Also, as premiums have increased to keep pace with higher costs, consumers have been opting for higher deductibles (the out-of-pocket amount a policyholder must pay before insurance kicks in) to keep premium costs down. The average deductible for a bronze Obamacare policy in 2019 is \$5,900. Other costs policyholders must pay are coinsurance, the percentage of costs paid after the deductible is met, and the copay, a fee that must be paid for a covered health care service.

Hospital Indemnity Insurance pays you directly when you go to the hospital. Policies differ, but most pay you for any of the following:

- * Hospital confinement
- * Hospital outpatient costs
- * Emergency room or urgent care treatment
- * Rehabilitation at a qualified facility
- * Physician care for covered accidents and illnesses
- * Wellness and preventative services
- * Prescription drugs
- * Labs, x-rays, imaging, diagnostics when these services are connected to a covered illness or accident
- * Ambulance — ground or air
- * Many plans offer additional or optional benefits (for an additional fee) such as ICU confinement, outpatient surgery and other services

To use indemnity hospital insurance, you must inform your insurance company immediately and submit a claim. When your claim is approved, your benefit payments will begin.

Many hospital indemnity insurance plans pay based on a fixed cash benefit. Here's an example: You are admitted to the hospital and your policy pays \$250 for the emergency room; \$1,000 for the hospital admittance; and \$9,000 for being in the hospital for three days.

You can then use the money for paying your deductibles, copays, coinsurance or any other expenses you might incur, such as your mortgage, transportation and food.

One of the benefits of hospital indemnity insurance is that you can opt for a higher deductible health care insurance policy with lower premiums knowing that you have hospital indemnity coverage for worse case situations. Other benefits include:

- * This coverage provides financial protection, limiting your out-of-pocket costs.
- * You can use the money for whatever you want — paying for either hospital costs or living expenses.
- * The plan is portable, meaning that it's yours even if you change jobs, move to a different state or go on Medicare.
- * Unlike health insurance premiums, hospital indemnity insurance premiums usually stay the same unless your state's insurance commission approves and allows the carrier to increase the rates on all policies of the same type.

ACA's constitutionality. The state attorneys general argued that the 2017 tax reform law made the ACA's individual mandate unconstitutional by zeroing out the tax penalty. They also stated that the ACA cannot be viable without the individual mandate, making the ACA unconstitutional.

In December 2018, a U.S. district judge agreed with the plaintiffs, but Democratic attorneys general from 18 states and the District of Columbia appealed the judge's ruling.

The ACA still is the law, although without the individual tax penalty. If the appeals court accepts the Trump administration's argument, ACA supporters worry that millions who gained coverage through Medicaid or who have subsidized coverage could lose coverage.

- * Your policy can be renewed, as long as you pay the premiums on time.
- * Your plan might include free telemedicine consultations or a bill negotiator who can help you if you have problems.

Although it is possible to rely solely on this type of insurance for medical costs, experts do not recommend it. Hospital indemnity insurance doesn't cover normal doctor visits, prescription drugs and various other regular health care costs. Hospital indemnity insurance is actually designed to supplement your health insurance.

Premium costs vary depending on the state where you reside, if you use tobacco,

your age and overall health. Insurance carriers determine how healthy you are through a process called underwriting, where they analyze your background and health status. You likely will be asked to answer questions about your health on the application and might need to answer additional questions over the phone. If you have severe pre-existing conditions, such as cancer or history of strokes, your application will probably be declined. If you contract severe conditions after being approved, the policy will pay.

Another option is to save enough money to pay your deductible and out-of-pocket maximum on your plan. However, if you don't think you can save enough money for a substantial emergency fund, talk to your broker about a hospital indemnity insurance policy that might be just right for you. ■

Important Changes to Medicare Part D

If you're retired and have health care coverage through Medicare Advantage Part C or Original Medicare and a Part D plan, you should know that a few changes have been made.



The Centers for Medicare & Medicaid Services (CMS) issued a final rule this year to modernize and improve the Medicare Advantage and Part D programs.

Medicare is the federal health insurance program for those 65 or older; or who have disabilities; or have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Part A often is referred to as hospital insurance. Part A covers inpatient hospital stays; care in a skilled nursing facility; hospice care; and some home health care. Coverage is free. Medicare Part B, also known as medical insurance, covers some doctors services; outpatient care; medical supplies; and preventive services. Coverage costs \$134 per month. If you do not sign up for Part B when you turn 65, and if you do

not have health coverage, you will have to pay more for Medicare Part B when you do decide to get coverage.

Some retirees want more than what Part A or B provide, since for the most part, neither one provides drug coverage. Medicare Part C is a Medicare Advantage plan, an option providing the same coverage as Original Medicare (Parts A and B) — but with additional benefits, such as routine vision services and prescription drug coverage. An interesting fact is that average Medicare Advantage premiums dropped by more than 30 percent in first quarter of 2019, according to data released by eHealth.

For those who are happy with Part A or B, but want drug coverage, they can go with Medicare Part D, known as prescription drug coverage, which adds coverage to Medicare A or B. Keep in mind that you can't

have a Medicare Advantage Plan and Part D coverage at the same time

New Rules

The new rules ensure that patients have greater transparency into the cost of prescription drugs in Part D and also enables Medicare Advantage plans to negotiate better prices for physician-administered medicines in Part C.

The changes include:

Part D Protected Classes

A drug formulary is a list of prescription drugs, both generic and brand name, that are covered under a plan. Part D policies must include these six drug classes on their formularies:

- 1 antidepressants
- 2 antipsychotics
- 3 anticonvulsants
- 4 immunosuppressants (for treatment of transplant rejection)
- 5 antiretrovirals (first-line HIV treatment)
- 6 antineoplastics (anticancer drugs) (except in limited circumstances)

The rules also codified an existing policy specifying that Part D sponsors can only impose prior authorization and step therapy requirements for those who are starting a new drug regime for five of the six protected classes, with no prior authorization or step therapy allowed for antiretrovirals. Step therapy is a procedure where the pa-

tient is required to try a generic drug before moving to the more expensive brand name drugs.

E-Prescribing and the Part D Prescription Drug Program

An electronic Real Time Benefit Tool (RTBT) gives prescribers visibility to cost and coverage information within their electronic health record (EHR). CMS requires each Part D plan sponsor to adopt one or more RTBTs capable of integrating with at least one prescriber's electronic health record. This must be in place no later than Jan. 1, 2021.

Medicare Advantage and Step Therapy for Part B Drugs

CMS will soon finalize regulations to require step therapy for Part B drugs. Part B step therapy regulations include a number of safeguards protecting beneficiaries and ensuring timely access to "new starts" for medically necessary Part B drugs.

Part D Explanation of Benefits

Beginning in 2021, Part D Explanation of Benefits should include information about how Medicare beneficiaries can lower their out-of-pocket costs by considering a lower cost medication.

Prohibition Against Gag Clauses in Pharmacy Contracts

Part D sponsors cannot prohibit or penalize a pharmacy from disclosing a lower cash price to an enrollee. ■

What to Know: Long-term vs. Short-Term Disability Insurance

No one really expects to become disabled, but it does happen.

According to the Social Security Administration, three in 10 workers entering the workforce will become disabled and will be unable to work before they reach the age of retirement. The Council for Disability Awareness reports that approximately 90 percent of those disabilities will be caused by illness rather than accidents.

If you are in your prime wage earning years, short-term disability and/or long-term disability insurance can protect your income when you become sick or injured. You won't be able to totally match your salary (the premiums would be prohibitive) but usually you can come close. In addition, disability benefits usually are not taxed, so your benefits should be close to your take home pay.

And while some people think that workers' compensation or government benefits offer protection in case of disability, workers' compensation is limited to work-related injuries and it can be difficult to qualify for Social Security disability.

ity insurance (SSDI). It's one reason many experts rank long-term disability as one of the top "must have" insurance plans to purchase.

Comparisons

The question for many people is what's the best fit for their situation, short-term or long-term disability insurance. To make that decision, consider the following:

- * How long will each type of disability insurance last?
- * How long you will have to wait before benefits are paid (this is known as the elimination or waiting period)
- * How much coverage does each offer?
- * What is the cost difference between short- and long-term insurance?

These are the main differences between the two:

Short-term Disability

- * How long coverage lasts – Typically lasts between three to six months.
- * Elimination (waiting) period – Usually fewer than 14 days.
- * How much coverage – Provides about 80 percent income replacement
- * Cost – Least expensive



Long-term Disability

- * How long coverage lasts – You can apply for a benefit period that lasts two, five, or 10 years, or until retirement.
- * Elimination (waiting) period – Ranges from 30 days to two years, but the most common is 90 days (the longer the elimination period, the cheaper the policy)
- * How much coverage – Provides about 60 percent income replacement.
- * Cost – More expensive

While it might be tempting to just go with the least expensive option, the Council for Disability Awareness says that the average individual disability claim lasts for less than three years. A short-term policy might not provide enough coverage. Many experts recommend purchasing short-term disability insurance as a supplement to long-term disability insurance since the short-term policy

would provide benefits before the long-term policy kicks in. By doing this, you can increase the elimination period of your long-term policy and significantly lower your costs for that plan.

Cost

As mentioned, what you pay for coverage depends on a number of factors, including the benefit period, elimination period, and coverage amount. Additional

factors include your age, health, occupation, location and any extra features you might want. Usually, it will cost you from one to three percent of your annual salary for a disability policy.

Another option is to get a subsidized short-term disability policy through your employer, which may be available to you free as part of your benefit package. Keep in mind that the policy will be tied to your employment, so if you leave your job, you will lose coverage or will have to pay a high cost to retain the policy.

If you have enough emergency savings for three to six months, you might not need short-term coverage.

When choosing a long-term disability insurance policy, look for a company with good ratings from places such as the Better Business Bureau and A.M. Best. ■

Travel Insurance for Peace of Mind

The best laid vacation plans can't prevent the unexpected.

The last thing you want to think about when planning your dream vacation is canceling your trip. Still, it pays to plan ahead and travel insurance can be one of the most important items you take.

Travel insurance generally covers trip cancellations, medical emergencies, travel delays and lost luggage. Medical and medical evacuation benefits are built into most travel insurance policies. It also can pay for the costs of getting you home if the hospital determines it's necessary.

With trip cancellation coverage, you get a 100 percent refund of your trip expenses if you cancel before leaving for a reason covered by your policy:

- * Sickness or injury
- * Your death or death of a family member or traveling companion
- * Hurricane damages to your destination or flight cancellation
- * Laid off from work or required to work
- * Terrorist incident at your destination
- * Travel supplier bankruptcy
- * Called for jury duty
- * Military deployment
- * Divorce or legal separation



Trip Interruption coverage covers many of the same reasons as trip cancellation coverage. Policies with trip interruption also cover additional transportation costs if you must return early and costs for the lost portion of your trip.

Some travelers chose to upgrade to “cancel for any reason” coverage. It offers a partial refund of expenses, usually 75 percent, for reasons not listed under trip cancellation. Adding this coverage will increase premiums about 40 percent and must be added 14 to 30 days after you book your trip.

Travel insurance also can cover travel delays when you miss a flight and helps pay for meals and hotel accommodations. Missed connection coverage pays for costs if you missed your departure for a reason covered by your policy, such as severe weather, a mechanical breakdown, or accident on your way to the airport.

To qualify, you generally should buy insurance within 15 days of booking your trip. ■

