Chapter 21
Employee Benefits: Group Life and Health Insurance Coverages

Overview

This chapter and the next chapter are devoted to employee benefits. Employee benefits are often taken for granted and you may be surprised by the magnitude of these plans. Each year the U.S. Chamber of Commerce surveys employers about their employee benefit plans. The Chamber uses a broad definition of employee benefits, including social insurance (Social Security, workers’ compensation and unemployment insurance), payment for time not worked, private insurance (life, health, and disability), retirement plans, and other benefits. Using the broad definition, the average employer spends an additional 30 to 40 percent of payroll on employee benefits. Employee benefits are an important part of total compensation and are important in assisting employees, their dependents, and retirees in achieving financial security.

In this chapter, we examine group life and health insurance coverages. As an introduction, group insurance underwriting principles and eligibility requirements are discussed. Next, group life and health insurance coverages are examined, as well as group health insurance providers, managed care plans, and group health insurance policy provisions. The chapter closes with a discussion of cafeteria plans.

Learning Objectives

After studying this chapter, you should be able to:

• Explain the underwriting principles followed in group insurance.
• Describe the basic characteristics of group term life insurance.
• Explain the major characteristics of the following group medical expense plans: basic medical expense insurance, major medical insurance, and dental insurance.
• Describe the basic characteristics of the following managed care plans: health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service plans (POS).
• Explain the basic characteristics of the following consumer-directed health plans: defined contribution plans and high deductible plans.
• Show how short-term group disability income plans differ from group long-term disability plans.
• Describe the major characteristics of cafeteria plans.
• Define the following:
  Basic medical expense insurance
  Blue Cross and Blue Shield plans
  Cafeteria plans
  Calendar-year deductible
  Capitation fee
  COBRA law
  Coinsurance provision
  Comprehensive major medical insurance
  Contributory plan
  Coordination-of-benefits provision
  Corridor deductible
  Defined contribution health plan
  Eligibility period
  Employee benefits
  Experience rating
  Family deductible provision
Consumer-directed health plans (CDHPs)  Flexible spending account
Gatekeeper physician
Group accidental death and dismemberment (AD&D) insurance
Group dental insurance
Group disability-income insurance
Group medical expense insurance
Group term life insurance
Group universal life insurance
Health Insurance Portability and Accountability Act (HIPAA)
Health maintenance organization (HMO)
Health reimbursement account (HRS)
High deductible health plan
Hospital expense insurance
Individual practice association (IPA) plan
Major medical insurance
Managed care

Master contract
Noncontributory plan
Nonoccupational disability
Out-of-pocket maximum
Point-of-service (POS) plan
Portability
Preexisting condition
Preferred provider organization (PPO)
Probationary period
Reasonable and customary charges
Self-insurance (self-funding)
Service benefits
Supplemental major medical insurance
Surgical expense insurance
Traditional indemnity plan (fee-for-service)
Voluntary accidental death and dismemberment insurance

Outline

I. Meaning of Employee Benefits

II. Fundamentals of Group Insurance
   A. Differences between Group Insurance and Individual Insurance
   B. Basic Underwriting Principles
      1. Insurance Incidental to the Group
      2. Flow of Persons through the Group
      3. Automatic Determination of Benefits
      4. Minimum Participation Requirements
      5. Third-Party Sharing of Cost
      6. Simple and Efficient Administration
   C. Eligibility Requirements in Group Insurance
      1. Eligible Groups
      2. Eligibility Requirements of Employees

III. Group Life Insurance Plans
   A. Group Term Life Insurance
   B. Group Accidental Death and Dismemberment (AD&D) Insurance
   C. Group Universal Life Insurance
IV. Group Medical Expense Insurance
   A. Commercial Insurers
   B. Blue Cross and Blue Shield Plans
   C. Managed Care Organizations
   D. Self-Insured Plans by Employers

V. Traditional Indemnity Plans
   A. Basic Medical Expense Insurance
      1. Hospital Expense Insurance
      2. Surgical Expense Insurance
      3. Physicians’ Visits
      4. Miscellaneous Benefits
   B. Major Medical Insurance
      1. Supplemental Major Medical Insurance
      2. Comprehensive Major Medical Insurance

VI. Managed Care Plans
   A. Health Maintenance Organizations (HMOs)
   B. Preferred Provider Organizations (PPOs)
   C. Point-of-Service (POS) Plans
   D. Advantages of Managed Care Plans
   E. Disadvantages of Managed Care Plans

VII. Consumer-Directed Health Plans
   A. Defined Contribution Health Plans
   B. High-Deductible Health Plans

VIII. Recent Developments in Employer-Sponsored Health Plans

IX. Group Medical Expense Contractual Provisions
   A. Preexisting Conditions
   B. Coordination of Benefits
   C. Continuation of Group Health Insurance

X. Group Dental Insurance
   A. Benefits
   B. Cost Controls
XI. Group Disability-Income Insurance
   A. Short-Term Plans
   B. Long-Term Plans

XII. Cafeteria Plans

■ Short Answer Questions

1. List the basic underwriting principles used in group insurance.

2. What groups are typically eligible for group insurance? What are the eligibility requirements for individuals who are members of these groups?

3. What are the major types of group life insurance plans? Describe the typical provisions of group term life insurance.
4. From what sources are group medical expense insurance plans available?

5. What coverages are typically provided through group basic medical expense plans?

6. How does supplemental major medical insurance differ from comprehensive major medical insurance?

7. What is “managed care” and how do managed care plans differ from traditional group health insurance plans?
8. What is a preferred provider organization (PPO)?

9. Why are preexisting conditions provisions and coordination of benefits provisions often used in group health expense insurance plans?

10. What cost control measures are typically included in group dental insurance plans?
11. How do group short-term disability income insurance plans differ from group long-term disability income insurance plans?

12. What are the common characteristics of cafeteria plans?

**Multiple Choice Questions**

*Circle the letter that corresponds to the BEST answer.*

1. Which statement(s) is(are) true with regard to group insurance underwriting principles?
   I. A flow of people through the group is undesirable.
   II. Benefits should be automatically determined.
   (a) I only
   (b) II only
   (c) both I and II
   (d) neither I nor II

2. Group basic medical expense plans usually provide all of the following benefits EXCEPT:
   (a) hospital expense insurance
   (b) supplemental major medical insurance
   (c) surgical expense insurance
   (d) physicians’ visits
3. Swanson Enterprises gives each employee covered under the employee benefit plan 250 credits. With the credits, the employees can select which employee benefits they desire, and the magnitude of the benefits (up to certain limits). This type of plan is called a:

(a) managed care plan  
(b) universal coverage plan  
(c) preferred provider plan  
(d) cafeteria plan

4. Under one cost control measure used in dental insurance, if the estimated cost of dental treatment exceeds a specified value, a plan of treatment is submitted to the insurer. The insurer calculates the amount that will be covered under the plan. This information is then shared with the employee who decides whether to have the procedure performed. Such a provision is called a:

(a) predetermination of benefits provision  
(b) coordination of benefits provision  
(c) flexible spending account  
(d) relative value schedule provision

5. Union Atlantic Railroad entered into an agreement with St. Joseph’s Hospital. Under the agreement, St. Joseph’s Hospital discounts services provided to Union Atlantic employees, and Union Atlantic provides a financial incentive for their employees to receive care from St. Joseph’s. In this relationship, St. Joseph’s Hospital is a(n):

(a) private health insurance company  
(b) Blue Cross/Blue Shield organization  
(c) preferred provider organization  
(d) health maintenance organization

6. Which statements is(are) true with regard to health maintenance organizations (HMOs)?

I. Health maintenance organizations emphasize cost containment.

II. Health maintenance organization members receive comprehensive health services in exchange for a fixed, prepaid fee.

(a) I only  
(b) II only  
(c) both I and II  
(d) neither I nor II

7. A group of cardiac rehabilitation patients exercise together at the local fitness club. All of these patients have had at least two heart attacks or coronary bypass surgery; and none have been able to purchase health insurance because of preexisting conditions. If these patients form a group to obtain group health insurance coverage, which group insurance underwriting principle would be violated?

(a) automatic determination of benefits  
(b) minimum participation requirements  
(c) insurance incidental to the group  
(d) flow of persons through the group
8. Tyndall Manufacturing covers employees under a basic medical expense plan supplemented with major medical insurance. Before the major medical insurance will begin to pay, the employee is required to pay a portion of covered medical expenses in excess of the limits of the basic coverage. This type of deductible is called a(n):
   (a) aggregate deductible
   (b) franchise deductible
   (c) corridor deductible
   (d) straight deductible

9. All of the following are characteristics of group major medical insurance EXCEPT:
   (a) first-dollar coverage
   (b) high maximum limits
   (c) broad coverage
   (d) coinsurance (percentage participation)

10. Which statement(s) is(are) true with regard to short-term disability income plans?
    I. The maximum duration of benefits is usually three years.
    II. Most of these plans cover nonoccupational disability.
    (a) I only
    (b) II only
    (c) both I and II
    (d) neither I nor II

11. All of the following are major characteristics of group universal life insurance EXCEPT:
    (a) coverage issued on a guaranteed basis up to certain limits with no evidence of insurability
    (b) the policyowner chooses where the cash value is invested
    (c) minimum guaranteed rate of return, but a higher rate may be credited
    (d) policy loans and withdrawals are available

12. One provision of the Health Insurance Portability and Accountability Act requires that when employees change jobs, the new employer must give credit for previous and continuous health insurance coverage. This provision is called:
    (a) convertibility
    (b) renewability
    (c) portability
    (d) renewal provision

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**True/False**

C*ircle the T if the statement is true, the F if the statement is false. Explain to yourself why a statement is false.*

T   F  1. Most group life insurance in force is term insurance.

T   F  2. Employer-sponsored group insurance plans typically cover part-time workers.
T    F   3. Without a flow of younger workers into the group and older workers out of the group, group insurance premiums will increase.
T  F  4. Group accidental death and dismemberment insurance will pay the principal sum regardless of the cause of death.

T  F  5. Group disability income insurance is not needed if the employer provides workers’ compensation coverage.

T  F  6. In a noncontributory group term insurance plan, the employer pays the entire cost of life insurance coverage.

T  F  7. Group major medical insurance is characterized by high limits, deductibles, and coinsurance (percentage participation).

T  F  8. Evidence of insurability is usually not required in group insurance plans.

T  F  9. Blue Cross and Blue Shield plans typically reimburse their members for medical services after their members have reimbursed the care provider.

T  F 10. Under a defined contribution health plan, the employer makes a fixed contribution toward an employee’s health coverage, but the employee selects the plan to which the premiums apply.

T  F 11. Under an individual practice association (IPA) health maintenance organization (HMO), physicians treat both HMO members and patients who are not members of the HMO.

T  F 12. Flexible spending accounts provide no tax advantages to cafeteria plan participants.

T  F 13. Employees are required to use the employer’s preferred provider organization (PPO).

T  F  14. High deductible health plans are used in conjunction with health savings accounts.

■ Case Applications

Case 1

Ned just attended an orientation session for new employees. The employee benefits director spoke for an hour about the various employee benefits the company offered and the provisions of these benefits. In the course of the presentation, the employee benefits director discussed (1) probationary periods, (2) eligibility periods, and (3) elimination (waiting) periods. Ned is confused about these terms and has asked you to explain the meaning and importance of each “period.” How would you explain these “periods” to Ned?
Case 2
The employee benefit plan at Taylor Brothers Stores provides the following group insurance coverages:

* **Life Insurance:** Accidental death and dismemberment insurance, with a principal sum of $50,000.
* **Health Insurance:** Basic medical expense plan, overall limit of $25,000.
* **Disability Income Insurance:** Short-term plan, no waiting period, 100 percent income replacement, six months duration.

All of these benefits are funded on a noncontributory basis.

Critique Taylor Brothers Stores’ group insurance offerings.

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**Solutions to Chapter 21**

**Short Answer Questions**

1. These principles include: insurance incidental to the group, flow of persons through the group, automatic determination of benefits, minimum participation requirements, third-party sharing of cost, and simple and efficient administration.

2. Eligible groups include individual employer groups, multiple-employer groups, labor union groups, debtor-creditor groups, and some other miscellaneous groups. Group insurers also require that the group satisfy a minimum size requirement.

   Employees must meet certain eligibility standards including: be a full-time employee, satisfy a probationary period, apply for insurance during the eligibility period, and be actively at work when the coverage becomes effective.

3. The major types of group life insurance are group term life insurance, group accidental death and dismemberment insurance (AD&D), and group universal life insurance.

   The amount of group term provided is typically a salary multiple such as one- to five-times salary. The coverage remains in force as long as the employee is a member of the group. If the employee leaves the group, the term insurance is usually convertible to individual cash value coverage without having to provide evidence of insurability. Small amounts of coverage may be available for dependents and retired workers.

4. Group medical expense insurance is available from commercial insurers, Blue Cross and Blue Shield plans, health maintenance organizations (HMOs), and through self-insured employer plans.

5. Group basic medical expense plans typically provide the following benefits: hospital expense insurance, surgical expense insurance, physicians’ visits coverage, and miscellaneous benefits.
6. Supplemental major medical insurance is written to supplement the benefits provided under a basic medical expense plan. Medical expenses not covered under the basic plan may be eligible for reimbursement under the supplemental major medical plan. Comprehensive major medical combines basic plan benefits and major medical insurance in one policy.

7. Managed care is a generic term for medical expense plans that attempt to provide covered medical services to members in a cost-effective manner.

These plans differ from traditional group health insurance plans in that the employee’s choice of physicians and hospitals may be limited to certain providers, utilization review is conducted at all levels, preventive care and wellness are emphasized, providers share in financial results through risk-sharing techniques, and prevention and wellness are stressed.

8. A preferred provider organization (PPO) is a plan that contracts with health care providers to obtain medical services for members at reduced fees. PPOs benefit employers because the care is provided to their employees at a discount compared to the provider’s normal charge. PPOs benefit care providers because they receive prompt payment and increased patient volume for their services. PPOs permit members to receive health services outside the network of health care providers, however the reimbursement rate for members may be lower.

9. A preexisting conditions provision excludes from coverage medical conditions diagnosed or treated prior to coverage commencing. The purpose of the provision is to reduce adverse selection against the insurer. The Health Insurance Portability and Accountability Act of 1996 limits the right of insurers and employers to restrict coverage for preexisting conditions in group health plans.

A coordination of benefits provision specifies the order of payment when medical services are covered under two or more group health insurance plans. The purpose of a coordination of benefits provision is to prevent overinsurance and the duplication of benefits.

10. Cost control measures typically found in group dental insurance plans include: deductibles and coinsurance, maximum limit on benefits, waiting periods, exclusions, and a predetermination-of-benefits provision.

11. Group short-term disability income plans typically pay benefits for 13 weeks to two years, with 26 weeks the most common duration of benefits. Group long-term plans pay benefits ranging from two years to age 65. Waiting periods in short-term plans are typically one to seven days, while long-term plans typically have waiting periods ranging from three to six months. Most short-term plans cover nonoccupational disability only, while long-term plans typically cover both occupational and nonoccupational disability. Short-term plans define disability in terms of your own occupation while long-term plans typically use a dual definition of disability. For the first two years, the employee’s own occupation is considered. After two years, the definition changes to any job for which you are reasonably fitted by education, training, and experience.

12. Cafeteria plans have a number of common characteristics. First, employees are given a number of dollars or credits that can be spent on benefits or taken as cash. The employee decides which benefits will be purchased with the dollars or credits. Second, many cafeteria plans are also premium conversion plans that allow employees to make their premium contributions with pre-tax dollars. Third, most cafeteria plans make available an optional flexible spending account (FSA). Finally, if the plan meets certain criteria required under the Internal Revenue Code, the employer’s credits are not considered currently taxable income to the employee.
Multiple Choice Questions

1. (b) Only the second statement is true. Automatic determination of benefits prevents individual selection of benefits and adverse selection. A flow of people through the group is desirable. As older employees leave the group, younger employees enter. Without such a flow through the group, the average age of members in the group would increase, and the premium charged for group insurance would also have to increase.

2. (b) Supplemental major medical is used to supplement basic medical expense plans. Medical expenses not covered under the basic plan may be eligible for reimbursement under the supplemental major medical plan.

3. (d) A cafeteria plan is described. These plans allow employees to choose the benefits they desire, within limits.

4. (a) This provision is known as a predetermination of benefits provision.

5. (c) St. Joseph’s Hospital is a preferred provider for Union Atlantic. In exchange for the guaranteed demand for health care services, St. Joseph’s Hospital provides care to Union Atlantic employees on a discounted basis.

6. (c) Both statements are true. HMOs deliver comprehensive benefits to members in exchange for a fixed, prepaid fee. These organizations emphasize prevention and cost containment.

7. (c) As the group would be formed for the purpose of obtaining group health insurance, clearly insurance would not be incidental to the group’s existence.

8. (c) The provision described is a corridor deductible. Such a deductible is used between basic medical expense plans and supplemental major medical insurance.

9. (a) Group major medical insurance does not provide first-dollar coverage. A variety of deductibles are used in major medical insurance plans.

10. (b) Only the second statement is true. Short-term plans typically cover nonoccupational disability only. While some short-term plans may pay benefits for as long as two years, the majority pay benefits for a maximum period of only 26 weeks.

11. (b) As with individual universal life insurance, policyowners do not select where the cash value is invested.

12. (c) Portability means that when an employee changes jobs, the new employer must give credit for previous and continuous health insurance coverage.

True/False

1. T

2. F Group insurance plans normally restrict eligibility to full-time workers.

3. T

4. F The death benefit will only be paid if the cause of death is an accident.
5. F Workers’ compensation provides benefits for work-related illnesses and injuries only. Disability income insurance is needed for nonoccupational illness and injuries.

6. T

7. T

8. T

9. F Blue Cross and Blue Shield plans are prepayment plans. The plans directly reimburses the care provider.

10. T

11. T

12. F Since flexible spending accounts are funded through before-tax reductions in workers’ pay, taxes paid are reduced, and spendable income is increased.

13. F Employees are not required to use the preferred provider. However, employees are given a financial incentive to do so, often through reduced deductibles or greater employer cost-sharing if the preferred provider is used.

14. T

Case Applications
Case 1
A probationary period usually begins when employment starts. It is a period of time a new employee must satisfy before he or she can participate in the employee benefit plan. Some workers may be with the firm for only a short period of time. A probationary period at the start of employment reduces the cost of adding workers who will only be with the company for a short period of time.

An eligibility period is used in contributory plans. Under a contributory plan, the employee funds part or all of the cost of an employee benefit. An eligibility period is a short period of time—typically 31 days—during which an employee can sign-up for a benefit without demonstrating evidence of insurability. The purpose of limiting the opportunity to select an optional benefit is to avoid adverse selection. For example, an employee benefit plan might allow employees to purchase additional life insurance. Without an eligibility period, a worker just diagnosed with a terminal illness might try to purchase more coverage. The eligibility period restricts the time during which a contributory benefit may be elected.

Waiting (elimination) periods are used in disability income insurance. The waiting period is a period of time after an illness or injury during which no benefits are paid. The waiting period is similar to a deductible because the insured must absorb a portion of the loss before the insurer begins payment.
Case 2

The group insurance coverages offered in this employee benefit plan are quite limited and not wisely designed. Accidental death and dismemberment insurance pays death benefits if the cause of death is an accident. There’s no coverage for death from cancer, heart disease, or other nonaccidental means. The health insurance is a basic plan with a $25,000 limit. This limit will not go far if an employee has a serious medical condition. The disability income plan is subject to abuse as employees can receive 100 percent of lost income without having to serve a waiting period. Also, there’s no coverage for long-term disabilities.

The risk management adage “insure for the large loss” also applies to group insurance. By modifying the benefits (e.g. dropping AD&D and replacing it with group term insurance, purchasing supplemental major medical insurance, etc.), additional security for the employees and their dependents can be achieved. If more funds are needed to pay for these benefits, some or all of the benefits could be made contributory.