Life & Health Insurance Advisor

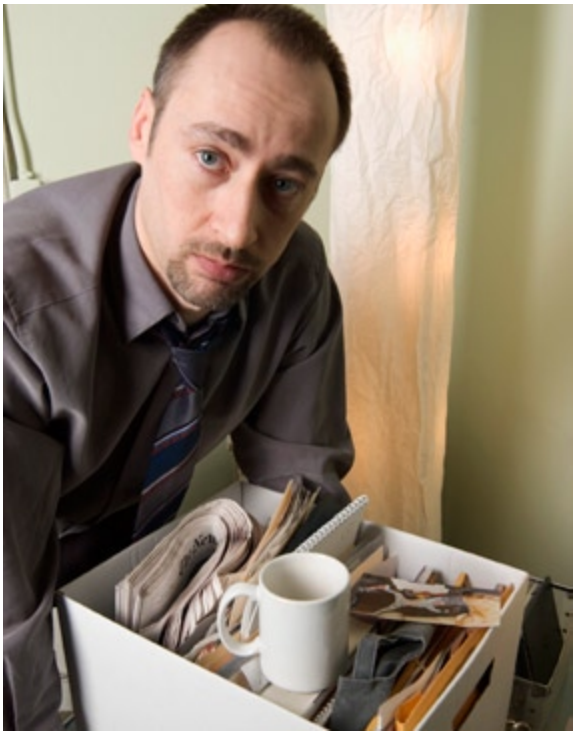
eHummel InsuranceServices

Eric B. Hummel, Agent Broker, info@erichummel.com
4995 Somerset Drive, PO Box 1538, Cornville, AZ 86325
Business: (928) 634-2123 • Toll-Free: (800) 452-9261

Health & Life Insurance Specialists Since 1989

Health Insurance **January 2009** **Volume 2 • Number 1**

Insurance After a Job Loss



If you have employer-provided health coverage and face loss of coverage due to reduction in hours or job loss, knowing your options can help you protect your insurability. Once coverage lapses, those with pre-existing health conditions can find it very difficult to get coverage again.

Those who lose employer-provided health insurance can explore the following coverage options:

Special Enrollment in Another Group Plan. If other group health coverage is available (for example, through a spouse's employer-provided plan), consider taking advantage of "special enrollment" in that plan. This gives you and your family an opportunity to enroll in a plan for which you are otherwise eligible, regardless of enrollment periods. To qualify, you must request enrollment within 30 days of losing eligibility for your other coverage. After you request special enrollment, coverage must be made effective no later than the first day of the first month following your request for enrollment. Although the cost for coverage under special enrollment in a spouse's plan is probably higher than what you paid before, generally it will cost less than private, individual health insurance coverage.

COBRA Continuation Coverage. If your employer continues to operate and offer a group health plan, you may be able to obtain COBRA continuation coverage. COBRA, which generally applies to employers with 20 or more employees, allows an individual and his/her eligible dependents to continue the same group health coverage at group rates. Your cost may be higher than what you paid before, as the employer will likely discontinue any premium contributions and can charge you up to 102 percent of the premium to cover administrative expenses.

When you lose coverage under a group health plan, the plan

JOB LOSS—continued on Page 3

This Just In

Some proponents say nationalized healthcare would cost less, because private insurers add a layer of administration to the system. However, a recent study by accounting firm PricewaterhouseCoopers found that administrative expenses account for approximately 13 percent of health premiums—which compares favorably to a well-run nonprofit.

Those expenses break down as follows:

- **✔ 4 percent of premiums: consumer services, provider support and marketing. According to PricewaterhouseCoopers, this includes "communications with consumers regarding their… benefits, disease management programs, care coordination, health promotion, wellness and prevention programs, and … health information technologies that benefit consumers" in addition to marketing and sales.**
- **✔ 2 percent of premiums: costs of complying with laws and regulations, such as filing and reporting, and premium taxes.**
- **✔ 3 percent of premiums: claims processing, including costs of reviewing, paying and recording claims.**
- **✔ 1 percent of premiums: miscellaneous costs, such as collecting premiums and underwriting and actuarial services.**

The rest of your premium dollars pay doctors, hospitals, pharmacies and other healthcare providers.

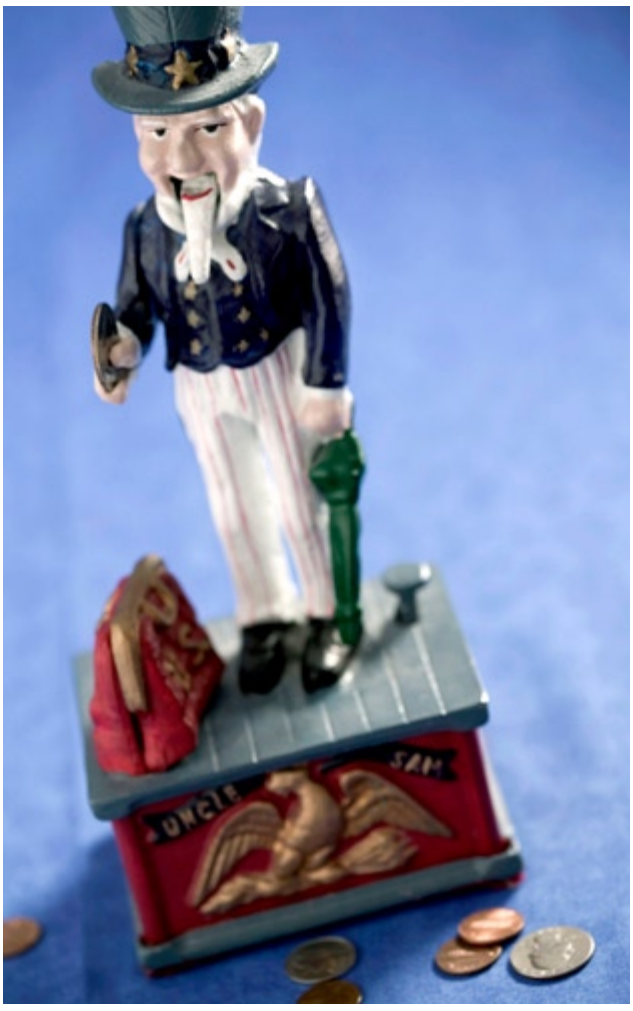
How to Get One Past Uncle Sam…Legally!

If you're self-employed, you probably think you pay enough in taxes. But did you know there's a way to deduct 100 percent of your accident and health plan costs—legally?

It's called a Section 105 plan, after the section of IRS Code that permits employees to exclude from taxable income employer-provided accident and health insurance premiums, or amounts the company pays to reimburse employees for eligible healthcare expenses. This arrangement has been utilized by the self-employed in partnerships, limited liability corporations, subchapter S corporations and sole proprietorships.

How does it work? The self-employed individual sets up a healthcare reimbursement arrangement (HRA) and then hires his or her spouse as an employee. The employer-spouse provides family accident and health coverage for the employee-spouse through the HRA. The employee-spouse can buy insurance coverage using HRA funds, covering the employer-spouse as dependent. Further, the HRA can reimburse the employee-spouse for eligible healthcare costs not covered by insurance.

Through this arrangement, the employer-spouse deducts 100 percent of the cost of providing health coverage to himself and his family, including insurance premiums and reimbursement for medical expenses that insurance doesn't cover, such as copayments and charges for office visits. The business deducts these expenses as a cost of doing business, while the employee-spouse can exclude from gross income the cost of the health coverage and/or medical expense reimbursements.



Sound too good to be true? Section 105 plans are legitimate, but you must meet a few very important requirements to protect deductibility.

First, your spouse must be a bona fide employee. That means he or she must meet the common law definitions of "employee" or otherwise provide services to the business for which the accident and health coverage is reasonable compensation.

According to the IRS, "the performance of nominal or insignificant services that have no economic substance or independent significance may be challenged." Generally speaking, a bona fide employee works 15 or more hours per week for the business. The dollar value of the services your employee-spouse provides must be equal to or more than the value of the health coverage he or she receives. If the employee-spouse does not meet this standard, the accident and health coverage the business provides will be considered a personal expense under IRS Code, and not deductible.

To qualify for a Section 105 plan, your spouse cannot be a joint owner, co-owner or partner of the business. For example, a significant investment of the spouse's separate funds in (or significant co-ownership or joint ownership of) the business assets may support a finding that the spouse is self-employed in the business rather than an employee.

Second, your employee-spouse must meet the eligibility provisions of your firm's plan. If you provide coverage to other employees already, you need to apply the same eligibility criteria to your employee-spouse. For example, if your plan imposes a waiting period, you must apply the same waiting period to your employee-spouse. Without documentation of eligibility, your employee-spouse might not be able to deduct healthcare reimbursements received from gross income.

Third, your plan must not discriminate. If your business provides health coverage — whether by paying for health insurance or through a healthcare reimbursement arrangement — to your employee-spouse, it must provide coverage to other employees who meet the same service criteria, such as length of service and hours worked per week. If you fail to do so, your business could be retroactively liable for eligible employees' healthcare expenses.

For more information on Section 105 plans and other healthcare coverage options, please call us.

JOB LOSS—*continued from Page 1*

should send a notice regarding the availability of COBRA coverage. After this notice is provided, you generally have 60 days to elect coverage, which is then available retroactive to the date you lost coverage.

(Note: Once you have elected COBRA, you won't be eligible for special enrollment in another group health plan, such as a spouse's plan, until all COBRA coverage available is exhausted. Therefore, it is important to consider special enrollment in another plan promptly.) COBRA coverage typically lasts 18 months, but may last longer in certain circumstances.

Health Coverage Through a Government Program. Health coverage may be available to certain qualified individuals through the state or federal governments. Information on government programs such as Medicaid (for low-income individuals and individuals with special needs), State Children's Health Insurance Program (for children of qualified families) or Medicare (for people aged 65 and over, and for certain people who are disabled or have end-stage renal disease), is available through your state insurance department or the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services at www.cms.hhs.gov.

Private, Individual Health Insurance. Another option to consider is private individual health insurance coverage. You may qualify for guaranteed access to such coverage, without any pre-existing condition exclusions, if:

- You had health coverage for at least 18 months without a significant break in coverage (generally 63 days or more) and the most recent period of coverage was under a group health plan;
- Group coverage was not terminated because of fraud or failure to pay premiums;
- You either were not eligible for COBRA continuation coverage (or similar state program), or if eligible for COBRA coverage (or similar state program), you both elected and exhausted COBRA coverage; and
- You are not eligible for other health coverage.

Even if you do not meet these criteria, you may still be able to obtain coverage. And once you have individual health insurance, HIPAA portability regulations guarantee that your insurer cannot cancel your coverage for health reasons. For information or quotes, please call us. ■

TERM VS. PERMANENT—*continued from Page 4*

value is the amount of money currently available to the policyholder. Permanent life offers other benefits — purchasers can withdraw some of the cash value, obtain a loan using the cash value as collateral or use the cash value to pay premiums, provided cash value is high enough.

The different types of permanent life policies include:

Whole or ordinary life. The face amount of the policy is fixed, while premiums remain level and must be paid on a regular basis. It offers a death benefit and a savings account, which grows based on insurance company-paid dividends.

Universal or adjustable life. More flexible, insureds can pay premiums at any time, in virtually any amount, and may change the amount of the death benefit, although an increase usually requires a medical examination. After accumulating sufficient funds in the cash value account, insureds can change premium payments, a useful feature if your economic situation suddenly changes.

Variable life. This policy combines death protection with a savings account that a policyholder can invest. The death benefit and cash value vary with the performance of the underlying investments, although some policies guarantee a minimum death benefit.

Variable-universal life. The policyholder has the investment risks and rewards of variable life insurance, coupled with the ability to adjust the premiums and death benefit available under universal life.

Many insurance experts advise purchasing life insurance with a death benefit equal to five to eight times the individual's income. Life insurance needs will vary greatly according to your assets, liabilities, income potential and expenses, both current and future. For assistance in determining how much and what kind of insurance you need, please call us. ■

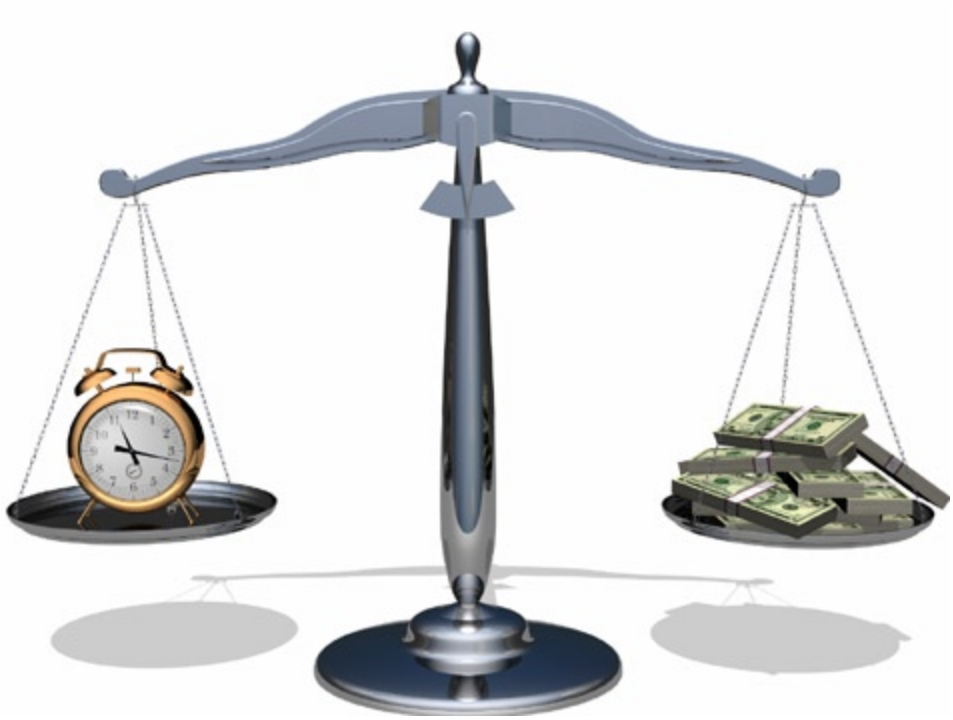
Judging the Quality of Long-Term Care

If you have a family member who needs long-term care services, how do you judge the quality of those services? The Paraprofessional Healthcare Institute says that quality care, whether received in the home or a residential facility, should be:

1. **Individualized, or directed by the consumer or his/her family members, offered when and where the consumer prefers, in a safe and unhurried manner, while honoring the consumer's preferences.**
2. **Respectful, protecting the consumer's dignity and privacy, supporting all involved and sustaining the consumer's relationships with family and friends.**
3. **Professional, or supporting the consumer's well-being and health, consistent with standards of clinical practice and provided by workers who have quality jobs.** ■

Term vs. Permanent?

You may have heard the phrase "Buy term and invest the difference." That works if you have the discipline for a regular investment program. But for some, a permanent life insurance policy will provide more security and better returns.



There are two categories of life insurance: term and permanent. Term coverage provides pure death benefit coverage only. Permanent, or cash value, programs provide some additional benefits, including the tax-deferred accumulation of cash. Term insurance provides financial protection for a specific time (one to 30 years), and gives a death benefit but no cash savings. If you have employer-provided life insurance, it is probably term insurance.

Term insurance comes in several varieties:

Renewable. Policy owners can renew coverage at the end of their policy term without having to submit new medical information, though the premium rate will generally rise with each renewal.

Convertible. A convertible policy allows the insured to convert term coverage into a permanent policy without providing evidence of insurability (usually a medical exam). This type of term policy costs more, but the premium remains fixed after conversion.

Level. Level-premium policies have a fixed premium for a certain number of years (usually 10 or 20), while the death benefit remains unchanged. Although the rate locks in for the policy period, it can jump considerably upon renewal.

Permanent life

Permanent insurance provides lifelong protection and includes a savings element that grows on a tax-deferred basis and may become substantial over time. Premiums are generally higher than for term insurance, but they remain fixed.

All permanent insurance has a face value and a cash value. The face amount is the money that will be paid at death, while cash

TERM VS. PERMANENT—continued on Page 3

Lack of Workers Will Make Long-Term Care More Expensive

The U.S. will face a severe shortage of direct-care workers by 2016, predicts the Paraprofessional Healthcare Institute. The PHI, a trade group for paraprofessional healthcare givers (such as home health aides, certified nurse aides and personal care attendants), warns that we will need a total of 4 million direct care workers by 2016, and the gap between open positions and available workers will increase through 2030 as the baby boomers reach their senior years.

So what does this mean to you?

It means that the costs of long-term care are likely to increase, as both facilities and families have to pay more to compete for a shrinking pool of employees. The PHI predicts the following growth in employment for direct-care workers in the following areas:

- **Services for elderly and persons with disabilities - 88 percent**
- **Home health care services - 62 percent**
- **Residential mental retardation facilities – 51 percent**
- **Community care facilities for the elderly – 49 percent**
- **Self-employed work – 37 percent**