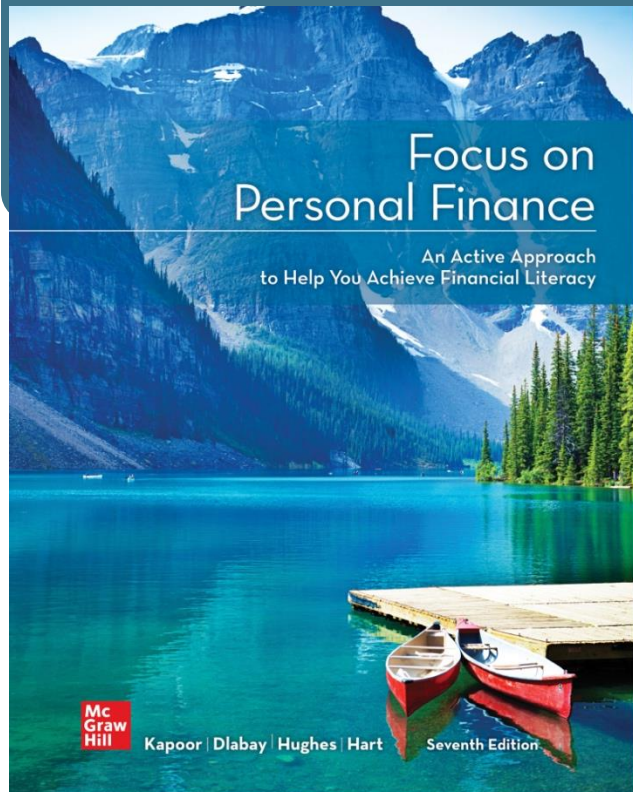




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Chapter 9

Health and Disability Income Insurance



Health and Disability Income Insurance

Chapter Learning Objectives

- LO9.1** Recognize the importance of health insurance in financial planning.
- LO9.2** Analyze the costs and benefits of various types of health insurance coverage as well as major provisions in health insurance policies.
- LO9.3** Assess the trade-offs of different health insurance plans.
- LO9.4** Evaluate the differences among health care plans offered by private companies and by the government.
- LO9.5** Explain the importance of disability income insurance in financial planning and identify its sources.
- LO9.6** Explain why the costs of health insurance and health care have been increasing.



Health Insurance and Financial Planning

LO9.1

- Health insurance is a form of protection that eases the financial burden people may experience as a result of illness or injury
- You pay a *premium*, or fee, to the insurer and, in return, the insurer pays most of your medical costs
- Health insurance includes both medical expense insurance and disability income insurance:
 - *Medical expense insurance* typically pays only the actual medical costs
 - *Disability income insurance* provides payments to make up for some of the income of a person who cannot work as a result of injury or illness



Group Health Insurance

- Most individuals have coverage under group plans
 - Usually employer sponsored, meaning the employer offers the plans and typically pays some or all the premiums
 - Cover you and your immediate family
- *The Affordable Care Act of 2010 (ACA):*
 - Requires large employers to provide health insurance coverage for all employees
- *The Health Insurance Portability and Accountability Act of 1996 (HIPAA):*
 - Set federal standards to ensure that workers would not lose their health insurance if they changed jobs
 - Protects against discrimination in health coverage based on certain health factors



Individual Health Insurance

- Some people do not have access to an employer-sponsored group insurance plan:
 - Self-employed individuals
 - Employer simply does not offer it
- In these cases, individual health insurance may be the answer
 - Can purchase directly from company of your choice
 - Plans usually cover you as an individual or you and your family
 - Rates vary



COBRA

- If you are covered under your employer's health plan and you lose your job, have your hours reduced, or get laid off (and your employer's health plan continues to exist), you and your dependents may qualify to purchase temporary extended health coverage under COBRA at group rates under the employer's plan
 - Not everyone qualifies for COBRA, and the coverage may be quite expensive
 - Generally, COBRA covers group health plans maintained by employers with 20 or more employees
 - Group health plan is required to provide you with a written notice indicating your eligibility for COBRA coverage
 - You have **60 days** from the date the notice is sent or from the date your coverage ends—whichever is later—to elect COBRA



Health Insurance Coverage

LO9.2

- **Basic health insurance coverage** includes hospital expense coverage, surgical expense coverage, and physician expense coverage
 - **Hospital expense coverage** pays part of all of hospital bills for room, board, and other charges
 - Most policies set a maximum amount they will pay for each day you are in the hospital
 - **Surgical expense insurance** pays part or all of the surgeon's fees for an operation
 - Specifies maximum benefits for each service
 - **Physician expense coverage** provides benefits for doctors' fees for nonsurgical care, X rays, and lab tests
 - Specifies maximum benefits for each service



Types of Health Insurance Coverage

- *Major medical expense insurance coverage* pays the large costs involved in long hospital stays and multiple surgeries
 - Maximum benefits can range from \$10,000 to more than \$1 million per illness per year
 - Most major medical plans require a deductible, some include a **coinsurance** provision, and may also include a **stop-loss** provision
- *Hospital indemnity policies* pay benefits when you're hospitalized, but these policies do not directly cover medical costs
 - You are paid in cash, which you can spend on medical or nonmedical expenses as you choose



Types of Health Insurance Coverage (Continued)

- *Dental expense insurance* provides reimbursement for the expenses of dental services and supplies
 - Encourages preventive dental care
 - Normally provides for oral examinations (including X rays and cleanings), fillings, extractions, oral surgery, dentures, and braces
- *Vision care insurance* may cover eye examinations, glasses, contact lenses, eye surgery, and the treatment of eye diseases
- *Dread disease insurance* plays upon unrealistic fears, and it is illegal in many states
 - Covers only specific conditions, which are already fully covered if you are insured under a major medical plan



Types of Health Insurance Coverage

(Concluded)

- **Long-term care insurance** provides day-in, day-out care for long-term illness or disability
 - Useful whether you require a lengthy stay in a nursing home or just need help at home with daily activities such as dressing, bathing, and household chores
 - Annual premiums range from less than \$2,000 to over \$19,000, depending on your age and extent of the coverage
 - According to experts, long-term care protection makes sense for people with a net worth of \$100,000 to \$2 million
 - Typically, individual insurance plans are sold to the 50- to 80-year age group, pay benefits for a maximum of two to six years, and carry a dollar limit on the total benefits they will pay



Major Provisions in a Health Insurance Policy

- *Eligibility* - People covered by the policy must meet specified eligibility requirements, such as family relationship and, for children, a certain age
- *Assigned benefits* - You are reimbursed for payments when you turn in your bills and claim forms
- *Internal limits* - A policy with internal limits sets specific levels of repayment for certain services
- *Copayment* – A **copayment** is a flat fee that you pay every time you receive a covered service (e.g., \$20-\$40)
- *Service benefits* - Policies with this provision list coverage in terms of services, not dollar amounts; always preferable to dollar amount coverage



Major Provisions in a Health Insurance Policy (Continued)

- *Benefit limits* - Defines a maximum benefit, either in terms of a dollar amount or in terms of number of days spent in the hospital
- *Exclusions and limitations* - Specifies services that the policy does not cover
- *Guaranteed renewable* - Insurer can't cancel the policy unless you fail to pay the premiums; forbids insurers from raising premiums unless they raise all premiums for all members of your group
- *Cancellation and termination* - Explains the circumstances under which the insurer can cancel your coverage; also explains how you can convert your group contract into an individual contract

Health Insurance Trade-Offs

LO9.3

- **Reimbursement versus Indemnity**

- *Reimbursement policy* pays you back for actual expenses
- *Indemnity policy* provides you with specific amounts, regardless of how much the actual expenses may be

EXAMPLE: Reimbursement versus Indemnity

Katie and Seth are both charged \$200 for an office visit to the same specialist. Katie's reimbursement policy has a deductible of \$300. Once she has met the deductible, the policy will cover the full cost of such a visit. Seth's indemnity policy will pay him \$125, which is what his plan provides for a visit to any specialist.

- **Internal Limits versus Aggregate Limits**

- Policy with *internal limits* will cover only a fixed amount for an expense, such as the daily cost of room and board during a hospital stay
- Policy with *aggregate limits* will limit only the total amount of coverage or it may have no limits



Coverage Trade-Offs

- **Deductibles and Coinsurance**

- *Deductible* is the set amount policyholder must pay toward medical expenses before insurance company pays benefits
- *Coinsurance provision* states what percentage of medical expenses policyholder must pay in addition to deductible amount

- **Out-of-Pocket Limits**

- Some policies limit the amount of money you must pay for the deductible and coinsurance; after you have reached that limit, the insurance company covers 100 percent of any additional costs

- **Benefits Based on Reasonable and Customary Charges**

- Some policies consider the average fee for a service in a particular geographical area; they then use the amount to set a limit on payments to policyholders



Which Coverage Should You Choose?

- Type of coverage you choose will depend on the following:
 - Amount you can afford to spend on the premiums;
 - Level of benefits that you feel you want and need; and
 - Kind of coverage your employer offers, if you are covered through your employer
- You can buy basic health coverage, major medical coverage, or both basic and major medical coverage
 - Ideally, you should get a basic plan and a major medical supplement
 - Another option is to purchase a comprehensive major medical policy that combines the value of both plans in a single policy



Health Insurance Must-Haves

Exhibit 9-1

A health insurance plan should:

- Offer basic coverage for hospital and doctor bills.
- Provide at least 120 days' hospital room and board paid in full.
- Pay at least 80 percent of out-of-hospital expenses after a yearly deductible of \$1,000 per person or \$2,000 per family.
- Impose no unreasonable exclusions.
- Limit your out-of-pocket expenses to no more than \$8,000 to \$9,000 a year, excluding dental, vision care, and prescription costs.

Although health insurance plans vary greatly, all plans should have the same basic features. Would you add anything to this list of must-haves?



Private Health Care Plans and Government Health Care Programs

LO9.4

- **Private Health Care Plans**
 - *Private insurance companies* provide mostly group health plans to employers, which in turn offer them to their employees as a benefit
 - *Hospital and medical service plans*, such as **Blue Cross** and **Blue Shield** (BCBS); BCBS are statewide organizations like private health insurers, but each state has its own BCBS
 - ***Health maintenance organizations (HMOs)*** are health insurance plans that provide a wide range of health care services for a fixed, prepaid monthly premium
 - ***Exclusive provider organizations (EPOs)*** are hybrid health insurance plans in which services are covered only if the plan's network providers are used (except in an emergency)

Private Health Care Plans

- ***Preferred provider organizations (PPOs)*** are a group of doctors and hospitals that agree to provide health care at rates approved by the insurer
- *Home health care agencies* offer medical care in a home setting in agreement with a medical order, often at a fraction of the cost hospitals would charge for a similar service
- *Employer self-funded health plans* are used when companies choose to self-insure; the company runs its own insurance plan, collecting premiums from employees and paying medical benefits as needed
- *Health savings accounts (HSAs)*, health reimbursement accounts (HRAs), and flexible spending accounts (FSAs) have their own rules about how money is spent, how it can be spent, and how it is taxed

How Managed Care Health Plans Compare

Exhibit 9-2

	HMO	EPO	PPO	Point-of-service
What's the cost?	Generally lowest of all plans	Usually lower than PPO	Generally highest of all plans	Usually lower than PPO
Do I have to use providers in the network?	Yes (except for emergencies and for care that isn't available in network)	Yes (except for emergencies and for care that isn't available in network)	No (but you'll have to pay more if you go out of network)	No (but you'll have to pay more if you go out of network)
Do I have to choose a primary care physician?	Yes	No	No	Usually
Do I need a referral to a specialist?	Yes	No	No	Usually

Source: Texas Department of Insurance, www.tdi.texas.gov/pubs/consumer/cb005.pdf, accessed March 6, 2020.

Comparison of HSAs, FSAs, and HRAs

Exhibit 9-3

Health Savings Accounts (HSAs)	Flexible-Spending Accounts (Arrangements) (FSAs)	Health Reimbursement Accounts (HRAs)
• Set-aside tax-free dollars you can use to pay for medical expenses that are not covered by insurance • Tied to a high-deductible policy • Unspent money can be carried over and accumulate year to year • Can invest the funds in stocks, bonds, and mutual funds • The money grows tax-free but can be spent only on health care • You own the funds; you take any unspent funds with you if you leave the employer	• Employer-sponsored • Set-aside tax-free dollars you can use to pay for medical expenses that are not covered by insurance • Not tied to a high-deductible policy • Money left over can't be carried over; if you don't use it, you lose it to your employer	• Employer-sponsored • Funded solely by your employer to spend on your health care • Reimbursement of claims is tax-deductible for employers • Tied to high-deductible policies • The maximum annual contribution is determined by your employer's plan document • Can carry over unspent money from year to year, but you lose the balance if you change jobs • Premiums tend to be lower than for traditional insurance but higher than for HSAs



Government Health Care Programs

- **Medicare** is a federally funded health insurance program available mainly to people over 65 and to people with disabilities
 - Constantly in financial trouble
 - Projected to be bankrupt by the year 2035 if no changes are made
 - *Balanced Budget Act of 1997* created the new Medicare Choice program
 - Allows many Medicare members to choose a managed care plan in addition to their Medicare coverage



Medicare

- Four parts of Medicare:
 - **Hospital insurance (Part A)** helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care
 - Funded by part of the Social Security payroll tax
 - Program participants pay a single annual deductible
 - **Medical insurance (Part B)** helps pay for doctors' services and a variety of other medical services and supplies not covered or not fully covered by Part A
 - Has a deductible and a 20 percent coinsurance provision
 - Supplemental program; regular monthly premium is charged, and the federal government matches this amount
 - **Medicare Advantage Plan (Part C)**
 - **Prescription drug coverage (Part D)**

A Brief Look at Medicare

Financial Literacy in Practice

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

ORIGINAL MEDICARE PLAN	
Part A (Hospital)	Part B (Medical)
Medicare provides this coverage. Part B is optional. You have your choice of doctors. Your costs may be higher than in Medicare Advantage Plans.	

+

Part D (Prescription Drug Coverage)
You can choose this coverage. Private companies approved by Medicare run these plans. Plans cover different drugs. Medically necessary drugs must be covered.

+

Medigap (Medicare Supplement Insurance) Policy
You can choose to buy this private coverage (or an employer or union may offer similar coverage) to fill in gaps in Part A and Part B coverage. Costs vary by policy and company.

or

MEDICARE ADVANTAGE PLANS SUCH AS HMOs AND PPOs
This "Part C" option combines your Part A (Hospital) and Part B (Medical).
Private insurance companies approved by Medicare provide this coverage. Generally, you must see doctors in the plan. Your costs may be lower than in the original Medicare plan, and you may get extra benefits.

+

Part D (Prescription Drug Coverage)
Most Part C plans cover prescription drugs. If they don't, you may be able to choose this coverage. Plans cover different drugs. Medically necessary drugs must be covered.

For information about Medicare, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

Source: Centers for Medicare and Medicaid Services, *Medicare & You*, 2020.

A Comparison of Various Medicare Plans

Exhibit 9-4

	Current Options	New Options (Medicare and Choice)	Plan Description
Original Medicare	✓	✓	- You choose your health care providers - Medicare pays your providers for covered services - Most beneficiaries choose Medicare supplemental insurance to cover deductible and copayment
Medicare health maintenance organization	✓	✓	- You must live in the plan's service area - You agree to use the plan network of doctors, hospitals, and other health providers, except in an emergency - Medicare pays the HMO to provide all medical services
Preferred provider organization		✓	- Works like an HMO, except you have the choice to see a health provider out of the network - If you do see an out-of-network provider, you will pay a high
Provider-sponsored organization		✓	Works like a Medicare HMO, except the networks are managed by health care providers (doctors and hospitals) rather than an insurance company
Private fee for service		✓	- Medicare pays a lump sum to a private insurance health plan - Providers can bill more than what the plan pays; you are responsible for paying the balance - The plan may offer more benefits than original Medicare
Medical savings account (MSA)		✓	- Medicare MSAs are a special type of savings account that can be used to pay medical bills - The Centers for Medicare and Medicaid Services will make an annual lump-sum deposit into enrollee's account (only Medicare can deposit funds into this account) - MSAs work with a special private insurance company and carry a very high deductible

Source: Centers for Medicare and Medicaid Services, Medicare & You, 2020.



Medicare

(Continued)

- **What is not covered by Medicare?**
 - Deductibles and coinsurance payments
 - Certain types of skilled or long-term nursing care, out-of-hospital prescription drugs, routine checkups, dental care, and most immunizations
 - Limits amount paid for covered services
- **Medigap (MedSup) insurance** supplements Medicare by filling the gap between Medicare payments and medical costs not covered by Medicare
 - Must have Medicare Part A and Medicare Part B to buy Medigap insurance
 - Offered by private companies
 - Exclude long-term care, vision or dental care, hearing aids, eye glasses, and private-duty nursing



Government Health Care Programs

Medicaid and Other Sources

- Medicaid is a medical assistance program offered to certain low-income individuals and families
 - Administered by states, but it is financed by a combination of state and federal funds
 - Unlike Medicare, Medicaid coverage is so comprehensive that people with Medicaid do not need supplemental insurance
- Other sources
 - You can get help from your state to pay for your Medicare premiums
 - Medicare savings programs may also pay Medicare Part A and Part B deductibles, coinsurance, and copayments if you meet certain conditions
 - Programs of All-Inclusive Care for the Elderly (PACE) organizations provide care and services in the home, the community and the PACE center



Health Insurance and the Patient Protection and Affordable Care Act of 2010

- Key provisions of the ACA include the following:
 - Offers tax credits for small businesses to make employee coverage more affordable
 - Prohibits denying coverage to children with preexisting medical conditions
 - Provides access to affordable insurance for those who are uninsured because of a preexisting condition through a temporary subsidized high-risk pool
 - Bans insurers from dropping people from coverage when they get sick
 - Eliminates copayments for preventive services and exempts preventive services from deductibles under the Medicare program
 - Requires new health plans to allow young people up to their twenty-sixth birthday to remain on their parents' insurance policy
 - Prohibits health insurance companies from placing lifetime caps on coverage
 - Restricts the use of annual limits to ensure access to needed care in all plans
 - Requires new private plans to cover preventive services with no copayment and with preventive services being exempt from deductibles



Health Insurance and the Patient Protection and Affordable Care Act of 2010 (Continued)

- Ensures that consumers in new plans have access to an effective internal and external appeals process to appeal decisions by their health insurance plans
- Provides aid to states in establishing offices of health insurance consumer assistance to help individuals with filing complaints and appeals
- Provides new investments to increase the number of primary care practitioners, including doctors, nurses, nurse practitioners, and physician assistants
- Requires health insurance companies to submit justification for all requested premium increases
- Creates state-based health insurance marketplaces (also called *insurance exchanges*) through which individuals can purchase coverage, with subsidies available to lower-income individuals
- Expands the Medicaid program for the nation's poorest individuals
- Requires employers with more than 20 employees to provide health insurance to their employees or pay penalties



Health Insurance and the Patient Protection and Affordable Care Act of 2010 (Concluded)

- **Subsidized Coverage**

- Provides numerous rights and protections along with subsidies through premium tax credits and cost-savings reductions (e.g., Medicaid and the Children's Health Insurance Program)

- **Health Insurance Marketplace**

- Starting in 2014, the Marketplace allowed you to compare health plans, get answers to questions, find out if you are eligible for tax credits for private insurance, and enroll in a health plan that meets your need
- Makes buying health care coverage easier and more affordable



Disability Income Insurance

LO9.5

- **Disability income insurance** provides payments to replace income when an insured person is unable to work
 - Provides regular cash income when you're unable to work because of a pregnancy, non-work-related accident, or illness
 - Exact definition of a disability varies from insurer to insurer
 - Many people make the mistake of ignoring disability insurance, not realizing that it's very important insurance to have
 - Disability can cause even greater financial problems than death



Sources of Disability Income

- **Workman's Compensation**

- If your disability is a result of an accident or illness that occurred on the job, you may be eligible to receive worker's compensation benefits in your state

- **Employer Plans**

- Many employers provide disability income insurance through group insurance plans

- **Social Security**

- If you're a worker who pays into the Social Security system, you're eligible for Social Security funds if you become disabled

- **Private Income Insurance Programs**

- Private insurance companies offer many policies to protect people from loss of income resulting from illness or disability



Disability Income Insurance Trade-Offs

- **Waiting or Elimination Period**

- You will have to wait anywhere between one and six months after you become disabled before you can begin collecting

- **Duration of Benefits**

- Every policy names a specified period during which benefits will be paid

- **Amount of Benefits**

- Your benefit amount, when added to other sources of income, should equal 70 to 80 percent of your take-home pay

- **Accident and Sickness Coverage**

- Some disability policies pay only for accidents, but coverage for sickness is also important

- **Guaranteed Renewability**

- Guarantees coverage if you continue to pay your premiums

Your Disability Income Needs

Exhibit 9-5

- Once you have found out what your benefits from the numerous public and private sources would be, you should determine whether those benefits would meet your disability income needs

	Monthly Amount:	After Waiting:	For a Period of:
Sick leave or short-term disability	_____	_____	_____
Group long-term disability	_____	_____	_____
Social Security	_____	_____	_____
Other government programs	_____	_____	_____
Individual disability insurance	_____	_____	_____
Credit disability insurance	_____	_____	_____
Other income:	_____	_____	_____
Savings	_____	_____	_____
Spouse's income	_____	_____	_____
Total monthly income while disabled:	\$_____		



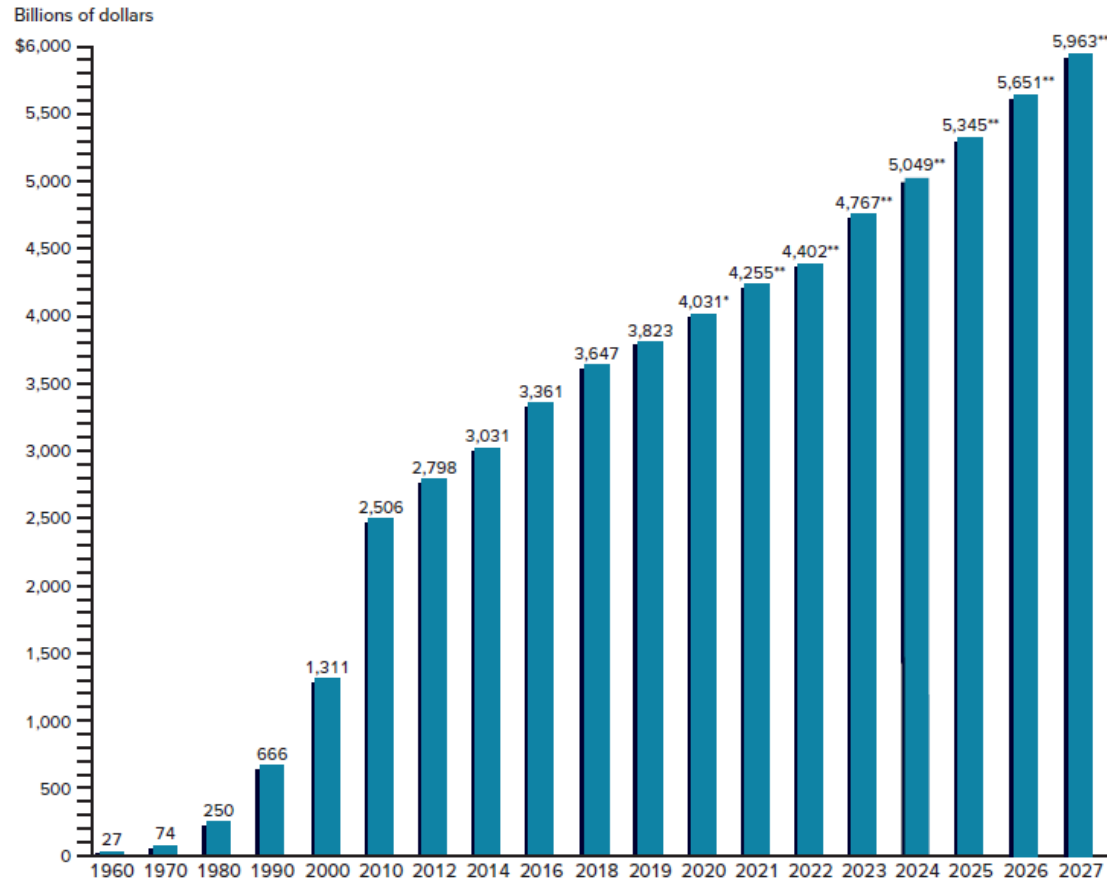
High Medical Costs

LO9.6

- U.S. has highest per capita medical expenditures of any country in the world, spending twice as much on health care as the average for the 24 industrialized countries in Europe and North America
 - Health care costs were estimated at \$4.26 trillion in 2021
 - In 2020, health care spending as a percentage of gross domestic product was 17.8 percent
 - An aging and overweight population, the cost of prescription drugs, the growing number of uninsured, and advancements in medical technology all contribute to rising health costs
- Administrative costs consume nearly 26 percent of health care dollars

U.S. National Health Expenditures, 1960–2027

Exhibit 9–6 U.S. National Health Expenditures, 1960–2027



Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected, accessed March 3, 2020.



Why Does Health Care Cost So Much?

- Use of sophisticated, expensive technologies
- Duplication of tests and sometimes duplication of technologies that yield similar results
- Increases in the variety and frequency of treatments, including allegedly unnecessary tests
- Increasing number and longevity of elderly people
- Regulations that result in cost shifting rather than cost reduction
- Increasing number of accidents and crimes that require emergency medical services
- Limited competition and restrictive work rules in the health care delivery system



Why Does Health Care Cost So Much?

(Continued)

- Labor intensiveness and rapid average earnings growth for health care professionals and executives
- Using more expensive medical care than necessary, such as going to an emergency room with a bad cold
- Built-in inflation in the health care delivery system
- Aging baby boomers' use of more health care services
- Other major factors that cost billions of dollars each year, including fraud, administrative waste, malpractice insurance, excessive surgical procedures, a wide range of prices for similar services, and double health coverage



What is Being Done about the High Costs of Health Care?

- In the private sector, concerned groups such as employers, labor unions, health insurers, health care professionals, and consumers have undertaken a wide range of innovative activities to contain the costs of health care, including:
 - Carefully reviewing health care fees
 - Incentives to encourage preventive care
 - Community health planning
 - Pre-paid group practices and other alternatives to fee-for-service
 - Community health education programs
 - Paying cash for routine medical care and lab tests



What Can You Do to Reduce Personal Health Care Costs?

- Consider a flexible spending account
- Consider a high-deductible health plan
- Ask for generic medicines
- Consider using a mail-order or legitimate online pharmacy
- Most states offer free or low-cost coverage for children under 19 who do not have health insurance
- Pharmacy assistance programs
- Ask if follow-up visits are necessary
- Think carefully about nonurgent procedures
- Review statements for billing errors
- Appeal unfair decisions by your health plan
- Practice preventative care and stay well



What Can You Do to Reduce Personal Health Care Costs? (Continued)

- The best way to avoid the high cost of illness is to stay well:
 - Eat a balanced diet, and keep your weight under control
 - Avoid smoking, and do not drink to excess
 - Get sufficient rest, relaxation, and exercise
 - Drive carefully, and watch out for accident and fire hazards in the home
 - Protect yourself from medical ID theft



Chapter Summary

LO9.1: Recognize the importance of health insurance in financial planning.

- Health insurance is protection that provides payments of benefits for a covered sickness or injury.
- Health insurance should be a part of your overall insurance program to safeguard your economic security.
- Health insurance plans can be purchased through group health insurance, individual health insurance, and COBRA.



Chapter Summary

LO9.2: Analyze the costs and benefits of various types of health insurance coverage as well as major provisions in health insurance policies.

- Four basic types of health insurance are available under group and individual policies:
 - Hospital expense insurance
 - Surgical expense insurance
 - Physician's expense insurance
 - Major medical expense insurance



Chapter Summary

LO9.2 (Continued)

- Major provisions of a health insurance policy include:
 - Eligibility requirements
 - Assigned benefits
 - Internal limits
 - Copayment
 - Service benefits
 - Benefit limits
 - Exclusions and limitations
 - Guaranteed renewability
 - Cancellation and termination



Chapter Summary

LO9.3: Assess the trade-offs of different health insurance plans.

- Health insurance policy tradeoffs include:
 - Reimbursement versus indemnity
 - Internal limits versus aggregate limits
 - Deductibles and coinsurance
 - Out-of-pocket limits
 - Benefits based on reasonable and customary charges



Chapter Summary

LO9.4: Evaluate the differences among health care plans offered by private companies and by the government.

- Health insurance and health care are available from the following:
 - Private insurance companies
 - Hospital and medical service plans, such as Blue Cross/Blue Shield
 - Health maintenance organizations (HMOs)
 - Preferred provider organizations (PPOs)
 - Point-of-service plans (POSs)
 - Home health care agencies
 - Employer self-funded health plans



Chapter Summary

LO9.4 (Continued)

- The federal and state governments offer health coverage in accordance with laws that define the premiums and benefits.
- Two well-known government health programs are Medicare and Medicaid.



Chapter Summary

LO9.5: Explain the importance of disability income insurance in financial planning and identify its sources.

- Disability income insurance provides regular cash income lost by employees as the result of an accident, illness, or pregnancy.
- Sources of disability income insurance include the employer, Social Security, worker's compensation, and private insurance companies.



Chapter Summary

LO9.6: Explain why the costs of health insurance and health care have been increasing.

- Health care costs, except during 1994–1996, have gone up faster than the rate of inflation.



Chapter Summary

L09.6 (Continued)

- Among the reasons for high and rising health care costs are the following:
 - Use of expensive technologies
 - Duplication of tests and sometimes technologies
 - Increases in the variety and frequency of treatments
 - Unnecessary tests
 - The increasing number and longevity of elderly people
 - Regulations that shift rather than reduce costs
 - The increasing number of accidents and crimes requiring emergency services
 - Limited competition and restrictive work rules in the health care delivery system
 - Rapid earnings growth among health care professionals
 - Built-in inflation in the health care delivery system