HEALTH INSURANCE

Section 4

Other Insurance Concepts

Total, partial, residual, and recurrent disability

Total disability

The definition of total disability found in a disability income policy can vary. Total disability may be defined as the inability to perform any job, or it may be defined as the inability to perform your job.

Partial disability

A partial disability does not meet the criteria of a total disability. The precise definition can vary between policies, but insurance companies often define partial disability as the inability to perform one or more of the important duties of the policyholder's occupation. If a disability insurance policy provides partial disability coverage, the benefit is usually a set percentage of the total disability benefit and there is often a limited benefit period.

For example, let's say Lewis has a disability income insurance policy that replaces 80% of his income for a benefit period of up to 15 years in the event of a total disability that prevents him from working. His policy also covers partial disability, but only at 50% for one year. 80% of Lewis's regular income is $5,000 a month. He would receive $5,000 as a monthly benefit in the event of total disability. Let's say that Lewis is disabled, but can still work part-time. He would be eligible to receive $2,500 a month for up to one year.

Residual disability

Policies often use the term residual disability benefits interchangeably with the term partial disability benefits. This means residual benefits tend to work like partial benefits. However, since the definitions and requirements can vary between policies and insurance companies, a residual disability benefit might be different in important ways.

For example, a residual disability provision may require the insured to qualify for total disability benefits before they can collect residual benefits. In other words, the insured would have to be totally disabled and unable to work. If they then recover, but not fully and they are unable to work full-time, they can claim residual benefits. A residual disability is one that never goes away.

Other differences can involve the way the policies calculate benefits. We looked at an example where the partial disability benefit was a set percentage of the total disability benefits. A residual disability affects a person's ability to earn their full earnings. Not all disability income policies cover residual disability. When a policy does provide coverage for residual disability the policy will pay the difference between what the insured made before the disability and what they can make now.

Recurrent disability

When an insured has met their policy's definition of total disability, and then returned to work, a recurrent disability occurs when that old injury recurs within 90 days of when they returned to work. There was a waiting period for the original injury. The waiting period does not apply the second time since it is the same injury recurring.

Owner's rights

The owner of a health insurance policy has the right to pay the premium and select a beneficiary in the case of an A&D policy.

Dependent children benefits

All medical expense policies are required to cover newborns from the moment of birth. Some policies will require an additional premium to be paid, and some will not. If payment is required it must be made within 31 days of birth for coverage to apply.

Children may continue to be covered on a parent's health insurance policy up until their 26th birthday. This is the current limiting age. If a child is handicapped coverage may continue past this age so long as proof of continued dependency is provided within 31 days of turning 26.

Medical expense policies may cover the employee; the employee, and spouse; or the employee, spouse, and kids. In a divorce, covered dependents have 31 days to convert to an individual policy. This is also true in the event of the employee's death, covered dependents have 31 days to convert to an individual policy.

Primary and contingent beneficiaries

Accidental death and dismemberment policies will allow the owner to designate primary and contingent beneficiaries. If there is no beneficiary listed when the insured dies from an accident, the death benefit will be paid to the insured's estate.

Modes of premium payments

Mode of payment refers to how frequently the premium is made. Most health insurance policies cannot be paid with a single premium. The more frequent the mode of payment the higher the premium will be due to service costs. Paying an annual premium is the least expensive. The grace period on a health insurance policy is tied to the mode of payment.

Nonduplication and coordination of benefits (e.g., primary vs. excess)

The coordination of benefits provision in a medical expense policy states that if you have two group policies one is primary and one is excess, helping to enforce the principle of indemnity.

Let's look at an example. Tom and Rita both have group medical expense policies from their jobs. Tom's policy includes coverage for Rita, and Rita's policy includes coverage for Tom. Tom's primary coverage is that he gets from his employer, with the coverage he gets from Rita's employer being excess. Similarly, Rita's primary coverage is that she gets from her employer, and the coverage she gets from Tom's employer is excess. Claims will be submitted to the primary coverage first, with any unpaid amounts being submitted to the excess insurer, ensuring that there is nonduplication of coverage.

Occupational vs. nonoccupational

Nonoccupational coverage is off-the-job coverage only. Occupational coverage is coverage both on and off the job. When a person does not have workers' compensation coverage, let's say they are self-employed, then their health insurance coverage is occupational, covering them both on and off the job. When a person has workers' compensation coverage, their health insurance policy only provides nonoccupational coverage.

Tax treatment of premiums and proceeds of insurance contracts (e.g., disability income and medical expenses, etc.)

Accidental death and dismemberment

Premiums paid for an AD&D policy are not tax deductible. AD&D benefits, including those paid to a beneficiary, are not taxable.

Disability Income

Individual

Individual disability income premiums are not tax deductible. An individual disability income policy insures a person's net income, thus the proceeds paid are not taxable.

Group

The premium paid by the employer for group disability income is tax-deductible to the employer as a business expense. Group disability income insures a worker's gross income. The benefit amount attributable to the employer-paid premium is taxable as ordinary income to the employee. The benefit is also subject to FICA withholding. FICA stands for Federal Insurance Contributions Act. FICA is a federal payroll tax. FICA helps fund both Social Security and Medicare programs, providing benefits for retirees, the disabled, and children.

Let's look at a group disability income example. The employer paid 100% of the group disability income premium, how much is taxable to the employee? 100% of the proceeds paid would be taxable to the employee. If the employer paid 75% of the group disability income premium how much of the benefit is taxable to the employee? 75% of the proceeds would be taxable to the employee. The other 25% the employee paid for out of their own after-tax dollars, 25% of the proceeds would not be taxable to the employee.

Business Disability Insurance

Business disability buy-sell insurance and key person disability insurance both benefit the owners of the business. The premiums paid for these policies are not tax deductible and the proceeds paid are not taxable to the business.

A business overhead expense policy benefits the employees. The premium paid for the policy is tax-deductible to the employer, and the proceeds paid are taxable to the business.

Medical Expense

Individual

Premiums paid for individual medical expense policies (including LTC) are not tax deductible unless a person itemizes on Schedule A. When a person itemizes on Schedule A medical expenses (including premiums paid) over 7.5% of the person's AGI are tax deductible.

Proceeds paid by medical expense policies are not taxable.

When a person is self-employed premiums paid for medical expense, dental, and long-term care insurance are tax deductible.

HSAs, HRAs, and FSAs

When a person has a high deductible health plan (HDHP) they may fund a health savings account (HSA). The HSA is funded with pre-tax dollars, the growth is tax-deferred, and the spending is tax-free when used for qualified medical expenses. There is a contribution limit that varies annually and is dependent upon whether the HDHP is self or family coverage.

A health reimbursement arrangement (HRA) is owned and funded by the employer. HRA contributions are tax deductible to the employer and benefits paid are tax-free to the employee.

A flexible spending account (FSA) may be funded by both the employer and the employee. The money put into an FSA is in pre-tax dollars. Reimbursements from an FSA that are used to pay qualified medical expenses are not taxable.

Cost containment in healthcare delivery

Managed care

Managed care plans have provider networks that service plan members over a certain geographic area. The providers in these networks agree to offer their services at reduced costs. Plan members only have insurance coverage in the network.

Often managed care plans will require a second opinion. This mandatory second opinion requirement results in fewer claims, saving the insurance company money.

Preventive care

Managed care plans often stress preventive services, such as covering annual exams, routine screenings, and certain vaccines at no cost to the members. In some studies, this stress on preventive care has been linked to reduced utilization of inpatient procedures, lower inpatient complications, and reduced mortality rates.

Outpatient benefits

Outpatient benefits are those that a person does not have to stay in a hospital for. An annual check-up, blood test, medical screenings, diagnostic tests, minor surgeries, dialysis, chemotherapy, and many other types of procedures all are outpatient benefits. Outpatient benefits may be provided in a hospital, as well as a walk-in clinic, an outpatient surgery center, and even a doctor's office. Outpatient care received without being admitted to a hospital is also referred to as ambulatory patient services, an essential health benefit under the ACA. The costs for outpatient care are typically considerably less than inpatient care.

Utilization management

Utilization management is a cost-containment strategy that's part of most public and private health plans. It's used for all medical services and care coordination, including behavioral health, inpatient care, and emergency services. Utilization management is a process that evaluates the efficiency, appropriateness, and medical necessity of the treatments, services, procedures, and facilities provided to patients on a case-by-case basis. There are three basic categories of utilization management: prospective review, concurrent review, and retrospective review.

Preauthorization

Preauthorization is also called prospective review. Prospective review is the first category of utilization management. Prospective review is used to determine whether services or scheduled procedures are medically necessary before admission.

The second category of utilization management is concurrent review. Concurrent review evaluates medical necessity decisions during hospitalization.

The third category of utilization management is retrospective review. Retrospective review examines coverage after treatment.

Gatekeeper

Within a managed care plan, the gatekeeper is the primary care physician. To see a specialist a referral from the primary care physician (PCP) is required. The gatekeeper helps managed care plans control costs.

Workers' compensation

Most health insurance provides non-occupational coverage, excluding coverage for anything covered by workers' compensation. When a business has one or more employees it must provide workers' compensation coverage, this is coverage that is required by law.

Eligibility

To be eligible for workers' compensation benefits the individual must be an employee of a business that has workers' compensation insurance. Additionally, the employee must have a work-related injury or illness. The work-related injury or illness must be reported under the deadlines required by state law.

Benefits

The benefit limits required under Part 1 of a workers' compensation policy vary by state. Workers' compensation provides medical expense benefits, disability income benefits, as well as death benefits. Part 2 of a workers' compensation policy provides coverage for an employer who is sued by an employee for work-related bodily injury or illness that isn't subject to state statutory benefits. It has a monetary limit. It also provides the employer coverage for legal defense costs.

Subrogation

Built into insurance contracts is the insurance company's right to subrogate. When an insurance company pays an insured's claim, it automatically has the right to sue the negligent party to recover the damages paid.