Disability Insurance Best Practices for Healthcare Clients

1. Can you really trust the insurance company to have your best interest at heart when adjudicating your claims?	The simple answer is that you cannot. Common sense tells us that there is a conflict of interest. Properly designed benefit contracts should remove as many "hammers" as possible from the insurance company and seek to contractually *guarantee* important provisions. It is imperative that you have an experienced broker to help negotiate your contract design and language as well as represent your interests at claim time with as much knowledge as the insurance company.
2. What are the dangers of disability definitions that are administratively provided versus contractually provided?	Many carriers include language in contracts which is administratively interpreted by the carrier, particularly at claim time. For example, an "own occupation" definition may be based on a physician's "usual duties" or more specifically defined based on specialty/sub-specialty. You must be aware of ERISA powers the insurance carrier has when the contract is not specific.
3. What provisions in a contract can negate an "own occupation" definition of disability?	An insurance company can contractually promise anything, so long as there is a contractual provision to take it away. A rehabilitation program that can be mandated by the insurance company is such an example. Self-reported illness limitations are another area which should be reviewed carefully to ensure alignment with the employer's philosophy.
4. Which is a better plan design, taxable or non-taxable disability benefits?	The answer is, "it depends". In most cases, for high income earners, the correct answer is non-taxable. There are several math models that can be used to determine the appropriate design. For example, a 50% plan, if written to provide a tax-free benefit, will provide more after-tax dollars than a traditional 60% employer-paid plan. Since the 50% plan requires fewer benefit dollars to be paid by the insurance carrier, premium rates are also typically lower.
5. Which is a better benefit for your organization, a 60/70% plan with offsets or a 66% benefit with offsets?	Depending on the level of incomes, either plan may have advantages and the correct answer may be different for each class of employee. It is advisable to walk through the math modeling to compare benefits provided and impact on plan costs. In some cases, the best decision can provide both a cost savings and benefit enhancement.

6. When is a 60% benefit plan not really a 60% benefit?	Reverse discrimination is not unusual for high income earning employees. Based on plan caps, your key employees may actually have only 25% to 50% of their earnings covered. Plan caps, definition of covered earnings, other income offsets, etc., must all be reviewed to determine the true amount of protection being provided.
7. Which partial disability benefit is better, a proportionate loss formula or a partial income offset method?	Depending on the amount of lost income, either method may produce more favorable results. The best contract would offer a "best of both worlds" method in determining benefits. Special attention should also be given to providing a "return-to-work" incentive in the early months of disability.
8. What is "compounded indexation" and why is it important in partial disability claims?	Partial disability claims measure the loss of income to determine the benefit payable. Indexation assumes that the income of a healthy worker would have continued to increase each year. Over time, this compounded indexation shows a greater loss of income than a non-indexed approach, creating a larger disability benefit for an employee who is disabled but continuing to work.
9. How do multiple sources of physician earnings impact plan design? What about at claim time?	Depending on the structure of the organization, physicians may have income from multiple entities, i.e., clinical/surgical practice, teaching income, and ownership in other medical facilities. The definition of Covered Monthly Earnings should address these sources. Careful attention should also be paid to negotiate what income can be measured in the event of a disability claim as this can materially affect the amount of benefit paid.
10. Are you confident that accurate incomes are being reported for your benefit programs, and on a timely basis? Do you understand how failure to report proper income levels will adversely affect benefits?	Disability and life insurance benefits are typically based on a percentage of "earnings". It is imperative that your benefits staff has an understanding of how earnings are defined by each plan, what is included in the definition and over what time period. Failure to properly report incomes enables the insurance company to pay benefits based on the lesser of reported income or actual income.
11. Do you understand the inherent liability to the employer of a self-administered plan versus a list bill?	A self-administered plan adds flexibility but also adds a liability to the employer for the accuracy of enrollment information, reporting of incomes, tracking of beneficiaries, etc. Some of this liability can be mitigated by having your benefit programs professionally administered.

12. When changing carriers for disability or life insurance are you aware that claimants may lose rights?	In spite of general "no-loss-no-gain" provisions, there are many details to be covered in changing benefit providers. For example, claims for disabled employees who have not yet completed the elimination period must be managed properly. Recurrent disability claims should also be negotiated. With life insurance, if an employee has previously assigned benefits, a Letter of Intent must be filed with the new carrier to make certain that the assignment will be honored. A thorough checklist of potential issues should be reviewed to make certain that nothing "slips through the cracks".
13. What type of information should be provided by your insurance carrier to help you run your benefits plans more effectively?	Useful, easy-to-understand reports help clarify what is occurring within a benefits program and prevent surprises at renewal, facilitating your budgeting and staffing processes. Your carrier must be willing to consult about this information and take action on issues of concern. An experienced broker can interpret the information in these reports, know the right questions to ask and advocate for your interests.
14. As a healthcare employer, how do you manage the conflict between an employee with an asymptomatic infection, patient welfare and employer liability?	Protecting your patients and avoiding malpractice may require that you limit your employee's ability to earn a living. A properly designed disability program will pay contractual benefits to the employee before symptoms have developed, even if the traditional definition of "disability" is not met.
15. How does your disability coverage protect an employee with a progressive illness if their income slowly decreases over time?	Disability benefits typically require a 20% loss of income as compared to the previous year to trigger benefits. Additionally, the amount of benefit is recalculated each year based on current earnings rather than the original earned income amount. An employee with a progressive illness, such as Multiple Sclerosis, may see their ability to work diminish over time. This slow process may make it difficult to measure a 20% loss from one year to the next, and when benefits are finally triggered, they may be based on a lower income. A properly designed disability program can lock-in an earnings level at diagnosis to better protect an employee while still allowing them to work productively as they are able.

16. Have you explored how additional benefits can be provided, on a cost-effective basis, in the event of a more serious disability?	While rare, catastrophic disabilities not only leave an employee without income, but likely with higher living expenses. Benefits can be added to a disability plan to cover the loss of activities of daily living and cognitive impairment, providing additional dollars at a time when they are needed most, at a cost that is much lower than most expect.
17. Are your long term disability (LTD) and short term disability plans coordinated? What about LTD and the waiver of premium on your life insurance plan? Have your plans been reviewed to ensure that they coordinate with your employment contracts, paid time off policies and potential Federal Medical Leave Act issues?	The process of claiming benefits requires an employee to provide financial and medical information at a time when they are most vulnerable. A well-designed program can coordinate this process to ensure a seamless flow of income to a disabled employee. As they say, "the devil is in the details". Employment contracts often contain provisions that may be in conflict with benefit programs. These should be reviewed by a firm that has a thorough understanding of physician compensation issues to be certain funds will be available to keep the promises made. Proper coordination of plans may also provide a cost savings to the employer.
18. Is insuring a short term disability benefit better than self-insuring?	The pros and cons of insuring versus self-insuring for short term disability may differ for each class of employees and will require an analysis of the organization size, accounts receivable cash flow and other factors. Math modeling and establishing a Beta Factor to evaluate risk is important.
19. How do you compare insurance carriers and make certain that you have a high quality contract design?	Insurance carriers are measured by both quantifiable means, such as financial strength ratings, size, claims-paying ability and also by less determinable measures such as fair adjudication of claims, service responsiveness, and dynamics of policy language. Your advisory team needs a broker with experience administering the benefit programs being implemented and significant experience in the healthcare industry. They should actually know and understand the contracts they are representing and not rely solely on the insurance companies to walk through the process with you. In other words, who is watching out for you?

20. How do you bridge the gap in culture and benefit design between hospitals and the physician practices they acquire?	Questions such as magnitude of benefits and plan design must be considered, along with a review of cost-sharing models, with an eye on the past as well as the future. With mergers, acquisitions and "partnering", decisions must be made on how to account for benefit differences and cost implications. This is especially true for physicians. While benefits may be viewed as a source of savings, cost is not the only consideration.