

Group vs. Individual Disability: The Simple Truth

Group disability coverage is typically the easiest coverage for a physician to obtain. It is offered through various sources, such as societies, associations, hospitals, and is even available for you and your employees within your own practice.



Ron Cohen

Seldom do physicians read their group disability insurance contracts. In most cases, doctors enroll by simply completing the application and mailing in the forms.

The brochure looked okay, the price seemed reasonable, no fuss, and no hassle, done.

What didn't you know?

Group coverage usually issues a *certificate* of coverage, not a policy. There is one *master contract* and you are issued a certificate number. This type of coverage can be canceled, modified and changed. The clauses, premiums and benefits can ALL be changed at any time by insurer. Does this happen? Often.

How do individual policies differ from group policies?

Quality individual disability coverage is issued to a *physician*. The application is underwritten based on that doctor's personal information. Once accepted, the policy is non-cancelable and guaranteed renewable. The premiums are guaranteed to be level, usually to age 65. The clauses cannot be changed or modified in any way. No restrictions can be added. The benefits cannot be reduced.

What you buy remains as is until age 65.

What should you know about group and association coverage?

When a physician enrolls in association coverage, the words *endorsed* and *endorsement* are generally used not only to entice the physician, but to assure the physician that "If it's good enough for the association, that's good enough for me."

What didn't you know?

Association or group coverage is just an offering to the members of that association. Remember, it is still insurance and in fact must be profitable in order to be maintained. Thus, the Master Contracts are controlled by the insurer. This allows for future changes in clauses, reduction of benefits, modifications, more restrictive definitions and even cancellation.

Association brochures touting "medical specialty" coverage are everywhere now. Truth be told, read further. You might read something like this: "The plan will pay benefits to you when

you are unable to perform the duties of your medical specialty for the first two years of a covered disability. Thereafter, you will receive benefits if you are unable to perform the duties of any occupation for which you are reasonably suited by education, training or experience."

That's not what you thought you were getting. *Caveat Emptor*.

Individual policies differ in their definitions of "medical specialty" coverage and some carriers will even write the physician a medical specialty coverage letter. This guarantees that if the physician is unable to perform the material and substantial duties of the regular occupation (medical specialty); they are deemed to be totally disabled for the full benefit pe-

riod. Even if you can work at another occupation, full benefits will be paid.

What else should I know?

Quality coverage is underwritten on an individual basis. If accepted, the benefits, exclusions and limitations are known once the policy is issued. In other words, you know where you stand. If you had back problems and the insurer excluded that condition from coverage, you know that no benefits will be paid for back problems. It should also be noted that after two years these policies are incontestable. That means that after two years, if you disclosed all the information required on the application and the medical history was disclosed a claim cannot be con-

tested; "pre-existing" is no longer a factor, as the insurer, during underwriting, knew of your past medical history.

What has happened in the past can surely happen in the future.

With the quality insurers re-entering the medical marketplace, more and more physicians are becoming aware of the shortcomings and pitfalls of association coverage. Typically, many physicians that remain with association coverage are those that have become uninsurable, and ineligible for individual coverage — thus leaving these groups and associations plans in positions of "adverse selection." When an association or group is over weighted

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meeting in 2003, the participants met in a small conference room at the hospital. By the time that the second meeting had rolled around, the hospital had to borrow a church hall to accommodate the attendees.

Once the committee had outlined a plan for services, the next step was financing. After considering options such as grants and donations, the group decided that the quickest way to get funding was through tax revenue. That July, 80 percent of the voters approved an ad valorem tax of 12 mills for the emergency room project.

The committee had calculated that the tax would generate about \$450,000 a year for ten years. To boost that revenue, the millage was leveraged against a \$1.5 million bond in October of 2003. With that money, the hospital paid for equipment and improvements to the physical plant.

On March 15, 2004, the emergency room reopened. The hospital had bud-

geted for the ER to treat 150 patients for the entire month of March. In the first 15 days of operation, the facility exceeded all expectations, seeing 166 patients. To date, the revitalized department is averaging about 13 patients a day.

Since the reopening of the ER, the entire hospital has reaped the benefits. "Prior to the opening of the ER, our census was running around 1.3 patients a day on our acute floor," Barrilleaux estimates. "And since the ER opened, our census has jumped to around seven patients a day. This has been a big impact on the acute services that we offer, which in turn helps our bottom line."

Despite its success, Allen Parish Hospital is still facing some of the same obstacles as its rural counterparts. "We still have to try to compete with some of the larger urban areas for staff, and it gets quite expensive for us," Barrilleaux says. "We're trying to make ourselves more competitive, not only with the patients that are out there choosing

health care providers, but also with all of the stakeholders — the employees, the businesses, the board members, etc. And, it's a slow, pain-staking process to pump life back into a place. But, I think that we're going in the right direction."

Another program which is steering emergency care in the right direction is the Louisiana Emergency Response Network, which was launched this summer by the Legislature. Once implemented, LERN will coordinate trauma care throughout the state in order to reduce incident-related deaths. "The current national death rate related to trauma is 15.1 deaths per 100,000," observes Coletta Barrett, RN, MHA, and vice president for Policy Development and Research at LHA. "In Louisiana, our rate is 22 deaths per 100,000. That's a 40 percent higher death rate due to trauma."

Louisiana's lawmakers had considered trauma legislation in the past without event. This year, however, LERN proponents focused on the

plight of rural hospitals, which grabbed the Legislature's attention. "One of the reasons that we feel that we were successful this year in actually passing enabling legislation to create LERN was because we looked at it as a rural health issue," Barnett explains. "We focused on what happens in our small rural hospitals when patients are involved in some sort of situation or time-sensitive illness, and they don't have the resources that they need to take care of them, or have trouble finding a hospital agreeing to accept patients for transfer."

LERN's goal is to coordinate emergency services around the state to ensure that patients get access to the most appropriate facility as quickly as possible. "We know that if you just coordinate care more efficiently, you can significantly decrease mortality with a trauma system," Barnett says. "In other words, identifying on the front end what the needs of the patient are, and matching them up with what the resources available in the hospital are, so that you can get the patient to the most appropriate place for definitive treatment in the shortest amount of time."

Now that the enabling legislation is in place, the next step is to appoint an administrative board to run the program. The board will have representatives from three types of hospitals — rural, service district and metropolitan. After the Governor's Task Force on Trauma prepares a list of nominees, Gov. Blanco will select the members. The Senate must then confirm the Governor's picks.

In the meantime, the task force will continue its efforts to get LERN ready for release. "We're still pushing forward the plans of assessment, evaluation, what federal grants are out there for infrastructure, and looking at technology," Barnett says. "We are continuing our work to get things prepared so that when this board does get convened, they can get a jump start."

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ened or eliminated when physicians perform the services on the patients they refer to the ASC or hospital in which they have an ownership interest.

The American Medical Association's Council on Ethical and Judicial Affairs weighed in on the self-referral and conflict of interest issue. The Council stated that many potential advantages are associated with physician referrals to entities in which the physician has an investment interest, such as better access, quality control and decreased costs. The AMA sees nothing unethical in physician referrals to physician-owned entities where the physician provides services.

Full-Service Hospitals Fight Back

Last year, full-service hospitals mounted a campaign in Congress and state legislatures seeking to prohibit physician-owned hospitals. In the 2003 Louisiana legislative session several bills were filed to prohibit physician-owned hospitals. None passed and most didn't make it out of various committees.

Some estimate that the American Hospital Association out-spent the American Surgical Hospital Association 100 to 1 to get the moratorium attached to the Medicare bill. What Congress did was to amend the Stark law to define "specialty hospital" and to place the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest. A specialty hospital is now defined in the Stark law as a hospital that is primarily or exclusively engaged in the care and treatment of patients with a cardiac condition, orthopedic condition, a condition requiring a surgical procedure and "any other specialized category of services that the Secretary of Health and Human Services designates." Hospitals under develop-

ment as of November 18, 2003 are exempt from the moratorium. After the 18 months, Congress must decide whether further action is warranted. Without additional legislation, the moratorium will expire in May 2005.

Hospitals also have begun to use a more direct tactic, denying or revoking the medical staff privileges to physicians who are in competition with the hospital. Physicians protest this tactic that they call "economic credentialing." But in 2001, the South Dakota Supreme Court upheld a lower court ruling permitting a general hospital to deny privileges to doctors who were also involved with a local specialty hospital. In Arkansas, six cardiologists who are investors in a heart hospital filed suit against Baptist Health for terminating their medical staff privileges. The hospital argues that it has a responsibility to protect the hospital and to give the public access to a broad range of services; the physicians' competition threatens that. This may be the beginning of a trend. In January, OhioHealth terminated 17 physicians who invested in a nearby surgical hospital, and Eastern Idaho Regional Medical Center terminated the privileges of five physicians who had invested in a multi-surgery facility.

In addition to the lawsuit, the Arkansas physicians have testified before the Federal Trade Commission arguing that the hospitals' actions are anti-competitive and violate fraud and abuse laws.

What Does the Future Hold?

Just who will win this stand-off is anyone's guess. The moratorium was designed to give federal officials time to study the issues. Congress directed the Medicare Payment Advisory Commission (Med Pac), the GAO and HHS to report to Con-

gress before the moratorium expires.

Policy experts expect that the study will focus on costs, reimbursement, referral patterns and quality issues. Two prior GAO reports did not support physician over-utilization in physician-owned ASCs or hospitals. Future legislation may require physician-owned hospitals to provide emergency services and treat a minimum number of indigent, Medicaid and Medicare patients. Congress may modify reimbursement so that payments are not so heavily skewed toward surgery and high-tech procedures.

However this particular debate ends, there will continue to be economic challenges that may force physicians and hospitals to take opposite sides on health care issues.

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with uninsurables, the plans and insurers are more likely to experience claims. Claims are losses after all, and will result in changes. Now, these carriers are left with options that are not very favorable. They must increase the premiums, change the master contracts, or cancel the groups completely.

What about the premiums?

Once purchased, the premiums for a quality individual disability policy remain level to age 65.

Group/association premiums will typically increase with age. The premiums are usually not guaranteed, and can be increased at any time. Although a physician might see a schedule of pre-

miums and benefits, either can usually be changed at the drop of a hat.

What should a physician do?

First, take a few minutes and read your group or association contract or certificate. You may only get one chance to make the right decision. As has been stated over and over and over again in *Medical Economics*, "Individual Non-Cancelable and Guaranteed Renewable Disability should be the bedrock of your coverage."

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