



Insurance

©2010 eNotes.com, Inc. or its Licensors. Please see [copyright information](#) at the end of this document.

- [Background](#)
- [Health Insurance Basics](#)
- [Employer Provided Health Insurance](#)
- [Medicare Coverage](#)
- [Medigap Coverage](#)
- [Medicaid](#)
- [Disability and Long-Term Care](#)
- [Denial of Claims or Reduced Payment of Benefits](#)
- [Selected State Laws](#)
- [Additional Resources](#)

Background

Perhaps there is no area of the law more complex for the average American than insurance law. Health care and [DISABILITY](#) insurance coverage is no longer a luxury; it is a necessity for most individuals. By far, the majority of private health care insurance policies that are underwritten in the United States are those covered by employer group plans. As such, the sheer number of insureds in each group plan helps to reduce the cost of premiums and helps to standardize many provisions of plan coverage. By contrast, personal insurance purchased by individuals tends to be more costly, less comprehensive, but ostensibly more "portable," (remaining in effect despite job changes, periods of unemployment).

Health Insurance Basics

Health insurance policies are contracts that require the insurer to pay benefits according to the terms of the policy, in return for the payment of premiums and the meeting of other conditions or criteria spelled out in the plan. Payment of benefits (upon the occurrence of a qualifying event such as illness, injury, office visit, etc.) may be reduced by a "deductible" paid by the insured, by a "coinsurance" payment shared with the insured, or by the reaching of a "maximum benefit amount," which caps the amount the insurer will pay for a covered charge. In such circumstances, the provider of the service may agree to accept the insurance payment and drop the remaining balance or may charge the remaining amount to the patient/insured.

Health insurance policy protection comes in many forms, some of the major ones are:

- *Base Plans:* These policy plans cover hospitalization and related charges
- *Medical and Surgical Benefit Plans:* These policy plans cover physician and service charges (radiology, laboratory, etc.) whether received as an "inpatient" or "outpatient"
- *Major Medical or Catastrophic Plans:* These policy plans only cover illnesses or injuries meeting the categorical criteria
- *Comprehensive Major Medical Plans:* Such plans cover all or most of the above under one policy plan

Two other forms of health insurance should be specifically noted and described:

- *Hospital Indemnity and/or Specified Disease Plans*: Instead of paying or reimbursing for a specific hospital charge, indemnity plans reimburse the insured a specified, fixed amount per day of hospitalization, irrespective of the actual hospital charges, and irrespective of any other insurance coverage. Likewise, specified disease plans pay the insured a fixed, flat amount for each day hospitalized as a result of the specified condition(s) or disease(s). It is important to note that these "insurance" plans are not intended to provide insurance coverage, but rather to supplement the needs of insureds who are hospitalized.
- *Blue Cross and Blue Shield Plans*: "Blues" Plans represent a national federation of local, independent community health service [CORPORATIONS](#) operating as not-for-profit service organizations under state laws. They contract with individual hospitals (Blue Cross) and physicians (Blue Shield) to provide prepaid health care to insured "subscribers." The "Blues" plans differ from conventional insurance plans in that they have already negotiated contractual charges with health care providers, so they will usually pay for a semi-private hospital room, or for nursing services, etc., in full rather than paying a fixed sum or "indemnity benefit" toward the total charge.

Employer Provided Health Insurance

At one time, most employers contracted with external insurance companies to provide benefits for their employees under a "group plan." The cost to the employer depended upon the number of employees, among other factors. Increasingly, employers have bought into "self-insured" or "self-funded" plans, wherein they establish trust funds or set aside other revenues to pay insureds' expenses. There are variations of these plans; for example, some provide for companies to pay benefits up to a certain amount, after which an insurer will take over and continue benefits. In some states, "multiple employer trusts" are established to pool funds and reduce costs for employer-paid benefits. Many states also have insurance "guarantee associations" to which employers may or may not contribute (depending on state law) and which ensure benefits for employees/insureds in the event of [INSOLVENCY](#) or failure to pay on the part of the employer plan.

Comprehensive Omnibus Budget Reconciliation Act of 1989 (COBRA)

Seldom do persons remember what the acronym "COBRA" stands for because its provisions relating to health care constitute such a minor part of the entire congressional act. However, there are two main ways that COBRA affects health care coverage. The first relates to conversion and continuation of health care insurance coverage for individuals who leave an employer group plan. The second (and less known) provision guarantees minimum, life-sustaining treatment and stabilization of the physical condition of anyone presenting for emergency care, irrespective of the absence or presence of health care insurance coverage:

- **COBRA Continuation or Conversion**: Federal law (PL 99-272 as amended) generally requires that employers/plan administrators provide notice to plan beneficiaries (the insured employees) within a specified number of days of the event (termination of employment, reduction of work hours, etc.) that triggers COBRA rights. These rights allow the insured employee and/or covered family members to retain/continue the insurance coverage and health insurance benefits they had when they were covered under the employer's plan. The continuation of coverage is for a specified period beyond employment (e.g., eighteen, twenty-nine, or thirty-six months). Importantly, the share of the premium or cost of the coverage remains the same during the COBRA period as it was during employment. However, there is no extension of coverage beyond the specified period, and insureds must then convert to a private policy or transfer to a new employer's plan (which can be done at any time during COBRA continuation of benefits). Not all employers are subject to COBRA mandates, but many offer their

own parallel conversion plans for continuation of benefits. Parallel conversion provisions were also created under changes to ERISA (the Employer Retirement Income Security Act) for self-insured plans.

Medicare Coverage

Virtually all persons who have been employed and who are 65 years of age or older are eligible for health care benefits under "Medicare." The program is administered by the Health Care Financing Administration, a branch of the U.S. Department of Health and Human Services.

Eligibility

Although primarily associated with persons 65 years or older (who are otherwise eligible for Social Security benefits), **MEDICARE** also covers those under 65 who are "disabled" under Social Security Disability Insurance criteria or suffer from permanent kidney failure. There are other ways to qualify (e.g., over 65 and a Railroad Retirement [BENEFICIARY](#); under 65 and previously eligible but returned to work in the interim, etc.). It is recommended that one consult a Social Security office for current eligibility criteria.

Coverage

Medicare "Part A" coverage helps cover hospital costs for medically necessary inpatient services customarily supplied in a hospital or skilled nursing facility, and/or for hospice care for the terminally ill. Also covered is 100 percent of home health care and 80 percent of approved costs for durable medical equipment supplied under the home health care benefit.

Medicare "Part B" helps cover the services of physicians and surgeons and certain other medical services and supplies, irrespective of the setting in which the services are provided (hospital, office, home, etc.) Certain other costs and expenses are Medicare-reimbursable, such as limited prescription drugs, x-rays and laboratory tests, ambulance services, etc.

Costs

Medicare "Part A" benefits are financed through the Social Security (FICA) tax paid by employees/workers and employers. "Part B" coverage is optional to all beneficiaries who enroll for "Part A" coverage, and a monthly premium is charged to the enrollee. Additionally, persons (over 65 or disabled) may purchase both Parts A and B if not automatically eligible for Part A by way of some other disqualifying factor.

Medigap Coverage

Private insurance companies often offer supplemental insurance coverage for those medical costs and expenses not covered by Medicare Parts A and B. They are not government sponsored, and consumers should thoroughly review their proposed coverage (for duplicate or overlapping coverage) in conjunction with covered charges, costs, waiting periods, premium increases related to age, etc.

Medicaid

MEDICAID coverage is not to be confused with Medicare coverage (although some persons may qualify for both). Both federal and state governments finance Medicaid programs, which are expressly created to serve the needs of low income or "medically-needy" individuals. Eligibility requirements differ among states. However, in addition to financial need, recipients must generally be under the age of 21 or over the age of 65 or blind or disabled. Some states expand criteria to include certain needy children with other profiles or other "categorically needy" persons. Eligibility criteria consider both income and assets (all states exempt a person's house from consideration). Medicaid benefits are paid directly to participating service providers.

Disability and Long-Term Care

Virtually all health insurance policies have a "maximum liability" clause that caps the amount of money that will be paid under the policy. For those who have been permanently disabled or diagnosed with permanent or terminal illness, benefits may run out, leaving persons with little or no financial resources to cover medical needs.

Separate and distinct from health care insurance policies, "disability insurance" and "long-term care insurance" policies are available for purchase from private companies. Generally, benefits may be in the form of "income" (providing for periodic payments of a fixed amount to cover lost income during extended illness or injury) or in the form of continued payment of medical costs and expenses once conventional health policy coverage has been exhausted.

Long-term disability income insurance must be distinguished from long-term care coverage. In the former, benefits are payable to replace lost income during the expected or normal work career. According to the terms of the policy, benefits will cease once the insured reaches a certain age or after a certain number of years that equal those that would have been worked by the insured had he or she not been disabled by illness or injury. In the latter, benefits are payable, irrespective of age. These policies are generally expensive but provide extended benefits to cover nursing home care, rehabilitation, etc.

It is imperative that persons interested in purchasing private policies of supplemental, disability, or long-term care insurance thoroughly investigate their options and carefully articulate their needs to the agent or provider. Otherwise, duplicate coverage, redundancy, or worse, absence of necessary or intended coverage may result.

Denial of Claims or Reduced Payment of Benefits

It is important to note that many states permit insurance providers to disclaim paying benefits already payable through other sources or to reduce the amount paid. These state provisions may be referred to as "priority rules" or "collateral source rules." Priority rules stack the order of insurance liability in the event of a claim (common in complex automobile accident cases). COLLATERAL source rules also affect whether persons who recover medical costs and expenses from other sources, e.g., a lawsuit, must reimburse the insurance company for benefits paid. In most states this is permitted, but many states require the insurer to play an active role in the [SETTLEMENT](#) negotiations and/or contribute toward the legal fees.

Beneficiaries/insureds do have recourse against insurance companies that delay or deny payment of benefits for covered charges. Although the term is often misused or abused, "bad faith" denials of claims by insurers are actionable in most states. However, the patient/insured generally has the burden of proving that the charge was for "medically necessary" care or treatment, and the charge was reasonable. Many states award

[PUNITIVE DAMAGES](#) to punish insurance companies for [BAD FAITH](#) denials. Other states have express laws requiring response to a claim (either payment or formal denial) within a specified number of days of receipt.

Selected State Laws

ARKANSAS: Contracts for health and accident insurance must include those dental services that would have been covered if performed by a physician (23-79-114). Health care plans or disability insurance policies that cover families must include coverage for newborn children (23-79-129). Disability insurance may not discriminate between inpatient or outpatient coverage for the same procedure (23-85-133). Exclusions for preexisting conditions are strictly regulated (23-86-304).

CONNECTICUT: The state has extensive provisions governing health and accident insurance. Some key provisions include mandated coverage for some preexisting conditions (38a-476), limitations on offset provisions as defined under 38a-519, and a provision that married couples working for the same employer under the same group policy do not have to pay double premiums unless it results in greater coverage (38a-540, 541).

INDIANA: No policy for accident or health insurance may be issued until a copy of the form, the classification of risk, and the premium rate have been filed with the state commissioner (IC27-8-5-1). The state maintains a Life and Health Insurance Guarantee Association that protects insureds, beneficiaries, annuitants, etc. from insolvency or failure in performance of contractual obligations owed by the insurer that issued the policy (IC27-8-8-1 to 18).

MAINE: The state has a special provision prohibiting [DISCRIMINATION](#) in maternity benefits coverage for unmarried women (T. 24-A-2741).

MARYLAND: Specific provisions are for AIDS/HIV positive individuals (15-201 to 205), breast implants (15-105), preexisting conditions (16-214, 15-208) and mental illness (19-703). Self-employed individuals must have annual open enrollment periods (15-411, 15-210).

MASSACHUSETTS: Policies providing supplemental coverage to Medicare must meet certain standards, with exceptions for employers and trade unions (175, Section 205).

MISSOURI: Insurers may not deny or cancel coverage because of [INCARCERATION](#) of insured (595.047(1)). Health care service claims must be paid within 30 days of receipt by insurer of all necessary documents (376.427).

NEW JERSEY: New Jersey has a [STATUTORY](#) Life and Health Insurance **GUARANTY** Association to protect insureds and beneficiaries against insolvent or defaulting insurers. (T.17B, c. 32A.1) It also has a Health Care Quality Act providing consumer protections through "plain language" disclosure requirements, etc. (T.26. c.25.1).

NEW MEXICO: Health insurance policies must provide coverage for handicapped children, newborns, adopted children, childhood immunizations, home health care options, mammograms, cytologic screening, diabetes, and minimum hospital stays for certain conditions (59A-22-1).

OKLAHOMA: State Health Care Freedom of Choice Act provides certain rights to select the practitioner of choice for providing certain services (36-6053 to 6057). Genetic Nondiscrimination in Insurance Act restricts

Encyclopedia of Everyday Law: Insurance

disclosure and/or use of genetic tests or information by employers or insurers (36-3614.1).

PENNSYLVANIA: Multiple statutory provisions cover various issues. Specific provision mandates coverage for serious mental illnesses (40-764g). False statements in applications are not automatic bars to coverage (40-757).

TENNESSEE: Health benefits coverage cannot be denied to victims of abuse (56-8-301). Policies may not exclude coverage for drugs not yet approved by FDA if the drug is used to treat life-threatening illness (56-7-2352).

WASHINGTON: Group policies must offer optional coverage for temporomandibular joint disorders (TMJ) (48.21-320) and mammograms (48.21.225). Employer-sponsored group contracts must provide coverage for neuro-developmental therapies (48.21-310).

Additional Resources

Family Legal Guide. American Bar Association, Times Books, Random House, 1996.

Health Insurance. 2nd ed. Enteen, Robert, Demos Vermande, 1996.

Martindale-Hubbell Law Digest. Martindale-Hubbell, 2001.

Copyright Notice

©2010 eNotes.com, Inc.

ALL RIGHTS RESERVED.

No part of this work covered by the copyright hereon may be reproduced or used in any form or by any means graphic, electronic, or mechanical, including photocopying, recording, taping, Web distribution or information storage retrieval systems without the written permission of the publisher.

For complete copyright information, please see the online version of this work:
<http://www.enotes.com/everyday-law-encyclopedia>