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RISK & BENEFITS

Employee Benefits: medical expenses

info sheet

A collective system for reimbursing medical expenses: why and how? We are pleased to tell all about it.

Why operate a collective system for reimbursing medical expenses?

Although the social security system covers most medical expenses, the individual usually has to make a contribution. This contribution is the part of the cost that you do not get back from the health insurance provider. Furthermore, supplements are often charged on certain fees or hospitalisation costs. These supplements can be high, leaving the patient saddled with a number of costs, especially where a stay in hospital is involved. This is the rationale for operating a system for reimbursing medical expenses.

Of course, a private individual can take out insurance for medical expenses but there are a number of advantages where the employer signs up for a collective contract on behalf of its employees: the premium is lower, and the acceptance criteria are less rigid.

How to design the group plan?

Subscription terms

The employee may join the group scheme either alone or together with his family members. Family members usually means the spouse or legally cohabiting partner and the children of the employee and the partner. Signing up for this benefit can be either compulsory or optional for the employee or his family. This, together with the size of the group, determines the subscription terms.

It is possible for a **waiting period** to be built into the contract for those who join late. In this case, during a predetermined period, which starts on the date of joining, the employee is not insured for illness or childbirth. For accidents, which are by definition unpredictable, there is obviously no waiting period. The introduction of a waiting period is useful in order to avoid workers suddenly signing up just before they expect to make a claim.

Furthermore, the insurer may use a medical questionnaire to assess whether or not the applicant can be insured. This medical questionnaire may be supplemented by additional medical questions or tests.

Pre-existing conditions are often not insured, or only under certain conditions, such as where no treatment was required during the first year of membership. For those who join late, pre-existing conditions are usually not covered at all. Pre-existing conditions means any injuries or medical conditions that were identified prior to the joining date and that result in hospitalisation and/or a serious illness.

These restrictions can be abolished for sufficiently large groups. This allows the full reimbursement of costs from the first day, even for pre-existing conditions. There is no medical questionnaire to be completed.

The employer can determine the terms of subscription, in consultation with the insurer.

Cover

A distinction is made between costs incurred inside and outside hospital. Costs incurred outside hospital are called ambulatory costs. It is less common in Belgium to insure ambulatory costs, often because of the cost of such insurance.

Most group policies offer insurance cover for hospitalisation. At a hospital where there are charges for the stay (including for one-day-clinic), all medical expenses are eligible for reimbursement except for costs of a personal nature (telephone, television). The admission must of course relate to a medical necessity resulting from illness, accident, pregnancy or childbirth.

Usually, this cover is extended to ambulatory costs incurred during a period before and after the hospital stay (e.g. 2 months before and 3 months after), subject to the costs being related to the condition that resulted in the admission to hospital.

Finally, a defined set of critical illnesses (including cancer, leukaemia, MS, etc.) is always insured, even if the patient is not admitted to hospital. The most extensive schemes include around 30 serious illnesses on their list. This guarantees that major medical expenses will always be taken care of, because it is precisely these costs that place the greatest strain on the family budget.

It is not usual to refund all medical expenses in full. There is usually an excess.

The excess, or personal contribution, may be defined as an absolute amount per insured person per year that is always payable by the insured (e.g. € 75), or as a fixed percentage. A combination is also possible (a percentage but with absolute minimum or maximum amounts), as are excesses for specific cost categories. We have noticed an increasing tendency for a higher excess to be charged for accommodation in a private room. Sometimes pay-outs are capped at a "ceiling" or maximum amount. This limits the total sum that can be paid to a fixed amount per insured person per year.

Another restriction that is often made is a limit per intervention (tests, doctors' appointments, medicine, etc.) to a multiple of the social insurance limits. It follows however that the insurer does not provide any cover for situations where social security does not make a payment.

A limit may also be applied selectively, e.g. max € 100 per night, or a maximum of € 1,000 for childbirth.

The introduction of limits is a useful way of maintaining a balanced policy and avoiding excessive costs.

How can the medical expenses policy be financed?

A medical expenses policy is financed by contributions from the employer or the employees or both. In most cases the employer pays the premium for the employee and the employee pays the premium for his family. Full payment by the employer or the employee is also possible.

In group contracts, premiums are usually not gender-based, as this would be discriminatory; they may, however, vary by age group: for example younger than 25 years, 25 to 65 years, over 65 years.

Upon retirement, the relationship between employer and employee terminates and in principle so does cover under the group medical insurance policy. In some cases, the retiring employee can continue the insurance for himself and his family, as long as he pays the premiums himself. This is also an option for the widow or widower.

The Verwilghen law, which came into force on 1 July 2007, provides that the insurer must offer an individual the option of continuing the policy where group insurance cover is lost.

As with a pension plan, the employer may choose not to insure for medical expenses but to carry the risk himself. This option is generally reserved to larger companies, where the large numbers mean 'economies of scale'. This is because likely medical costs are fairly predictable for larger populations. Taking an uninsured approach means that there are no premium taxes or quasi-fiscal levies. The employer carries the risk, which is limited, and usually outsources the full administrative processing and claims handling activity to an experienced operator like Vanbreda Risk & Benefits.

Stop-loss insurance can also be used to build some certainty into the budget. The employer bears the expected cost of claims but also protects his budget by taking out an insurance policy to cover any claims that would exceed its own capacity.

How can Vanbreda Risk & Benefits help you?

We specialise in providing advice and support and monitoring group medical expense plans for large companies. We handle both traditional insurance concepts and alternative funding mechanisms as described above.

Vanbreda Risk & Benefits provides a total concept in which the employer can outsource most of the administration to an independent provider. Membership, complete claims processing, social security monitoring and comprehensive management reporting are a few of the activities we automatically provide for our clients.

If you are considering introducing a group medical insurance scheme or amending an existing one, you will be confronted with a number of important questions. Is the policy tailored to the needs of your business and your employees? Have you thoroughly considered the decision as to whether to take out insurance or not? Is the claims service fully guaranteed? We would be pleased to help you answer these questions.

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