



A Guide to Understanding **Health Coverage for Micro-Businesses**



Health Resource Guide

Introduction

As a micro-business owner, you often perform many roles within your business. You manage the positions of CEO, CFO, marketing director, office manager, and even, at times, janitor. Yet, one of the most important roles you take on is that of benefits administrator. For some people, it can also be one of the hardest to figure out.

The search for affordable, quality health coverage is an overwhelming task and understanding the complexities in your plan options can be very challenging. This *Guide to Understanding Health Coverage for Micro-Businesses* will assist you in your efforts to understand health coverage. In addition to explaining the ins and outs of health care, the guide will take you step-by-step through the process of finding coverage that fits your needs, and those of your employees and business.

With all the roles you take on in your business, you deserve a little help. Use this guidebook as your reference manual to being your micro-business benefits administrator.

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Health Insurance Basics for Micro-business

As a micro-business owner you confront many financial challenges. But none are more daunting — or more important — than finding and keeping affordable, quality health insurance. Saddled with bills for office space, computer equipment, and business supplies, you may be tempted to go without. But before you forgo coverage, consider this: illnesses and injuries trigger half of all personal bankruptcies in the United States. Even a relatively minor accident or illness can cost you thousands of dollars out of your own pocket. Health insurance should be an integral part of your financial protection planning.

Shopping for health insurance is often frustrating and confusing, complicated by the fact that health insurers and medical providers have their own terminology. In addition, each state has its own rules and regulations for various products and funding arrangements. However, if you do your homework — the same way you would as if you were buying a brand new home or a car — you should be able to find a satisfactory coverage option.

Group Power

Anyone who belongs to a wholesale shopping club knows you can get a better deal when you buy in bulk. The same is true for health insurance. You'll pay lower premiums if you're enrolled in, or sponsoring, a group health plan.

This is why many small employers have joined forces to create group purchasing alliances. The best way to locate a purchasing coalition is to visit your state's Department of Insurance (DOI) Web site, or call your DOI directly. The National Association of Insurance Commissioners has a list of state DOI Web sites at www.naic.org. In addition, you can contact your local Small Business Development Center (www.asbdc-us.org) or your local Chamber of Commerce. The folks in both your local Chamber and Small Business Development Center can steer you in the right direction.

If these options prove unsuccessful, investigate whether you can form your own group. In some states, self-employed people can form a group with as few as two employees, including yourself, as long as your business meets certain criteria and you pay the employer's share of Social Security taxes for your employees. A few states permit a "group of one," but you will most likely have to submit tax forms to prove you're a legitimate business.

If you do need to buy individual health insurance, the medical underwriter's spotlight will be tightly trained on you. Any "pre-existing" condition, such as asthma, diabetes, heart disease — even pregnancy — can nix your application, boost your premiums, or cause the underwriter to exclude coverage of some conditions altogether. A few states mandate that individual health insurers must offer everyone a policy regardless of their health history. While these states ensure that everyone has a right to purchase health insurance, they don't guarantee that everyone will have the ability to pay for it. Individual health insurance premiums in states with "guaranteed issue" can be substantially higher.

Know Your ABCs

Whether you end up buying an individual health plan for yourself or a small group health plan for you and your employees, you should know there are several plan design variations to choose from. These include indemnity or fee-for-service plans (FFS), preferred provider organizations (PPO), point of service plans (POS), and health maintenance organizations (HMO). Each plan design has its own pros and cons that you must weigh before making your decision.

Fee-for-service or indemnity plans typically give you the most flexibility. You can see any provider you wish without a referral. However, you will probably pay more out-of-pocket expenses and higher premiums. Managed care plans (PPO, POS, and HMO) operate differently. They use "networks" of contracted physicians, hospitals, and other providers that have agreed to provide comprehensive health care services to the plan's members. Most managed care plans require you to seek treatment only from their network providers. Others pay for care from any provider, but offer you financial incentives to stay within their network. In exchange for greater patient volume, the network providers agree to charge lower rates. With a managed care plan, you generally trade provider choice for increased affordability.

Group Health vs. Individual Coverage

When it comes to health insurance, it pays to be part of a group. Group premiums are cheaper because insurers spread the risk of claims over a greater number of people. Most group plans are offered as part of a comprehensive employer benefits package, but they can also be purchased through professional associations, trade unions, or churches.

Sold directly to you, individual insurance may be a good choice for the self-employed, those that can't otherwise join an association, or those who work for a company that doesn't offer health benefits.

Guaranteed Issue – Requirement that health plans offer coverage to all businesses during some period each year.

Network – An affiliation of providers through formal and informal contracts and agreements.

Out-of-Pocket Expenses – Your portion of health care costs that are not reimbursed by the insurer, including deductibles, co-payments, and co-insurance.

Pre-existing Condition – A medical condition that you developed prior to applying for, or receiving, a health insurance policy that may trigger a limitation of your benefits. Some policies can exclude coverage of such conditions, often indefinitely. New statutes in 1997 and 1998 altered the freedom other health plans have enjoyed in setting pre-existing time limits. (See HIPAA).

Referral – Permission from your doctor to consult with another physician or hospital.

The chart below explains some of the pros and cons of the most popular health plan designs.

	Fee for Service (FFS)	Preferred Provider (PPO)	Point of Service (POS)	Health Maintenance Organization (HMO)
Pros	<p>Your choice of doctors and hospitals.</p> <p>May visit any specialist without a referral from a primary care physician.</p>	<p>\$10 or \$20 co-pays to see a network physician.</p> <p>You don't need a referral to see a specialist, as long as you stay within the plan's provider network.</p>	<p>Slightly more flexible than HMOs, these plans tend to offer more preventive care and well-being services than PPOs.</p> <p>In some POS plans, you may choose to see a non-network provider and still receive some coverage.</p>	<p>Lower co-pays.</p> <p>Minimal paperwork.</p> <p>Coverage for many preventive and health improvement programs.</p>
Cons	<p>Usually a deductible (from \$500 to \$1500) before the insurer starts paying claims and then doctors are reimbursed about 80 percent of the bill while you pick up the remaining 20 percent.</p> <p>You may have to pay up front for health care services and then submit the bill for reimbursement.</p> <p>Some FFS plans only pay for "reasonable and customary" medical expenses. If your provider charges more than the average for your area, you will have to pay the difference.</p>	<p>If you visit an out-of-network provider, you may have to pay the entire bill yourself and then submit it for reimbursement.</p> <p>You may have to pay a deductible if you choose to go outside the network, or pay the difference between what network doctors and out-of-network doctors charge.</p>	<p>You must select a Primary Care Physician (PCP).</p> <p>If you do see a non-network provider without permission from your PCP, you'll end up submitting the bills yourself and receiving only a small reimbursement — if any at all.</p>	<p>You must choose a Primary Care Physician (PCP).</p> <p>HMOs require you to see only network physicians, or they won't pay.</p> <p>You must get a referral from your PCP to see a specialist.</p>

Catastrophic Health Insurance – Health insurance that protects you against the high cost of treating severe injuries or lengthy illnesses. These policies usually cover some, if not all, of your medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

Claim – Your request (or your provider's) submitted to your insurer to pay for health care services.

Deductible – The amount you must pay before your health insurance benefits kick in. You must meet your deductible each year.

Out-of-Network Provider – A health care provider with whom an insurer does not have a contract. You must pay either part or all of the costs of care from an out-of-network provider, depending on the provisions of your health plan.

Preventive Care – Health care that emphasizes prevention, early detection, and early treatment, thereby ultimately reducing health care costs. Health care that focuses on keeping you well in addition to helping you when you are sick.

Primary Care – Basic or general health care given by general practitioners, family practitioners, internists, obstetricians, and pediatricians with referral to secondary care specialists, as necessary.

An Alternative: Catastrophic Health Insurance

If you're self-employed, or you work for a micro-business owner that doesn't offer health insurance, you may be a candidate for a catastrophic health plan. These plans are characterized by high deductibles (anywhere from \$500 to \$15,000) and lower monthly premiums. While they typically cover hospital stays, surgery, intensive care, diagnostic X-rays, and lab tests, they generally do not pay for

routine doctor visits, prescription drugs, mental health treatment, or pregnancy. They also have lifetime "caps" between \$1 million and \$3 million. If you reach that cap, your policy is voided and you are on the hook for any additional expenses. While these plans are not for the risk-adverse, they are an alternative to going uninsured. The catch is that if you want to purchase catastrophic coverage, you must be healthy. Pre-existing health conditions such as diabetes, emphysema, or heart disease (along with many others) may cause your premiums to be higher, or prevent you from buying a plan.



Consumer-Directed Health Plans

The future of health care is here and it's called "consumerism," the same principle that drives your choice of supermarket each week. As food prices soar, you think more carefully about how much money you have to spend and which stores offer the best deals on the highest quality food. Consumerism in health care is no different. If you were given \$1,000 to buy your groceries for a year, you would study the weekly supermarket flyers, clip coupons, and forgo the extras. This is exactly the same kind of consumer-driven behavior that health policy experts are hoping will curb runaway health care costs.

This is a fundamental shift away from the strict managed care plans that shielded us from the true costs and consequences of our health care decisions. Not long ago, we could get a brand name cholesterol-lowering prescription drug for a \$10 co-pay rather than ask our doctors to prescribe the lower-cost generic. Today, under a consumer-directed health plan, our portion of the cost of that drug is likely to be closer to \$100, an incentive for us to seek out lower-cost alternatives.

Health Accounts

Most consumer-directed health plans feature health accounts that allow you to control a portion of your own health care dollars and pay directly for routine medical needs such as doctor visits and prescription drugs. They are intended to be used to help pay for out-of-pocket medical expenses or when working in tandem with a high-deductible health plan (HDHP), to pay for smaller medical expenses until your deductible is met. Once your deductible is met, your insurance begins paying for covered benefits.

Both health reimbursement arrangements (HRAs) and health savings accounts (HSAs) are tax preferred alternatives to traditional health insurance products that create incentives for you to weigh your health care spending options. Both are similar to flexible spending accounts (FSAs), except there is no “use it or lose it” rule. Balances roll over from one year to the next. However, there is one fundamental difference between the two. An employer owns your HRA; you own your HSA. However, if you are self-employed, you are the company — so you own the HRA, too.

Health Reimbursement Arrangements (HRAs)

If you are a micro-business or self-employed, Health Reimbursement Arrangements (HRAs) can be helpful in managing your medical costs. HRAs allow a micro-business to reimburse employees for all out-of-pocket medical costs, including health insurance. If you are a self-employed business owner whose spouse works part-time or full-time in your business, an HRA allows you the opportunity to fully deduct your medical expenses such as premium costs, dental expenses, vision expenses, co-pays, prescription drugs, and much more. This is particularly beneficial for sole proprietors who are unable to deduct health insurance costs as a business expense and must pay self-employment tax on their premiums. See the sidebar, *HRAs and the Self-Employed* for more information.

Unlike HSAs, a qualifying high deductible plan is not required when you have an HRA. Contributions to an HRA are 100 percent tax deductible and are not subject to federal, state or Social Security taxes. In addition, many micro-business owners and self-employed individuals favor HRAs because there is no “pre-funding” of the HRA. This means that the reimbursement only happens when medical expenses are incurred. You don’t have earmark money upfront for these accounts.

Health Savings Accounts (HSAs)

Health savings accounts (HSAs) are tax preferred accounts that can be set up in coordination with a qualifying high-deductible health plan (HDHP). An HSA is primarily funded by you and is fully portable. You own your HSA, regardless of your business structure or employment situation. HSAs are similar to individual retirement accounts in that your money is typically invested in mutual funds by your account administrator and your account accrues interest. HSAs are typically administered by a financial institution, such as a bank, or an employer. There are contribution limits. Your annual HSA contribution cannot exceed the deductible of your high deductible health plan. For example, if you choose a plan with a \$1,000 deductible, you may not deposit more than \$1,000 in your HSA for that year. If you want to save more than \$1,000, you must choose a higher deductible plan. In 2009, your maximum contribution is \$3,000 a year for individuals and \$5,950 for families. For more information on HSAs and updated contribution limits, please visit the Department of the Treasury’s HSA web site at <http://www.treas.gov/offices/public-affairs/hsa/>.

If you’re a micro-business through which your employees access a qualifying high-deductible health plan, as an additional benefit you can assist your employees in setting up an HSA and contribute annually to their accounts. Some employers favor HSAs because they believe sole ownership in an HSA provides an added incentive to manage money and health care expenses wisely.

HRAs and the Self-Employed

Micro-businesses tend to be a family affair. If you’re self-employed and your spouse works part-time or full-time for your business, Health Reimbursement Arrangements (HRAs) can assist you in fully deducting medical costs for you and your family.

Step One: Make certain your spouse is a bona fide employee of the company. Your spouse must provide services to the company in exchange for compensation (i.e. salary and/or access to benefit plans) and must be treated as every other employee.

Step Two: Your business must adopt a formal, written non-discriminatory plan. You can write the plan on your own as long as it is consistent with IRS guidelines (www.irs.gov) or get assistance from numerous vendors that offer prototypes of written HRA plans. HRA plan design options are limitless. As the business owner, you may permit all allowable medical expenses to be paid through the plan or restrict expenses.

Step Three: Implement the plan. When your spouse incurs allowable medical expenses, he or she must submit to the business a request for reimbursement with a receipt/invoice indicating payment. The business pays your spouse via check for those expenses and you are able to fully deduct those costs from your company’s taxes. Only expenses incurred after the plan is adopted are deductible so be certain to have the plan in place.

Tax professionals can be helpful in answering questions on HRAs and offer you assistance in setting up and managing an HRA.

Co-pay – Unlike coinsurance, which is based on a percentage of the cost, a co-pay is a flat fee paid for a specific service, such as \$15 for an office visit. This cost-sharing arrangement is typical of an HMO-based plan. (See *Health Insurance Basics for Micro-businesses*.)

Covered Benefit – A medically necessary service that is specifically provided for under the provisions of your health plan’s Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. Always check the fine print in your health insurance policy.

Flexible Spending Account (FSA) – An IRS-sanctioned plan that allows you to use pre-tax dollars set aside from your salary to pay for any unreimbursed health care or dependent care services.

HSA's: Are They For You?

You can put a significant amount of money into a health savings account — up to \$3,000 a year for individuals and \$5,950 for families in 2009. You can even make “catch-up” contributions if you’re 55 or older.

HSA's tend to favor the young, healthy, and those with no children or whose children are older. These are the folks who can build up a substantial HSA account in a short time. The main purpose of an HSA is to conserve as much of your money as possible so that you can pre-fund your retirement medical expenses.

The drawback is that not everyone is eligible for an HSA. In order to qualify, you must be covered by a high-deductible health insurance policy, either through your employer or one you purchase as an individual. (See *Health Insurance Basics*.) “High deductible” means your policy does not begin paying until you have accumulated at least \$1,150 worth of out-of-pocket medical expenses that year. The family deductible must be at least \$2,300.

Additionally, you’re ineligible for an HSA if you are also covered under another health plan that is not a high-deductible health plan, whether as an individual, spouse, or dependent.

Dependent – Someone other than yourself who is covered under your health plan. This may be a spouse, child, unmarried partner, or, in rare instances, a parent.

Section 125 Plan – A plan which provides flexible benefits. This plan qualifies under the IRS code which allows employee contributions to meet with pre-tax dollars. (See Flexible Spending Accounts.)

How Do High-Deductible Health Plans Work?

Under an HDHP, you generally choose your own deductible and you’re free to see any doctor you want without a referral. However, these plans also increase your share of the costs and risks. This is where HRAs and HSAs come in.

For example, under an HRA arrangement, let’s say your employer funds your health care account to cover the first \$500 to \$1,500 of your medical care. After that, you pay the next \$1,000 to \$3,000 of your medical costs out of your own pocket. Once your deductible is reached, your group health insurance plan kicks in and covers 60 to 70 percent of your medical costs if you see an out-of-network doctor, or 80 to 100 percent of your costs if you remain within the provider network. If you don’t use the initial \$500 to \$1,500 given to you by your employer, you can roll over the remaining amount to use the following year, if allowed by your company.

HSAs work basically the same way, except in addition to your employer, you can also make contributions to your own account, either through payroll deduction or a lump sum deposit up to the annual limit. The distributions from your HSA are restricted to the amount of funds that are actually available in your account. Under an HRA arrangement, if your employer agrees to fund your account with \$1,000 annually, the entire amount is immediately available to you at the start of each plan year, similar to an FSA. However, if you are funding your own HSA through payroll deduction, you will have to “pay as you go” from your HSA, or use other personal funds while the money and interest in your HSA grows.

What about FSAs?

Offered by many small employers since 1996, flexible spending accounts (FSAs) are the granddaddies of all health accounts. Allowed under Section 125 of the Internal Revenue Code, they let you to set aside money to pay for certain medical, dental, or even dependent care expenses. Your contributions are deducted from your paycheck before federal and state income taxes and Social Security taxes are withheld.

Though popular, FSAs have one inherent flaw. You must forfeit any unspent money at the end of the year. In addition, while FSAs can be fully integrated with HRAs, *technically* the IRS does not permit you to contribute to an HSA while covered by an FSA or HRA.

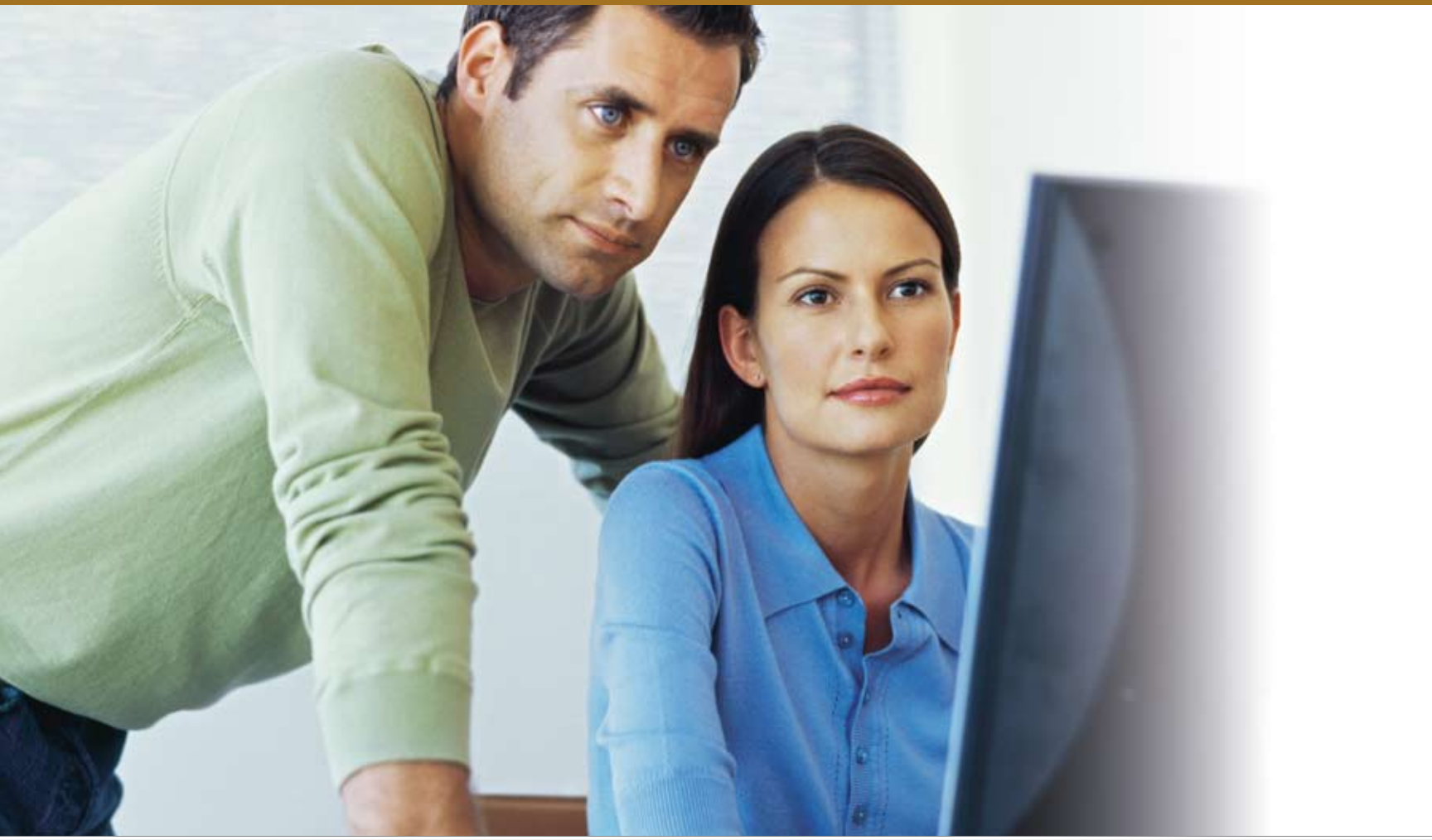
However, there are legal workarounds. The IRS has issued rulings which clarify under which conditions you are still permitted to access benefits from an FSA and HRA while remaining eligible to contribute to an HSA. They include:

- Limited-purpose FSAs and HRAs that restrict reimbursements to certain benefits such as vision, dental, or preventive care benefits.
- Suspended HRAs where you elect to forgo health reimbursements for the coverage period.
- Post-deductible FSAs or HRAs that only provide you with reimbursements after the minimum annual deductible has been satisfied.
- Retirement HRAs that only provide you with reimbursements after you retire.

The main feature of these workarounds is that used either alone, or in combination, they prevent you from seeking multiple tax-favored reimbursements for the same expense. In other words, you can’t pay for a medical expense with your HSA, and then expect to be reimbursed through your company-sponsored HRA.

The chart on page 9 shows the main features of FSAs, HRAs, and HSAs for comparison purposes.

Account features	FSA	HRA	HSA
You own the account?	Yes.	Your company or employer owns it.	Yes.
"Use-it-or-lose-it" by end of benefit year?	Yes.	No. Unused funds may be carried over from one benefit year to the next.	No. Unused funds may be carried over from one benefit year to the next.
You can access your account when you leave your job?	Yes.	Maybe — your company may opt to give you access, or may keep the money.	Yes.
Roll over unused funds when you leave your job?	No.	Yes, but only if your company allows you to do so and only for medical expenses.	Yes.
You can contribute to the account?	Yes.	No, the company reimburses your medical costs to you.	Yes.
Must be paired with a high-deductible health plan?	No.	No. An HRA can work in conjunction with any health insurance plan or no insurance plan at all.	Yes. An HSA must be paired with a high-deductible health plan with minimum deductibles of \$1,150 for individual coverage and \$2,300 for family coverage. Out-of-pocket expenses for co-pays and insurance are capped at \$5,800 annually for individuals and \$11,600 for families.*
May be used in conjunction with other health care spending accounts?	Yes.	Yes.	No. You must use the funds in your HSA before you can be reimbursed for qualified medical expenses from your FSA.
You may use the money for expenses other than health care?	No.	No.	Yes. The funds in the account can be used for non-medical expenses, but they are then subject to ordinary tax, plus a 10 percent penalty if the participant is under age 65. (This penalty does not apply if the distribution occurs after the individual becomes disabled or dies).
Tax consequences?	An FSA reduces your taxable income.	HRA reimbursements to you are tax-free.	An HSAs reimbursements to you are tax-free, within annual limits.
Contribution limits?	No. You decide how much you want deducted from your paycheck to fund your FSA.	No.	Yes. You and/or your employer contributions are limited to \$3,000 annually for individual plans and \$5,950 for a family.*
* 2009 Health Savings Account requirements. For up-to-date HSA information, visit the Department of Treasury's HSA website at http://www.treas.gov/offices/public-affairs/hsa/ .			



How Your State Affects Your Health Insurance

Health insurance is one of the most heavily regulated industries in the United States. These regulations give consumers a measure of protection against unscrupulous business practices and monitor the ability of managed care organizations to pay claims. Individual states can also adopt health insurance mandates, such as requiring insurers to pay for Pap smears and prostate cancer screenings. While mandates make health insurance more comprehensive, they also drive up the cost. This is because insurers must cover care that consumers previously paid for out of their own pockets.

The number of mandates has increased significantly over time. In 1965, there were only seven health insurance benefits mandated by states, according to the Council for Affordable Health Insurance (CAHI). Today, there are more than 1,900. In some markets, CAHI estimates that mandated benefits have increased the cost of individual health insurance by as much as 45 percent.

The problem is that when health insurance costs increase, more people drop or refuse coverage. The self-employed and micro-business owners who employ ten or fewer workers are hardest hit. This is because the current tax code favors large corporations that are able to deduct health insurance premiums as a business expense while the self-employed are forbidden to do so. In addition, the self-employed are required to pay an additional 15.3 percent self-employment tax on these expenses as well.

State Laws Designed to Help Small Businesses

Some states (including Arkansas, Colorado, Florida, Georgia, Kentucky, Montana, North Dakota and Utah) are now trying to counter health insurance purchasing inequities by allowing mandate-free or mandate-light health insurance policies to be sold to those who need a lower-cost alternative. These bare bones policies still provide a measure of financial protection against a catastrophic accident, illness, or injury.

Other states have created their own small health insurance purchasing pools. These pools allow businesses with 50 or fewer employees to join and then take advantage of discounted rates and lower administrative costs and broker fees. The problem is that these pools can potentially flounder and go bankrupt when rates escalate and all the healthier and younger employees abandon it, leaving the sickest individuals behind. This is commonly known in the managed industry as a “death spiral.”

States Fight Health Insurance Scams

State Departments of Insurance (DOI) also serve as agencies where consumers can verify the license status of insurance agents and insurance companies. This is important, say federal investigators, because there has been a sharp increase in recent years in the number of unlicensed health insurance companies. These bogus companies have left an estimated 200,000 policyholders stuck with virtually worthless health coverage. In fact, most victims don't discover the scam until they file a claim for a major illness.

According to the United States General Accounting Office, many of the scams sell policies to the self-employed, small-business owners, and uninsured workers struggling to find affordable health insurance. These fraudulent plans often claim that they are a “union plan,” or a “self-funded” or “ERISA plan,” in which other employers participate, and are immune from state regulations. The truth is that “multiple employer welfare arrangements,” or MEWAs as they are known, must be licensed by the state in which they do business. Never buy an insurance policy unless you have verified that the company from which you are buying is licensed in your state to sell health insurance. You can do this by calling your state DOI. (*For a list of numbers, see State Departments of Insurance.*)

The National Association of Insurance Commissioners (NAIC) urges small-business owners to take a hard look at all health insurance marketing materials and Web sites before making a purchase. The following are guidelines to help you detect illegal health benefit plans:

- Be suspicious of any coverage that boasts low rates and minimal or no underwriting. Always be wary of any health insurance application that features only a few questions. Most legal applications will consist of many detailed questions, including those about your current and prior health status.
- Verify that a licensed insurance agent is selling a state approved insurance product. If an agent is marketing a “union plan,” a “self-funded” or an “ERISA plan,” in which other employers participate, contact your state's DOI to confirm approvals.
- Only deal with reputable agents. If the person trying to sell you coverage claims he doesn't need a license because the coverage isn't an “insurance product,” or is exempt from state regulation, immediately notify your state's DOI.
- Ask the agent to provide all documents related to the plan, including the name of the insurer and documentation that the insurer is licensed and fully insuring the coverage (paying all claims).

Get More Help

For more information about the health insurance options in your state, see our *Health Insurance Basics for Micro-businesses*. In addition, you can visit your state Department of Insurance on the Internet.

State Mandates

If you want more information about mandated health insurance laws in your state, please read CAHI's “Health Insurance Mandates in the States 2008” (www.cahi.org) or visit *State Health Facts at the Kaiser Family Foundation Web site*.

Mandated Benefits – Benefits that health plans are required by law to provide.



Assess Your Health Insurance Needs

When making a major purchase, such as buying a new car, you assess your needs. Do you need transportation primarily for yourself or will you be carting around school-age children and their friends? Do you live just down the street from your workplace or do you have a long commute? If you belong to the child-toting, long-haul group, then a two-seater sports car with a gas-guzzling engine just doesn't make practical sense for you.

The same is true for purchasing health insurance. Even if you're healthy, it would not be a wise financial decision to join a high-deductible catastrophic health plan with no maternity coverage if you plan on having a child within the next year.

While you may find that all the homework and preparation that goes into finding the right health insurance coverage is an unpleasant task, there is no way of getting around it if you don't want to sabotage your financial goals. Think about it. The lowest premium doesn't always signal the best plan for you and even good coverage at a mid to high price can have big loopholes. What if you regularly take an expensive medication for high-blood pressure and one of the plans you are thinking of choosing doesn't cover prescription drugs? Can you consistently afford to pay for this medication out of your own pocket? You must assess your needs and use these results to compare your health plan options before you enroll. Otherwise, when you seek medical treatment, you may be in for an unwelcome surprise. (See *Health Plan Comparison Worksheet*.)

Step One: Which Plan Will Work Best for You?

Once you know the difference between various kinds of health plans (See *Health Insurance Basics*), you must decide which type of coverage best suits your needs. You can use the series of questions below to help you determine whether a strictly managed HMO-based plan or an open access PPO-based plan will make the most sense for your personal situation.

Directions: Answer the following questions and record your answers. If a question is not applicable to your situation, skip it.

1. **Do you prefer to have a primary care physician (PCP) to coordinate all aspects of your health care?**
 Yes (0) No (1)
2. **Do you mind asking a PCP for a referral in order to see a specialist?**
 Yes (1) No (0)
3. **Are lower out-of-pocket expenses more important to you than the freedom to see any doctor you choose?**
 Yes (0) No (1)
4. **Are you currently being treated by a number of specialists?**
 Yes (1) No (0)
5. **Do you plan on having a baby in the next year?**
 Yes (0) No (1)
6. **Are you willing to pay for office visits as a trade-off for using any provider you choose?**
 Yes (1) No (0)
7. **Do you have chronic conditions that require specialty care?**
 Yes (1) No (0)

Be the Consumer

Shopping for health insurance can sometimes make you feel like you're back in school, cramming for a big exam. Although you may dislike the homework, it has its rewards. At the very least, you will be a more informed health care consumer and you will feel empowered to take greater control over your health coverage decisions.

Unless you don't mind being blindsided by coverage denials or saddled with unexpected out-of-pocket medical expenses, you really have no choice. Today, employers and insurers alike are asking you to shoulder more of the costs and burden of decision-making, so it's best to be prepared before you check off the boxes on your enrollment form or insurance application.

Price, while important, should not be the sole consideration in your purchasing decision. You must also make sure you know the answers to the following key questions.

– Do you fully understand what benefits are covered under this policy?

– Is the insurer (or the agent you are buying from) licensed to sell health insurance in your state?

– What is the complaint ratio of this insurer? Where available, these ratios provide consumers with a way to compare complaints filed against an insurer that takes into account the size of the company.

To find out whether an insurer or agent is licensed or whether your state tracks insurers' complaint ratios, check with your state's Department of Insurance (DOI). The National Association of Insurance Commissioners has a list of state DOI Web sites at www.naic.org.

Open Access – Open access means that you can visit any participating network provider without a referral.

8. *Do you need coverage for preventive care such as Pap tests, mammograms, blood pressure screenings, etc.*

- Yes (0) No (1)

9. *Do you mind doing some homework and perhaps filing your own claim forms to save money on your out-of-pocket health care expenses?*

- Yes (0) No (1)

10. *Would you rather pay one co-pay for an office visit and let your PCP's office staff handle the claim forms — even if it means paying a higher monthly health insurance premium?*

- Yes (0) No (1)

Add up all your points. The lower your score, the more an HMO-based plan is best-suited to meet your health care needs. The higher your score, the more satisfied you will be with the flexibility of a PPO-based plan. A score in the middle indicates you could benefit from aspects of either plan or perhaps a hybrid that combines features of both.

Step Two: A Few More Questions

Now that you have an idea which type of plan will work best for you, don't make your final selection just yet. Please consider the six critical health care questions featured below. The answers to these questions will help you choose wisely and shape your overall satisfaction with your coverage.

1. *If you have a favorite doctor (nurse practitioner, therapist, or some other health care provider), is she or he a participating provider in the plan you're considering?*

Call your provider or the plan's member services number to inquire. This information may also be located on their Web sites.

2. *If you prefer to seek treatment at a particular hospital, does that facility participate in the plan you're evaluating?*

Call your provider, the plan, or check any affiliated Web sites.

3. *Are the benefits you most need covered by the plan?*

Use the *Health Plan Comparison Worksheet*. Make sure you read all plan documents and brochures. Ask your agent or plan administrator directly.

Accreditation – The stamp of approval for a health plan or hospital that meets predetermined standards. Two organizations that accredit managed care plans are the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). JCAHO also accredits hospitals and clinics. While NCQA accredits HMO-based health plans, the Utilization Review Accreditation Commission, or URAC, is the leading organization that accredits PPO-based plans. (See *Health Insurance Basics for Micro-businesses*.)

Coinsurance – The amount shared by you and your insurer for covered services after you have met your deductible. This is expressed in a ratio, typically 80/20 (80 percent paid by your insurer and 20 percent paid by you).

Plan Document – The document that contains all of the provisions, conditions, and terms of a pension, health, or welfare plan. This document may be written in technical terms and is different from a summary plan description (SPD) that, under ERISA, must be written in language that can be understood by the average plan participant. (See ERISA.)

Report Card – An accounting of the quality of services, compared among providers over time. You can use report cards to choose a health plan or doctor, or check up on the overall program effectiveness of your current plan or provider.

Utilization Review – A cost control mechanism by which the appropriateness, necessity, and quality of health care is monitored by both insurers and employers.

4. *How much will your premiums cost you over the next year?*

Read all plan documentation. Ask the health insurance provider.

5. *What out-of-pocket expenses can you reasonably expect over the next year?*

Add up everything, including possible inpatient and outpatient hospital visits, doctor visits, and prescription drugs. Don't forget vision and dental care if the plan you're evaluating covers these. Figure in your deductible, any coinsurance, and co-pays.

6. *What is the maximum amount you will have to pay out in the event of a catastrophic accident, illness, or injury?*

No one wants to dwell on worst-case scenarios, but a serious illness or injury can strike you or a loved one without warning. Again, make sure you figure your deductible, coinsurance, and co-pays into the equation.

Step Three: Is Your Health Plan Accredited?

When you're assessing your health insurance needs, don't forget to factor in the plan's accreditation status. For HMO or PPO plans, a stamp of approval from the leading accrediting bodies (NCQA, URAC, or JCAHO) means the plan (or hospital) has made a commitment to consumer accountability and national health care quality standards. For insurance companies, independent outside rating agencies, such as A.M. Best, assigns a rating. Look for a rating of excellent or better.

NCQA

The National Committee for Quality Assurance (NCQA) is the leading accrediting body for HMO-based plans and is used by most of the nation's Fortune 500 employers, federal and state governments, and consumers to help select among competing health plans. NCQA compiles an annual report card that evaluates plans on clinical quality and member satisfaction. These report cards can often be found on your state's Department of Insurance Web site. You can also search report cards at the NCQA Web site, located at www.ncqa.org.

URAC

The Utilization Review Accreditation Commission (URAC) is nationally recognized as the leading accrediting body for PPO-based plans. It audits a broad array of health care services and systems. URAC's quality benchmarking activities cover health plans, preferred provider organizations, medical management systems, health call centers, specialty care, and Web sites that feature health content. You can find out more about the accreditation status of the plan you're evaluating by visiting www.urac.org.

A.M. Best

Named after its founder Alfred M. Best, A.M. Best was founded in 1899 as a worldwide insurance-rating and information agency. It is the largest and longest-established company devoted to issuing in-depth reports and financial-strength ratings about insurance organizations. A.M. Best has offices in the United States, United Kingdom and Hong Kong. Find them online at www.ambest.com.

Health Plan Comparison Worksheet

Plan Feature or Benefit	Plan A	Plan B	Plan C	Notes
Monthly Premium				
Deductibles				
Individual/Annual				
Family/Annual				
Inpatient Deductible				
Out-of-Pocket Maximums				
Individual/Annual				
Family/Annual				
Lifetime Maximum				
Patient Services	Plan A	Plan B	Plan C	Notes
Primary Care				
Covered				
Co-pay				
Specialist				
Covered				
Co-pay				
Urgent Care				
Covered				
Co-pay				
Ambulance				
Covered				
Co-pay				
Emergency Room				
Covered				
Co-pay				
Maternity				
Covered				
Mental Health and Substance Abuse				
Inpatient				
Outpatient				

Directions: Under each plan you're comparing, note whether the benefit is offered and the required co-payment or deductible, if applicable. In the last column, jot down any benefit limitations or plan features that you believe are a particular advantage/disadvantage to that plan. Don't restrict your evaluation to the data fields presented here. Feel free to add rows or columns to suit your personal health plan comparison needs.

Benefit Limitations – Any provision which restricts coverage, regardless of medical necessity. Limitations are often expressed in terms of dollar amounts, length of stay, diagnosis, or treatment descriptions. Make sure you receive and read the fine print in your Evidence of Coverage or Summary Plan Description that comes with your policy.

Durable Medical Equipment (DME) – Medical equipment, such as a walker, that you own or rent to assist in your home treatment or rehabilitation.

Plastic Reconstructive Surgery				
Covered				
Organ Transplants				
Covered				
Skilled Nursing Facility				
Covered				
Preventive Care	Plan A	Plan B	Plan C	Notes
Well Baby/Child Visit				
Covered				
Co-pay				
Immunizations				
Covered				
Co-pay				
Adult Physical Exam				
Covered				
Co-pay				
GYN Exam				
Covered				
Co-pay				
Pap Smear				
Covered				
Co-pay				
Mammogram				
Covered				
Co-pay				
Eye Exam				
Covered				
Co-pay				
Hearing Exam				
Covered				
Co-pay				

Health Plan Comparison Worksheet

Continued

Outpatient	Plan A	Plan B	Plan C	Notes
Surgery				
Covered				
Co-pay				
Laboratory and X-Ray				
Covered				
Co-pay				
Infertility Treatment				
Covered				
Chiropractic				
Covered				
Co-pay				
Physical Therapy				
Covered				
Co-pay				
Speech Therapy				
Covered				
Co-pay				
Occupational Therapy				
Covered				
Co-pay				
Home Health Care				
Covered				
Co-pay				
Durable Medical Equipment				
Covered				
Co-pay				
Prescription Drugs				
Brand				
Generic				
Mail-order				
Oral Contraceptives				

Notes



Shopping for Health Insurance: Online or In Person?

There's no doubt the Internet has changed the way people conduct business, including the way many of us shop for insurance. Ten years ago, there were only a handful of Web sites from which you could obtain an insurance quote. Today, there are hundreds.

Web sites that sell individual and small group health insurance continue to rise in popularity despite getting off to a slow start. The skepticism surrounding the purchase of health benefits via the Web is natural given that strict industry regulation prevents health insurers from issuing binding health insurance policies online. While Web applications can collect your personal information and deliver a quote to you in the privacy of your own home, you will still need to interact with a real live person at some point in the process, whether face-to-face, by telephone, or through e-mail. This reality doesn't detract from the main appeal of the best Web sites — the ability to compare the ballpark prices of policies with varying benefit levels from several different insurers. Even if you don't wind up purchasing a policy online, you can certainly benefit from the initial cost information you can obtain through the Internet quoting process. In addition, some of these Web sites offer a wealth of self-help in the form of online tools, calculators, and articles.

A Word of Caution

Finding the right health insurance policy in cyberspace can be every bit as frustrating as trying to locate the same by visiting brick-and-mortar insurance companies. Unless the online entities you choose have superior telephone or chat-enabled customer service support, you may find yourself left with plenty of unanswered questions. This lack of the personal touch may hurt your ability to make an informed choice. It's easier for most people to simply ask an agent to show them a license to sell health insurance than it is to go clicking through a Web site to find the legal language that discloses the exact same information. The other major drawback is that not every Web site will feature all the health insurance offerings that may be available in your state. If your state only allows certain types of policies to be sold online, you will be getting an incomplete picture of your policy options.

Completing an Online Quote Request

Filling out an online quote request for just yourself is a relatively straightforward matter, but you will need more time and information to complete a request for small group health insurance. Before you sit down at the computer to get quotes for your business, make sure you have the following:

- Your company's North American Industry Classification System (NAICS) or Standard Industrial Classification (SIC) code. NAICS, which is replacing SIC, is used by the statistical reporting agencies of the United States. NAICS groups together businesses that use similar processes to produce goods or services. For more information, visit the U.S. Census Bureau Web site at: www.census.gov/epcd/www/naics.html.
- Employees' names.
- Employees' home ZIP codes.
- Employees' dates of birth.
- Number of employees' dependents and their dates of birth.
- Plan requirements. Will you offer your employees dental insurance? Vision

benefits? Add-ons will increase your costs, so you need to decide ahead of time which benefits are an absolute must and which you and your employees can do without.

- Premium Share. How much of the premium can you afford to share with your employees? If you're struggling to strike a balance between offering affordable coverage and business profitability, look into ways you can lower your costs, such as raising the plan's deductible. (See *Tips for Cost Cutting*.)

If you are looking for coverage for yourself and/or your family only, you will need the above pertinent information for each family member to be covered by the plan.

Once you supply this information, you will either receive an instant online quote or you will be referred to an agent. Either way, you will eventually have to complete a detailed health insurance application as if you had visited a brick-and-mortar insurance agency in the first place.

Choosing an Agent

Perhaps you prefer to deal face-to-face with an agent. Or you've already shopped for quotations online and now you're ready to sit down with someone who can help you weigh your options. How do you find the right agent?

Ask your family, friends, or trusted business acquaintances. These are the folks whose opinions you most value. Make sure the person they recommend has experience selling the type of health insurance product you need. Don't hesitate to quiz them on how well the agent performed. Was the agent polite and prompt in answering questions about their policies? Do they feel the agent took the time to fully explain the terms and conditions of their coverage? On a scale of 1 to 10 (10 being the highest), how knowledgeable is the agent about the products he or she sells? Use their answers to make a short list of the names of agents you intend to contact.

Protecting Personal Data

Spammers and identity thieves are everywhere, preying on your personal information. Always use caution when transacting business over the Internet. Before disclosing any personal information, make sure you:

- **Know who you're buying from. Any one who sells insurance, whether online or from an office, must be licensed. Verify licenses with your state's Department of Insurance (DOI). A list of state DOIs can be found at www.naic.org, or at the back of this guide.**
- **Only use a secure Web browser to send personal data over the Internet**
- **Make sure the Web site asking for your personal data allows you to send it in an encrypted format.**
- **Only send personal information to a Web site that clearly discloses how it tracks and uses your data.**
- **Never send Social Security, bank account, or credit card numbers via e-mail. No reputable business should ever ask you to do so.**

Find an Agent or Broker Through a Professional Organization

There are numerous professional organizations and associations for insurance professionals. Three national organizations which feature online agent locators are:

- The Association of Health Insurance Advisors (AHIA) at www.ahia.net.
- The National Association of Health Underwriters (NAHU) at www.nahu.org.
- The Independent Insurance Agents and Brokers of America (IIABA) at www.independentagent.com.

Telephone agents in your area and don't be afraid to ask them about their experience in finding affordable group coverage for small

businesses like yours. Ask how they would help you and your employees get the maximum protection you can afford. Ask which insurers they represent. Determine if the agent has any professional designations such as Registered Health Underwriter (RHU), Health Insurance Associate (HIA), or Registered Employee Benefits Consultant (REBC). If you don't like someone's answers, move on to the next name on your list.

Once you have narrowed down the field, interview the candidates and then select the agent that is right for you. Make sure you verify his or her license to sell health insurance with your state Department of Insurance. A list of state DOIs can be found at www.naic.org, or at the back of this guide.

Questions to Ask Your Agent

When you are ready to sit down and evaluate your small group health insurance choice with your agent, bring a list of questions that will help you compare products. If there are any unanswered questions, ask your agent to contact the insurer and get the information for you.

Before making your selection, you should know the answers to:

- Do we need to choose a primary care physician (PCP)? Do we select the doctor from a list of contracted physicians or from the available staff of a group practice? How do we know which doctors are accepting new patients? Is it difficult to change a PCP if you decide you want someone else? How are referrals to specialists handled?
- How easy is it to get an appointment with the doctors in the insurer's network? Does the insurer have access standards that ensure enough physicians are available for all its members? How far in advance must routine visits be scheduled? What arrangements must be made for emergency care?
- Does the health plan offer the standard services we need? Are there any limits on medical tests, surgery, mental health care, or home care? What if an employee or dependent needs a special service not provided by plan? Are preventive services such as annual physical exams and immunizations covered?
- What is the plan's service area? Where are the doctors' offices and hospitals located in our community that serve this plan's members? How convenient to our homes are the doctors, hospitals, and emergency care centers that make up the plan's network? What happens if one of us is out of town and needs medical treatment?
- What will the plan cost? What is the yearly total for monthly fees? In addition, are there co-payments for office visits, emergency care, prescribed drugs, or other services? How much? Does this plan feature a deductible and coinsurance rates for care outside of the provider network? If yes, is there a limit to the maximum each of us would pay out of our own pockets?

Agent or Broker? Is There a Difference?

Any individual who sells insurance must be a licensed agent. Agents who sell for multiple insurance companies are commonly referred to as brokers. Whether you use an agent or broker, you will want to be confident that he or she is looking out for your best interests so be sure to ask questions.

Notes



Tips for Health Insurance Cost Cutting

Nobody has to tell you that your health insurance premiums have gone through the roof. Your wallet or pocketbook is already feeling the strain. Recent studies confirm the skyrocketing costs. In 2008, premiums for employer-sponsored health insurance rose to an average of \$12,680 annually for family coverage (\$1,057 per month) and \$4,704 (\$392 per month) for individual coverage. The cost of family health insurance has now eclipsed the gross earnings of a full-time minimum wage worker and continues to push the price tag of health coverage beyond the reach of the average American worker.

However, there are several ways you can cut costs. Some, like increasing the amount you already pay out of your own pocket in order to lower your premiums, are more painful than others. However, it's clear that both you and your employees must make some sacrifices and become more educated consumers of health care if you want to stem the tide. Here are the top 10 ways you can reduce your health care costs.



Ten Tips to Cut Health Insurance Cost

1. Raise Your Deductible, Co-pays, or Coinsurance.

The higher you set your plan's deductible, co-pays, or coinsurance, the lower your premium payments will be. Be careful, though, that you don't put your out-of-pocket expenses beyond your reach, or your employees'. Make sure your plan limits out-of-pocket expenses and you understand what that threshold is before signing any policy.

2. Take Advantage of Tax Breaks.

If you're a self-employed business owner, utilize a health reimbursement arrangement (HRA). An HRA allows you the opportunity to fully deduct medical expenses if your spouse works part-time or full-time in your business. Deductible medical expenses include premium costs, co-pays, prescription drugs and much more.

Consider pairing a high-deductible health plan (HDHP) with a health savings account (HSA). HSAs are designed to lower health care expenses through the HDHP while providing tax-advantaged savings to the consumer. The HDHP provides the necessary insurance coverage while the HSA gives you and your employees the means to fund these costs on a pretax basis. Both you and your employees can contribute to HSAs, and, unlike some other tax-advantaged plans, the funds in the account are not forfeited if they are not used during the plan year. Savings can be "rolled over" and they are completely portable, meaning your employees own their accounts, giving them increased incentive to use the funds wisely.

Offer a flexible spending account (FSA) which will allow you and your employees to set aside pre-tax dollars through payroll deduction to pay for

eligible medical expenses. Set aside only funds you know you will use, since you lose any money that you don't spend by the end of the year. Dental and vision care count as reimbursable medical expenses under an FSA, so don't forget to save your receipts for these services.

3. Search for Free or Low-Cost Services.

Does your local pharmacy offer free blood pressure checks? Does your Town Hall organize flu clinics every fall? Does your local high school offer classes in nutrition, dieting, or exercise? These are all valuable free or low-cost programs that can help you cut costs and avoid trips to the doctor.

4. Get Healthy.

It's a no brainer: quit smoking, exercise more, and lose weight. These will reduce your health care costs. In a nation where the rise in obesity rates is alarming, a recent RAND Corporation study showed the annual average health care costs for moderately obese people were about 20 to 30 percent higher than health care costs for normal weight people. A body mass index over 40 doubles those health care expenditures.

5. Get Informed.

Ignorance is not bliss when it comes to health insurance, it's financial Russian roulette. Know your health insurance plan's rules and then follow them. If you don't, your insurer can deny your claims and you may wind up getting stuck with the bill. Always double-check whether the benefits, services, or providers you need are covered under your plan before you receive treatment. Do this by calling your plan's

member services department. Make sure you follow through by obtaining any necessary pre-authorizations or by scheduling treatment with a doctor within your insurer's network of providers.

6. Practice Self Care.

Many minor ailments and illnesses can be cared for at home without a trip to the doctor's office. If you need more information, visit a reliable Web site like the Mayo Clinic at www.mayoclinic.com or call your insurer's 24-hour nurseline. If the situation worsens, then call your physician. Improve your knowledge of minor illnesses so you better understand when you should visit your physician and when you can take care of an ailment or illness at home.

7. Plan Ahead.

If a health crisis crops up in the middle of the night, do you know which hospitals in your area are affiliated with your health plan? If you don't, then you may wind up paying from your own pocket for emergency services. Make sure you have this information posted near your telephone, along with any emergency phone numbers.

Additionally, find out if any of your family's doctors' offices are open on nights or weekends, their hours, and the co-pays for an after-hours visit. Although an after-hours visit may cost you more than a visit during regular business hours, it is still cheaper than a trip to the emergency room. An emergency room visit can cost you a \$50 to \$100 co-pay.

8. Cut Pharmacy Costs.

Most health plans now have a three-tiered co-pay system for prescription drugs. The top tier usually consists of brand name drugs that cost the most. The middle tier consists of drugs your health insurer considers to be "cost effective." The cheapest tier includes generic drugs. You can significantly lower your pharmacy cost by asking your doctor to only prescribe you drugs in the bottom two tiers.

Ask your doctor about the possibility of splitting your pills. For example, if you take 50 mg of a particular medication per day, you can ask your doctor to prescribe the 100 mg tablets and then you split them. **NOTE: You must consult**

with your doctor about the safety of this practice. Some medications require exact dosing, therefore splitting some pills can be dangerous.

Finally, make sure you need the drug in the first place. The pharmaceutical industry spent approximately \$5.3 billion in 2003 on promotional activities directed toward physicians and distributed another \$16.4 billion worth of free samples that same year, according to IMS, a health industry research firm. Ask your doctor what the medicine is for, what are the benefits versus the risks, and whether there is a non-drug alternative. If your physician dismisses your concerns, you need to find another doctor who will honestly address them.

9. Avoid Unnecessary Medical Tests.

Press your physician or specialist about the necessity of medical tests. Nine out of 10 doctors admit that they practice some form of "defensive medicine" (including ordering unnecessary tests) to head off malpractice lawsuits, according to a survey of 824 Pennsylvania physicians that was published in the *Journal of the American Medical Association*. More than half of the emergency physicians, orthopedic surgeons, and neurosurgeons surveyed said they have ordered unnecessary imaging procedures, such as CT scan, MRI, or X-ray that they didn't believe was absolutely necessary.

10. Find a Subsidy.

If you or a family member is in a low-income situation, uninsured, or disabled, you or they may qualify for low-cost health insurance through a state or federal program such as Medicaid or Medicare. One program that is highly popular, but still underused is the State Children's Health Insurance Program, or SCHIP. Families who earn too much to qualify for Medicaid may still qualify for SCHIP, even if the parents are working. Each state has different eligibility rules, but most uninsured children under the age of 19, whose families earn up to \$34,100 a year (for a family of four) are eligible. For little or no cost, SCHIP covers doctor visits, immunizations, hospitalizations, and emergency room visits. Please see the Insure Kids Now Web site at www.insurekidsnow.gov.

State Children's Health Insurance Program (SCHIP) – Created in 1997 by the Balanced Budget Act, SCHIP gave each state permission to offer health insurance for children, up to age 19, who are not already insured. SCHIP is a state-administered program and each state sets its own guidelines regarding eligibility and services.

Notes



The Truth About Prescription Drugs

Given the brainpower and the billions of dollars the pharmaceutical industry devotes to developing new medicines, you'd think the latest brand-name drug is always the best for whatever ails you, despite the higher price tag.

Studies say it isn't necessarily so.

In July 2007 the nonprofit Consumers Union published an analysis of 11 diabetes drugs. It reported that newer products, which aren't yet available as generics, are no safer or more effective than older medicines, although they "cost many times more."

The study shored up the U.S. Food and Drug Administration's vigorous support of generics. It also generated new heat in the conflict between the pharmaceutical giants that make newer, branded drugs and the government, public-interest groups and insurers, which recommend generic drugs as a cost-saving measure.

The Rise of Generic Drugs

It's hard to believe, but aspirin, introduced in 1899, was once a trademarked product. In the 1920s the maker of Bayer Aspirin fought unsuccessfully to prevent generic aspirin from going to market.

Until the Food and Drug Act was passed in 1906, consumers had no assurance that any medicine — branded or not — was pure, safe, correctly labeled or effective. Legislation passed in the 1930s through the 1950s toughened the requirements that companies prove their drugs were safe. And in 1962, Congress passed laws that required manufacturers to prove their medicines safe and effective before they were sold. Both branded and generic drugs now had to undergo extensive testing.

In 1980 the first edition of what's called the Orange Book was published. Updated monthly and now available online, the Orange Book lists all approved prescription and nonprescription drugs and indicates the availability of all generic equivalents.

Generics accounted for 63 percent of U.S. prescriptions filled in 2006, according to drug research firm IMS Health Inc.

More than 13,000 prescription drugs are currently available, reports the U.S. Office of Personnel Management, and about 50 percent have generic equivalents.

What's the Difference Between Generic and Branded Medicines?

The short answer is virtually none.

By law, generics must be identical copies of innovator drugs (the original branded versions, also called pioneer drugs) in terms of safety, effectiveness, quality, dosage and performance.

As the National Institute for Health Care Management (NIHCM) Foundation put it in a 2002 report, each generic drug "contains the identical active ingredient or ingredients as the innovator drug in the same amount and behaves in the body in the same way. For all practical purposes they are the same drug."

The FDA says generics are:

- Safe
- Equally potent and effective
- As quick to act in the body
- Made in factories with identical safety and manufacturing standards

In fact, about half of all generics are made by the same companies that produce and sell the branded version.

But despite having the same active ingredients, generics and branded medicines will look and even taste differently because different colors, flavors, binders and other inactive ingredients are used. U.S. trademark laws don't permit generics to look like their branded equivalents.

The stringent FDA drug-review process for generics is "much the same as new, brand-name drug review," says the agency.

Among other things, makers of generic drugs must:

- Prove that generic drugs are bioequivalent, which means that the active ingredient works just as it does in the brand, and as quickly
- Provide detailed documentation of a drug's chemistry, manufacturing process and quality-control procedures
- Show that the raw materials and finished drug meet the standards of the U.S. Pharmacopeia
- Meet all federal regulations for manufacturing practices, with proper facilities for making, testing, packaging and controlling the medicine

In addition, as with the makers of branded drugs, generic manufacturing sites are inspected before drug approval and periodically afterward, and the quality of the product is monitored.

Manufacturing facilities for brands and generics must meet the same standards, and the FDA conducts nearly 300 inspections each month, on average.

Assistance with Prescription Drug Costs

The cost of your prescriptions can add up quickly and the discounts you receive from your health insurance may not be enough. For help with prescription drug costs, consider the following:

Talk to your doctor or pharmacist. Let your doctor or pharmacist know that you are concerned about the cost of your prescription drugs and ask about generic options.

Shop around for the best price. Before heading to your nearest pharmacy, do some research to find the lowest drug prices in your area. Call local pharmacies, grocery stores, large chain stores and even warehouse stores such as Costco to price your prescriptions before purchasing. You will be surprised at how much you can save if you shop around.

Take advantage of online drugstores. In today's Internet age, there are numerous online drugstores that will fill your prescription and mail you your medicines. These online stores usually offer low prices. In addition, many will offer discounts for bulk ordering thus for those medicines you take regularly, consider asking your doctor to write out a 90-day prescription.

Join a discount drug program. To supplement the drug benefit provided to you by your health coverage or if you do not have health insurance, consider joining a discount drug program to help lower your prescription drug costs. Pharmacies, professional organizations, local chambers of commerce and the Internet are all resources which can assist you in finding out information about discount drug programs available to you and your family.

Public and private assistance programs for prescription drug costs. For those that are unable to afford the cost of your prescription drugs, there is help out there in the form of public and private assistance programs. Various pharmaceutical companies and patient organizations can assist you in getting your medications for no cost or low cost. Visit the Partnership for Prescription Assistance (www.pparx.org) to learn more. Also, contact your state and local government to find out about public assistance programs in your area that can help you get access to your medicines.

What's the Cost Difference Between Generic and Branded Medicines?

Generics are usually 30 percent to 60 percent cheaper than branded drugs, according to Caremark, a national mail-order pharmacy.

The Congressional Budget Office estimates that generics save consumers \$8 billion to \$10 billion annually.

Here are some sample price comparisons from the online pharmacy drugstore.com:

- 30 pills of Celexa, a popular antidepressant, in 20-mg strength, cost \$86.39; the same prescription filled with generic citalopram hydrobromide costs \$39.99
- Glucophage, the most popular diabetes drug in the U.S., runs \$139.97 for 180 pills, 500 mg; the generic equivalent, metformin HCl, is \$85.99
- Zocor, a statin drug used to treat high cholesterol, is \$404.97 for 90 pills, 20 mg; simvastatin, the copy, costs \$73.97

We cite drugstore.com's prices merely as examples from a large retailer — not to recommend that you order from it or any particular company. The cost of drugs varies greatly from one pharmacy to another. Comparison shop before filling a script, especially one you'll be taking for an indefinite time.

Why is There Such a Price Discrepancy Between Brands and Generics?

According to the U.S. Office of Personnel Management, discovering and developing just one new medicine costs an average of \$500 million and takes 12 to 15 years.

Drug pioneers are rewarded with patents that enable them to be the sole suppliers of a new drug for a period of 17 years, with possible extensions of one to six years. Naturally, being the only seller of a drug means a company can charge more, and not until the patents expire can manufacturers make and sell generic copies.

When you buy a branded drug, you're also paying for the company's investment in marketing. In 2006 alone drug companies spent \$5 billion in direct-to-consumer advertising, Nielsen Media Research says.

Which Should You Choose — Branded or Generic?

In almost all cases, generic is your best bet — but there's one caveat.

Of the thousands of generic drugs listed in the FDA's Orange Book, 96 percent are considered bioequivalent and therapeutically equivalent. In other words, they're considered to work just like the brands they replace.

What about the other 4 percent? In most cases, these are "older drugs on which modern tests have not been conducted," says the NIHCM Foundation's 2002 primer on generic drugs. A few of those drugs are considered nonequivalent because the body is extremely sensitive to minuscule variations in the dose — in other words, they have what's called a "narrow therapeutic index."

Over time, stricter FDA rules and better testing have significantly reduced the percentage of nonequivalent drugs. It was 10 percent in 1990, says the NIHCM primer.

If you know the name of a drug, you can look it up in the online version of the [Orange Book](#) to see whether the available generics have been found bioequivalent and marked with a "therapeutic equivalence evaluation code" beginning with the letter A. That means there are no known or suspected bioequivalence issues or that any actual or potential problems with bioequivalence have been resolved.

If a drug's code begins with a B, it means "actual or potential bioequivalence problems have not been resolved by adequate evidence," according to the Orange Book. After completing its investigation and review process and being satisfied, the FDA may change a drug's B code to an A.

In a handful of cases, the FDA and certain scientists disagree about whether generics are truly bioequivalent. A few examples include clozapine, used to treat schizophrenia; procainamide hydrochloride, for irregular heartbeat; warfarin, a blood thinner; and phenytoin, used to prevent seizures.

When Should You Ask Your Doctor About Generics?

Whenever your doctor prescribes medicine, it's smart to have a brief discussion about brand versus generic.

Talk with her about whether there's any reason not to choose a generic. She may be familiar with new research on a given drug or she may have preferences based on her clinical experience. If she recommends a brand, ask why and whether the drug is one with a narrow therapeutic index.

All 50 states now have laws regulating when generic drugs can be substituted. And in many cases a pharmacy is required to substitute a generic unless the physician has specified that the brand must be dispensed. If you're in doubt about what's been prescribed or whether a substitution is appropriate, talk with your doctor, pharmacist or both.

Bottom line: Today's drugs, both generics and brands, are safer and more rigorously tested than ever. In almost all cases there's an effective and less expensive generic available — but it's up to you to work with your doctor to make an informed decision.

For More Information

To learn more, check these government-sponsored sites.

The online [Orange Book \(Approved Drug Products With Therapeutic Equivalence Evaluations\)](#), updated regularly by the FDA:
<http://www.fda.gov/cder/orange>

The home page for the FDA's Office of Generic Drugs:
<http://www.fda.gov/cder/ogd>



Wellness Boosts Health and Bottom Line

Premiums for virtually all small group health plans are based on the health history, or “experience,” of the entire group. Major illnesses, such as a heart attack, or chronic illnesses, such as diabetes, can instantly spike up a plan’s rates. This can have particularly devastating consequences if you’re a micro-business owner.

“For small-business owners who often measure profits in the thousands of dollars, the net effect of healthy employees could mean the difference between profit and loss,” says William S. Kizer, Jr., founder of The Wellness Councils of America. This nonprofit membership organization is dedicated to promoting health initiatives at the workplace.

Soaring health care costs and the prevalence of avoidable threats to health (obesity, smoking, stress, etc.) have prompted businesses to get more involved with their workers' well-being. For instance, of all worksites with 50 or more employees, approximately 95 percent of them sponsored at least one health-promoting activity in 1999, according to the Association for Worksite Health Promotion. These ranged from modest educational efforts, such as handing out pamphlets on weight management, to providing free flu shots or discounts to local gymnasiums or smoking-cessation classes.

You should also take full advantage of your health plan's wellness component. (If your plan doesn't offer one, consider finding another one that does.) Many plans offer at least a Web site stocked with credible health and wellness information. They may also offer online health risk assessments or annual worksite health-screenings to check for warning signs like high-cholesterol and high-blood pressure. Even if your plan doesn't offer a comprehensive program, or it wants to impose a hefty charge for those screenings, don't give up just yet. Investigate whether one of your local hospitals or community health organizations will administer the screenings for a small fee. Another good alternative is to network with other small businesses and pool resources to sponsor a health fair where workers can participate in health and wellness workshops and preventive screenings.

As a micro-business owner, it's crucial that you begin exploring ways to implement health and wellness strategies for your employees. Wellness programs not only help reduce medical and disability costs, they can reduce absenteeism and promote a general sense of well-being. Although this may seem like a daunting task, invaluable information is already right in front of you, five days a week. Your employees are your best resource when designing an effective program. If you don't know what health issues your workers most care about, then you can't put a relevant program in place. Don't hesitate to ask them which health and wellness topics are most interesting to them, either through a survey or during an informal open forum. This information-gathering can serve as a springboard for you to introduce the wellness concept to the group.

Help Increase Health Literacy

It's not enough to just hand your workers educational pamphlets or line up monthly speakers. In order for you and your employees to get the most out of these promotions, you have to understand the information being communicated. While a great deal of health and wellness information is available today, not all of it is communicated in clear language that employees can understand. This problem is compounded when you consider that over 90 million American adults are functionally illiterate. According to the United States National Institute for Literacy, out of 191 million American adults, as many as 44 million cannot read a newspaper or fill out a job application. Another 50 million more cannot read or comprehend above the eighth grade level. Researcher and readability consultant Mark Hochhauser says the average adult will have difficulty understanding health information, including information found on the Internet, because it is often written at very high reading levels (10th grade and higher).

What can you do to help? Don't just order health and wellness information without first reading it to see if it makes sense. Also, try and find materials that will take into account individual learning styles. Some workers will find visual aids like posters or videos easier to comprehend, while some will prefer written material they can take home and re-read. Provide workers with a glossary of common health care terms or direct them to reliable Internet sites, such as WebMD, that present health information in an easy-to-understand manner. Lastly, don't just communicate the importance of flu shots, preventive screenings, or weight management classes to your workers. Tell them where they can go in your community to obtain them.

Ways to Incorporate Wellness in Your Workplace

Encourage physical activity. If possible, sponsor daily walk breaks.

Post Body Mass Index. Post BMI charts at the workplace or provide an online link through e-mail. Link to a good BMI calculator, such as the one that appears on the U.S. Centers for Disease Control's Web site at: www.cdc.gov/nccdphp/dnpa/bmi/bm.

Make plenty of drinking water available. It's important that you and your staff stay hydrated. Water is the best alternative to soft drinks and/or coffee.

Post proper handwashing techniques. You and your workers carry millions of germs on your hands. Most are harmless, but some cause illnesses, such as colds, flu, and diarrhea. These germs are found on doorknobs, stair railings, telephones, desks, and money when touched by folks who aren't good handwashers.

Sponsor a safety audit. Have an industrial hygienist or ergonomics expert review your workplace to identify potential threats to workplace health and safety.

Communicate regularly with family and/or workers on health and wellness. If you're self-employed, make wellness a priority for your family. As a micro-business owner, use meetings, posters, e-mail or payroll inserts to get your message across to employees.

Sponsor "lunch-and-learns." Invite workers to bring their own lunch and provide them with one or more speakers on relevant health and wellness topics.

Provide an incentive. Whether it's a \$20 gift certificate for completing a health risk assessment or a Friday afternoon off for graduating from a smoking-cessation program, incentives are an effective way to reinforce and reward participation in health promotion activities and programs.

Wellness – In health care, wellness refers to preventive medicine and the associated lifestyle that promotes general well-being and reduces health care usage and costs.



Managing Chronic Illnesses: How to Save Your Health and Your Money

In recent years, dire reports about the human and financial costs of chronic illness have spilled over from medical journals to the pages of newspapers and consumer magazines. The headlines are grim, the stories full of astonishing numbers about the prevalence and expense of these diseases.

But what are chronic illnesses?

Think of the leading causes of death and disability:

- Coronary heart disease
- High blood pressure (hypertension)
- Kidney disease
- Cancer
- Diabetes
- Arthritis

All are considered chronic illnesses — health problems that last indefinitely and may not be completely curable, although they can be managed.

Multiple sclerosis, lupus, sickle-cell anemia, asthma and some mental disorders are considered chronic diseases. Incurable infections such as HIV/AIDS and hepatitis C also qualify.

And some experts call obesity a chronic illness because of its well-established links with diabetes, kidney disease, certain cancers and other maladies.

Finding out that you have a chronic disease is stressful — but millions of Americans are learning how to take charge of their condition and maintain a high quality of life nonetheless.

Chronic Diseases Are on the Rise

The incidence of many preventable chronic illnesses has increased in recent decades.

- **Kidney disease.** It's on the upswing, say researchers, now affecting about 13 percent of Americans. Much of the increase is thought to be due to increases in diabetes, high blood pressure and obesity, as well as the aging of the population.
- **Obesity.** More than 64 percent of U.S. residents are now overweight or obese, say the latest figures from the National Health and Nutrition Examination Survey (NHANES).
- **Diabetes.** A 2003 document from the U.S. Centers for Disease Control and Prevention (CDC), "The Burden of Chronic Disease and the Future of Public Health," calls the

incidence of diabetes "an epidemic that parallels . . . the epidemic in obesity." Cases of diabetes have gone up 50 percent to 60 percent overall since 1990 and 70 percent to 80 percent in people in their 20s and 30s.

- **High-blood pressure.** Also known as hypertension, it has increased substantially, NHANES finds. Older people, non-Hispanic blacks and women are especially susceptible. It's likely that much of the increase in hypertension is due to the obesity rate.

One exception is coronary heart disease, which — although still the leading cause of death in the U.S. — has gone down significantly since the mid-1960s. However, the CDC reports that many more cases could be prevented.

Chronic Illnesses Are Costly

The costs of chronic diseases aren't merely personal. They affect not only individuals, but also employers, insurers, health care providers, communities and governments.

In a 2007 Boston Globe article, a prominent diabetes expert called chronic illness "the driver behind the rising cost of health care."

The numbers paint a dramatic picture: Chronic diseases account for three-quarters of the \$1.7 trillion spent annually on health care in the U. S., reports the World Health Organization (WHO).

And in 2003, lost-productivity costs due to chronic illness exceeded \$1 trillion, as documented in the Milken Institute's 2007 publication "An Unhealthy America."

The American Institute of Preventative Medicine indicates that the average health care cost per employee was \$3,900 in 1997 — and was projected to double by 2007.

Among those who have been diagnosed with a chronic illness, 45 percent said their medical expenses are a financial burden, and 89 percent said they've had trouble getting adequate health insurance, a 2003 Harris survey found.

Among those who do have health insurance, more than one in five said not all the care they need is covered.

But economic hardship isn't the only impact of chronic illnesses.

Such health problems often cause pain, fatigue, stress, reduced capabilities, social withdrawal and depression, experts say. The emotional impact — and the burden of care — affects not only individuals, but also their families, friends and employers.

Stopping the Spread of Chronic Disease

What can you do to halt the increase of chronic illnesses? Plenty.

In fact, many chronic illnesses are preventable.

A 2007 speech by an official of WHO notes that “at least 80 percent of premature heart disease, stroke, respiratory diseases and diabetes, and 40 percent of cancer could be prevented through healthy diet, regular physical activity, and avoidance of tobacco products and harmful use of alcohol.”

Here's an eye-opening example from a CDC presentation: a 50-year-old nonsmoking man who exercises regularly and is not overweight has an 11 percent chance of having heart disease, a stroke or diabetes by age 65. His counterpart of the same age who smokes and is obese and sedentary has a 58 percent chance of developing those diseases in the same time frame.

Prevention efforts and lifestyle changes clearly work to head off chronic diseases.

Learn to Manage Chronic Disease

The most significant step to managing a chronic illness is taking responsibility for your health — by learning as much as possible about the condition, working closely with your physician, and doing what you can for yourself. That may include taking prescribed medication, eating better, stopping smoking, exercising and taking steps to relieve stress.

Think of your doctor as a health care partner, not an all-knowing figure who hands down advice. Work closely with her, asking questions and keeping her apprised of changes in your symptoms.

Take notes during visits and discuss the pros and cons of treatment options. Don't be shy about expressing opinions on how your care should proceed.

Honestly assess your lifestyle and set goals for changes you'd like to make. Specific, achievable goals might include:

- Losing 10 pounds over the next three months
- Eating an additional serving of vegetables every day
- Walking 20 minutes during your lunch hour

Talk over your goals with your physician so she can support your efforts.

Seek help from family and friends, online forums, disease-specific support groups or a therapist, counselor or religious adviser.

Remember that you're not helpless, and no matter what your health problems, you can make changes for the better.

Help Employees Manage Chronic Illnesses

Be supportive; don't blame employees for their health problems even if they might have been prevented.

Understand that receiving a diagnosis of chronic illness can cause a range of emotional reactions, including shock, anger, fear and depression. Try to see employees as people who happen to have medical problems; don't define them by their illness or by what they can't do.

Do as much as possible to help employees prevent disease. Talk with community organizations such as the YMCA, local hospitals and public-health agencies to see what services are available. Take part in health fairs, stop-smoking events, and free and inexpensive health screenings.

Turn your office into a healthier place by making it smoke-free, giving employees time for exercise breaks, and encouraging healthy nutritional choices during meetings accompanied by food.

If you have the space, set up a treadmill for employee use and give small incentives for those who log, say, three 20-minute sessions each week.

Lead by example: Your efforts to take charge of your own health can have a positive influence on employees.

Prevention Efforts Can Improve Your Small Business

The immediate payoff of improving your own health and that of employees is greater productivity and less lost time.

Employee-wellness programs can deliver big long-term benefits by helping workers take charge of their health and perhaps avoid illness and lost time on the job. A side effect is improved employee morale and loyalty.

Fortunately, some disease-prevention efforts can be provided at low or no cost.

For example, the American Cancer Society works with employers to help them offer programs to encourage physical activity, early screening tests and stopping smoking. The society's Web site, www.acsworkplacesolutions.com, provides reliable health information for employees.

Smoking-cessation programs in particular can offer big benefits. Smoking, says the CDC, is the No. 1 preventable cause of death in America. The agency adds that every smoking employee costs employers an average of \$1,300 per year in expenses related to illness, lost time, workers' compensation payments, accidents, fires and property damage.

The American Cancer Society reports that the average smoker loses five times as many work days as a nonsmoker as a result of breaks and sick days.

Another successful intervention is helping employees lose weight. The American Association of Occupational Health Nurses Inc. indicates that almost half of those who participated in workplace weight-loss programs succeeded in attaining and maintaining their goals. Even losses as little as 10 pounds can have significant health benefits.

Helping employees get a handle on healthy lifestyles — with even small changes — can benefit not only them, but your business, too.

For More Information

Learn more about managing and preventing chronic illnesses at these government-sponsored Web sites.

CDC's Chronic Disease Prevention homepage
Research and detailed information on prevention
www.cdc.gov/nccdphp/index.htm

MedlinePlus
An extensive guide to health conditions, medicines, providers and more, from the U.S. National Library of Medicine and the National Institutes of Health
www.nlm.nih.gov/medlineplus

Next Steps After Your Diagnosis
Information and support, available in English and Spanish, from the U.S. Department of Health & Human Services' Agency for Healthcare Research and Quality
www.ahrq.gov/consumer/diaginfo.htm

HealthierUS.gov
Accurate information on disease prevention, nutrition, physical activity, stop-smoking programs and more
www.healthierus.gov/index.html



Health Insurance Help

Sooner or later, everyone who has health insurance encounters questions about their coverage or has a claim denied. Fortunately, most questions are easily answered by calling your insurer's member services number. Fixing a claim denial often amounts to nothing more than supplying data that was missing or incorrect in the first place.

But what if you, a family member, or one of your employees runs into a problem that is not so easily solved? Where can you go for help?

First, try the agent that sold you the policy. If you did your homework before you purchased the policy, you selected someone that you were confident would offer you personalized attention and act as a liaison between you and your insurer if you or your employees should ever have any questions or problems. Hold him or her to that promise.

If the agent can't help, then contact your insurance company. Many insurance companies have extensive customer service departments that can answer questions regarding your coverage and assist you with any claim difficulties. If your agent or your insurance company were unable to solve the problem, contact your state Department of Insurance (DOI). You can find contact information for your DOI at www.naic.org. Many state DOIs have consumer health insurance advocates or managed care ombudsmen that can help you untangle a problem. State DOIs often sponsor Web sites that will point you in the right direction. Another good alternative is your state Department of Health. Check health department Web sites as well for consumer health insurance information.

A Word About Web Sites Featuring Health Care Content

There are thousands of online resources for health and insurance information, but it is often difficult to distinguish which Web sites feature information you can trust and which are mainly advertising portals. The Internet Healthcare Coalition, located at www.ihealthcoalition.org, is a nonpartisan, nonprofit corporation that offers *Tips for Health Surfing Online*. Adhering to these guidelines will help you search safely for consumer health care information. According to the Coalition, a good rule of thumb is to find a Web site that has a person, institution, or organization in which you already have confidence. If possible, you should seek information from several sources and not rely on a single source of information.

What to Do When Your Claim is Denied

Even if you've read and followed all your health plan's rules, you may still one day wind up with a claim denial. Although your immediate reaction may be to get angry, don't take the notification of denial of payment personally. More likely than not, a computer software program automatically generated the decision. Don't forget that most billing and precertification communication between your doctor and your insurer is in codes. One misplaced number can mean the difference between an approval or denial.

If calls to your insurer's member services don't help, ask your physician's office for help in pleading your case. Health insurers grant or deny treatment based on whether a treatment is "medically necessary" for your well-being and whether the treatment is appropriate for your health condition. Ask your doctor to contact your insurer on your behalf.

Document Everything

Keep all your records, not just the denial-of-care notice. This includes any and all correspondence from the insurer and a detailed phone log that documents the name of the people you have spoken to, their titles, and the date you spoke to them. Jot down the general gist of your conversation. This will prove invaluable if you have to reconstruct the steps you have taken thus far to resolve your problem for an independent panel.

Know Your Plan's Rules

Most members do not read the handbooks their health plans give them, according to a study by the U.S. General Accounting Office, so many denials are simply a result of the members' ignorance of their plans' requirements. Make sure the treatment you are planning on receiving is covered under your insurance *before* treatment is received.

Medically Necessary – Services or supplies which are necessary for the symptoms, diagnosis, or treatment of a medical condition. They meet the standards of appropriate medical practice within the medical community in your service area and are not primarily carried out for your convenience or your doctor's.

Information Your Insurer Should Provide With Your Denial

- **A statement of specific medical reasons for the denial.**
- **A statement identifying the treatment exclusion.**
- **The name, state of licensing, medical license number, and title of the person making the denial decision.**
- **Instructions for filing an internal appeal, including whether your appeal has to be in writing, time limits, and the name and phone number of a contact person.**
- **Instructions for filing an external request for review if the denial is upheld in the internal review.**

If you do not receive this information from the insurer, ask for it in writing.

When to File an Appeal

If initial phone calls by you and/or your physician to straighten out the denial are unsuccessful, it's time to file a written appeal. Make sure you review your health plan's appeal process so you don't miss any important deadlines. Some plans require you to file an appeal within 60 days of the denial. In the event that you or your employee needs a treatment decision within 72 hours, find out your plan's requirements for an expedited appeal.

There are usually two methods of appeal: internal and external. The internal appeal is to the insurer; an external appeal is to your state department of insurance or other governing body. During the internal appeal, you request more information and ask the insurer to reconsider its decision. External appeals are filed when internal appeals have been exhausted and your insurer won't reconsider your case.

Many states have implemented laws governing external appeals that in certain cases give you the right to a review by an independent review board of qualified experts. If the appeal is determined in your favor, your insurance company cannot deny your claim.

When appealing your denial, it is essential that you find the correct person to whom you should send your appeal letter. If you're not sure, call your plan's member services and ask for the name and address of the appropriate person. Also, send all letters by certified mail so you have a record of having sent the letter and a receipt that it was received.

Sample appeal letters can be found at the Patient Advocate Foundation's Web site, located at www.patientadvocate.org. The Patient Advocate Foundation was founded on behalf of cancer patients seeking insurance payment for evolving cancer therapies.

Finally, if you absolutely need the treatment or medication, get it anyway and file an appeal later when there is less stress involved. Delaying treatment is never a good health care strategy.

Appeal – When you ask your health insurer to reconsider a decision, such as a claim or treatment denial. (See *Health Insurance Help*.)

Exclusions – Conditions or situations not covered under your health plan. Some common exclusions include cosmetic surgery, dental expenses, and infertility treatment.



How to Protect Your Employees' Health and Privacy Rights

It's a jungle out there — the tangled thicket of government rules and regulations companies must navigate to protect employees' health and privacy rights. Naturally, you want to do what's best for your workers. But good intentions won't keep you from a brush with the health police — the numerous federal and state agencies that enforce key health provisions.

Keep reading to find out more about the rules and regulations that may apply to your micro-business.

Workers' Compensation Insurance

If you have employees, you need workers' compensation for your own protection. If you don't have it, and an employee is injured at work, you could be faced with a civil suit as well as fines and stop-work orders.

Workers' comp represents a "compensation bargain" between employer and employee. Employees hurt on the job receive money and medical benefits; in exchange, they forfeit the right to sue employers.

State law may or may not oblige you to get coverage. In Missouri, you must have insurance if you employ five or more people. Minnesota requires it if you have even one part-time employee.

In most states you can purchase workers' comp insurance from private insurers. A dozen states operate insurance funds to provide riskier businesses with coverage. Talk to your insurance agent or broker about options and costs.

The U.S. Department of Labor Web site at www.dol.gov/esa/regs/compliance/owcp/wc.htm provides contact information for state workers' comp officials and links to state workers' comp Web sites.

The Family Medical Leave Act

Companies with fewer than 50 employees aren't bound by the federal Family Medical Leave Act (FMLA), although state laws may be more restrictive. For instance, Maine's family and medical leave laws apply to employers with 15 or more workers.

The act as passed in 1993 says that covered full- or part-time employees are eligible for as much as 12 weeks of unpaid leave each year under certain circumstances. Qualifying events are:

- The birth of a child or placement of an adopted or foster child
- The need to take care of an immediate family member with health issues
- The employee's own serious health condition

In January 2008, FMLA was amended to allow an immediate family member or next of kin to take as much as 26 weeks of leave to care for a member of the Armed Forces who is receiving medical treatment or therapy for serious injury or illness.

Leave needn't be taken in a lump. Employees may request it in increments as small as an hour.

To learn more about complying with FMLA:

- U.S. Department of Labor, www.dol.gov/esa/whd/fmla
- Your state labor office, www.dol.gov/esa/contacts/state_of.htm

Americans with Disabilities Act

The Americans with Disabilities Act (ADA), signed into law in 1990, prohibits employers from discriminating against qualified people with disabilities when it comes to hiring, firing, advancement, pay, training, benefits and job conditions. A "qualified individual" is one who can perform a job's essential functions with or without "reasonable accommodation."

At the federal level, the law applies if you have 15 or more employees. But, your state may have stiffer rules. In Massachusetts, for example, businesses with six or more employees must comply with ADA.

For details, contact your state department of labor or one of the 10 government-sponsored regional Disability and Business Technical Assistance Centers, www.adata.org, 800-949-4232.

Reasonable accommodations could include making your worksite accessible to someone who has a disability, restructuring a job, and buying or modifying equipment needed to perform the work. Note that "reasonable accommodation" does not force an employer to reduce her standards or to make changes that would impose "undue hardship" on the business.

What about accommodating customers? Unless your company is a private club or religious entity, ADA obligates all public businesses to offer customers "access to goods and services," although the government says the provisions do not require "any action causing undue financial burden."

As an example, even though your business is off limits to dogs, you must allow access to customers (or employees) who use service animals.

Admittedly, key ADA phrases such as “undue financial burden” and “reasonable accommodation” are fuzzy and open to wide interpretation. When questions come up, take advantage of these resources:

- Free consultation from your regional Disability and Business Technical Assistance Center, www.adata.org
- The U.S. Equal Employment Opportunity Commission, www.eeoc.gov, 800-669-4000, TTY: 800-669-6820
- The small-business page of the Department of Labor’s Office of Disability Employment Policy, www.dol.gov/odep/business/small.htm
- Free consultation and technical assistance from the Job Accommodation Network, www.jan.wvu.edu, 800-526-7234, TTY: 877-781-9403

Small businesses may qualify for tax credits and deductions that can help offset the cost of accommodations, building modifications and barrier removal. Ask your tax professional or visit the IRS Web site at www.irs.gov.

HIPAA Regulations

Passed in 1996, the Health Insurance Portability and Accountability Act (HIPAA) has two aspects. Title I has to do with protecting workers’ health coverage when they change jobs. Title II governs, among other things, the security and privacy of health information.

Title I obligates all employers who offer a health plan to provide a “certificate of creditable coverage” when an employee changes jobs or buys individual health insurance. When you hire someone, ask about his or her certificate if your company’s health plan has exclusions for pre-existing conditions. The certificate assures that credit for such conditions carries over from one health plan to the next.

As part of Title II, HIPAA’s “privacy rule” sets the conditions under which a health plan can share individually identifiable health information with an employer or plan sponsor. If you sponsor a group health plan for employees, the plan is a “covered entity” subject to HIPAA regulations. The only exception is self-insured and self-administered plans with fewer than 50 people participating. These small plans are not subject to the privacy rule.

Even when a group health plan is administered by an insurance company, you and the insurer are both responsible for making sure the plan complies with HIPAA.

The privacy rule means an employer can’t ask an employee direct questions about medical problems and treatment because the answers constitute “protected health information” (PHI). Nor can a human resources clerk in your business give you this information — for example, that another employee has been diagnosed with a disease.

Experts recommend that businesses keep PHI wholly separate from other employment records, in secure filing cabinets and protected computer databases. Share it only on the strictest need-to-know basis.

To protect your company — and employees’ information — designate a specific company official who’s responsible for implementing privacy policies and safeguards. Make sure all employees are aware of your policies and document any training or policy statements workers have received.

To learn more, consult the Department of Health and Human Services Office for Civil Rights, www.hhs.gov/ocr/hipaa, 866-627-7748.

Forbidden Questions: What You Can and Can't Ask Employees

You're in dangerous territory when it comes to discussing health issues with workers.

The less you ask, the better. And when you do discuss medical concerns that have a bearing on work, focus on whether the employee can perform essential job tasks rather than his specific health conditions or problems.

If an employee says he needs several days off for medical treatments, you can't inquire what the problem is or what the treatment will be. You are within your rights, though, to ask whether he will need any special assistance to perform his duties after coming back to work. You can also require medical documentation — such as a note from a doctor — but only if all workers who take sick leave must also abide by the policy.

If an employee appears to have a disability, you can ask whether she needs accommodation to help her do her job. If she discloses her disability to you and asks for accommodation, you can discuss the options. You can also request medical documentation for a disclosed disability.

If you have good reason to suspect that a medical problem renders an employee unable to perform essential job functions or that it puts him, employees or customers in danger, you can ask for specific medical information or compel him to have a doctor's exam. But tread lightly. Make sure you can document a legitimate business need for the information. When in doubt, consult an attorney before initiating that conversation.

The bottom line is that your requests for medical information must be based on one of the following:

- Disclosed problems
- Documented performance issues
- Requests for accommodation
- A stated need for family or medical leave

Help Employees With Health Issues Without Overstepping the Law

Focus on ways you can help rather than the employee's specific health challenges. Always be ready to consider and discuss modifications that can help an ill or disabled worker maintain high job performance.

Keep health concerns confidential, telling other workers the bare minimum that's necessary to provide accommodations, maintain a safe environment or process workers' comp or insurance claims.

Defuse concerns that some people get special treatment (for example, a diabetic worker who is allowed to snack at his desk) by making it clear that you'll do what you can to help any employee who has health issues.

Of course, it's illegal to discriminate based on health or disability — but your group health plan is allowed to encourage good health habits by offering discounts or rebates for those who take part in wellness or disease-prevention programs.

For More Information

To learn more, visit these government-sponsored Web sites.

The Department of Labor (DOL) eLaws Advisors: Employment Laws Assistance for Workers and Small Businesses

www.dol.gov/elaws

DOL compliance assistance site for federal employment laws

www.dol.gov/compliance

Contact information and links to Web sites for all state labor offices

www.dol.gov/esa/contacts/state_of.htm

Note: The information presented in this article does not constitute legal advice.

Resources

California Patient's Guide www.calpatientguide.org is a guide intended to inform Californians of their rights to receive quality health care, but contains useful information for any health care consumer. Prepared by The Foundation for Taxpayer & Consumer Rights. Telephone: 1.800.952.5210 or 310.392.0522.

Employee Benefit Research Institute (EBRI) www.ebri.org is dedicated to research that aims to provide objective, unbiased information on employee benefits and does not act as an advocate or opponent of any position. Its purpose is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. Telephone: 202.659.0670.

U.S. Department of Labor www.dol.gov provides consumer information on health plans, COBRA (continuation of health benefits for unemployed workers), the rights of newborns and mothers, the portability of health coverage (HIPAA) and women's health and cancer rights protection. Telephone: 1.866.4.U.S.A.DOL.

National Institutes of Health (NIH) www.nih.gov is the primary federal agency for conducting and supporting medical research. Its health pages provide comprehensive information on conditions and illnesses and health and wellness. Telephone: 301.496.4000.

The Centers for Disease Control and Prevention (CDC) www.cdc.gov is the principal agency in the U.S. government for protecting the health and safety of all Americans. Contains information on chronic diseases, health and wellness, and child and adolescent health. Telephone: 1.800.CDC.INFO.

Cover the Uninsured www.covertheuninsured.org is a project of the Robert Wood Johnson Foundation with the goal of attaining affordable and stable health care through changes in public policy. Telephone: 202.572.2928.

Your Health Resource Center health.NASE.org provides health information specifically geared toward the self-employed and micro-business owners.

WebMD www.webmd.com provides health information, tools for managing your health, and support to those who seek information. The site features message boards on a variety of health topics.

National Association of Insurance Commissioners (NAIC) www.naic.org is the organization of insurance regulators from the 50 states, the District of Columbia and four U.S. territories. NAIC's Web site has resources for consumers, including how to spot a fraudulent agent or insurer. Toll Free Consumer Hotline: 1.800.470.NAIC.

HealthInsuranceInfo www.healthinsuranceinfo.net is produced by The Georgetown University Health Policy Institute. The site features "A Consumer Guide for Getting and Keeping Health Insurance" for each state and the District of Columbia. The guides summarize your protections.

The Robert Wood Johnson Foundation www.rwjf.org is the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans. The site features publications and timely research about health insurance coverage. Telephone: 1.877.843.RWJF.

Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov supports research designed to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The research sponsored, conducted, and disseminated by the AHRQ provides information that helps people make better decisions about health care. The AHRQ is a sister organization to the Centers for Disease Control (CDC) and the National Institutes of Health (NIH). Telephone: 301.427.1364.

Consumers Union www.consumersunion.org, publisher of Consumer Reports, is an independent, nonprofit testing and information organization serving only consumers. Consumers Union features articles on access to health insurance and a guide to making a health care appeal. Telephone: 914.378.2000.

FamilyDoctor www.familydoctor.org, sponsored by the American Academy of Family Physicians, features health information and a variety of tools, including a body mass index calculator and a search-by-symptom tool.

Hospital Compare www.hospitalcompare.hhs.gov is a tool that provides you with information on how well the hospitals in your area care for all their adult patients with certain medical conditions. This information can help you compare the quality of care hospitals provide. Hospital Compare was created through the efforts of the Centers for Medicare and Medicaid Services (CMS) and organizations that represent hospitals, doctors, employers, accrediting organizations, other federal agencies and the public. Telephone: 1.877.696.6775.

The Commonwealth Fund www.commonwealthfund.org promotes a health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Web site has many articles about health care coverage and access. Telephone: 212.606.3800.

The Leapfrog Group www.leapfroggroup.org is an initiative driven by organizations that buy health care who are working to initiate breakthrough improvements in the safety, quality and affordability of healthcare for Americans. It is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality, and customer value will be recognized and rewarded. Telephone: 202.292.6713.

America's Health Insurance Plans (AHIP) www.ahip.org is the voice of America's health insurers. AHIP is the national association that represents nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. Telephone: 202.778.3200.

Insurance Information Institute (III) www.iii.org has a mission to improve the public's understanding of insurance — what it does and how it works. Each year, the III works on more than 3,700 news stories, handles more than 6,000 requests for information, and answers nearly 50,000 questions from consumers on a wide variety of insurance topics, including health insurance. Telephone: 212.346.5500.

Patient Advocate Foundation www.patientadvocate.org is a national nonprofit organization that serves as an active liaison between the patient and their insurer, employer and/or creditors to resolve insurance, job retention and/or debt crisis matters relative to their diagnosis through case managers, doctors, and attorneys. Patient Advocate Foundation seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment, and preservation of their financial stability. Telephone: 1.800.532.5274.

HSA Insider www.hsainsider.com is the leading online destination for information on Health Savings Accounts. Leveraging the Internet to provide better choice and transparency, HSA Insider informs and enables better decisions about the purchase and consumption of health care.

Consumers for Health Care Choices www.chcchoices.org is a not-for-profit grassroots organization that represents the views of the health care consumer to policy makers and health industry leaders. Telephone: 301.606.7364.

Council for Affordable Health Insurance www.cahi.org is a research and advocacy association whose membership includes insurance companies, small businesses, providers, nonprofit associations, actuaries, insurance brokers and individuals. Since 1992, CAHI has been an active advocate for market-oriented solutions to the problems in America's health care system. Telephone: 703.836.6200.

Coalition for Affordable Health Coverage www.cahc.net is a broad-based coalition that came together because of a strong common desire to address the issue of the uninsured by increasing access to private sector health insurance. Members include physician groups, business groups, insurance carriers, insurance brokers, consumer groups and others who believe that affordability of coverage is the most basic component of access to health care. Telephone: 202.266.2669.

Key Health Insurance Terms and Definitions

Accreditation – The stamp of approval for a health plan or hospital that meets predetermined standards. Two organizations that accredit managed care plans are the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). JCAHO also accredits hospitals and clinics. While NCQA accredits HMO-based health plans, the Utilization Review Accreditation Commission, or URAC, is the leading organization that accredits PPO-based plans. (See *Health Insurance Basics for Micro-businesses*.)

Activities of Daily Living (ADL) – Your daily habits such as bathing, dressing, and eating. ADLs are used as an assessment tool to determine whether you can function at home after a hospitalization for a serious injury or illness.

Acute Care – Treatment for an immediate and severe illness, for the subsequent treatment of injuries related to an accident or other trauma, or recovery from surgery. You receive acute care for only a short time, usually in a hospital.

Ambulatory Care – Health services provided to you outside of the hospital, also known as “outpatient care.” Ambulatory care centers, hospital outpatient departments, physicians’ offices, and home health care services all fall under this heading, provided that you don’t stay overnight while receiving treatment.

Ancillary Services – Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy that are provided to you along with medical or hospital care.

Appeal – When you ask your health insurer to reconsider a decision, such as a claim or treatment denial. (See *Health Insurance Help*.)

Balance Billing – The practice of billing you for the fee amount remaining after your health insurer’s payment.

Behavioral Health – Includes mental health, psychiatric, marriage and family counseling, addictions treatment, and substance abuse. Services can be provided by a wide variety of providers, including social workers, counselors, psychiatrists, psychologists, neurologists and family practice physicians.

Benefit Limitations – Any provision which restricts coverage, regardless of medical necessity. Limitations are often expressed in terms of dollar amounts, length of stay, diagnosis, or treatment descriptions. Make sure you receive and read the fine print in your Evidence of Coverage or Summary Plan Description that comes with your policy.

Benefit Package – The services available to you through your health plan. The package will detail costs, limitations on the amounts of services, and annual or lifetime spending limits.

Birthday Rule – A method of determining which parent’s medical coverage will be primary for dependent children: the parent whose birthday falls earliest in the year will be considered as having the primary plan.

Board Certified – A physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Board Eligible – A physician who has graduated from an approved medical school and is eligible to take the specialty board examination. Some HMOs accept board eligibility as equivalent to board certification.

Cafeteria Plan – An arrangement under which you may select your own benefits. Sometimes you are offered varying benefit plans or add-ons provided through the same insurer, other times this refers to plans offered by different insurers.

Carrier – Any licensed organization, which underwrites or administers your life, health, or other insurance programs.

Carve Out – A health care delivery and financing arrangement in which certain services are administered and funded separately from the general health care services. Common carve outs include such services as psychiatric, rehabilitation, chemical dependency, and ambulatory services. HMOs and insurers use this strategy when they don’t have in-house expertise related to the service that they have “carved out.”

Case Management – Method designed to monitor and coordinate your treatment when you have a specific diagnosis, such as diabetes or coronary artery disease, or if you require high-cost services. Case management aims to ensure that you receive the appropriate level of services delivered in the most cost-effective manner in order to achieve the best outcome.

Case Manager – A nurse or social worker who works with you, your doctor, and your insurer to coordinate health care services and provide you with a plan of necessary and appropriate care.

Catastrophic Health Insurance – Health insurance that protects you against the high cost of treating severe injuries or lengthy illnesses. These policies usually cover some, if not all, of your medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

Centers for Medicare and Medicaid Services (CMS) – The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP).

Certificate of Coverage (COC) – Outlines the terms of your coverage and benefits.

Centers of Excellence – Hospitals that specialize in treating particular illnesses or performing certain procedures, such as cancer or organ transplants.

Charges – The published prices of services supplied by a provider or facility. There is often a wide disparity between the amount your doctor or hospital charges you and the amount your insurer actually pays. This is because your insurance company has negotiated a lower rate with the provider or facility which is often 40 percent to 60 percent lower than the published rate. This is why you’re at such a huge disadvantage if you’re trying to pay for health care out of your own pocket.

Chronic Care – Long term care of persistent diseases or conditions such as asthma or low back pain. Chronic care promotes self-care to improve your state of health and prevent further loss of function.

Claim – Your request (or your provider’s) submitted to your insurer to pay for health care services.

Claims Review – The process used by insurers to determine whether the services you’ve received are covered under your policy.

Closed Access – A “gatekeeper” health plan that requires you to seek treatment only from providers contracted with that plan.

Closed Panel – Medical services delivered in an HMO-owned health center or satellite clinic by physicians who belong to a specially formed, but legally separate, medical group that only serves the HMO.

Coding – A mechanism for consistently identifying and defining health care services in order to ease billing procedures and prevent fraud. The International Classification of Diseases (ICD) is the official system of assigning codes to diagnoses and procedures associated with inpatient hospital stays, while Current Procedural Terminology (CPT) codes identify outpatient services.

Coinsurance – The amount shared by you and your insurer for covered services after you have met your deductible. This is expressed in a ratio, typically 80/20 (80 percent paid by your insurer and 20 percent paid by you).

Comorbid Condition – A medical condition that exists side-by-side with a principal diagnosis at the time of a hospital admission that is expected to increase your length of stay by at least one day.

Comprehensive Major Medical Insurance – A policy which provides you with a high level of protection against routine and major medical expenses. It is generally characterized by a low deductible, co-insurance, and a plan fairly “rich” in benefits.

Concurrent Review – Review of a procedure or hospital admission done by health care professional (usually a nurse) other than the one providing your care. Concurrent review is conducted during a hospital stay to determine the appropriateness of the confinement and the medical necessity for a continued stay.

Confidentiality – The protection of your personal information as required by state or federal law or by policy of your health care provider.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – Federal law that continues your employer-sponsored health care coverage for a certain amount of time after you lose your job.

Conversion – In group health insurance, the opportunity given to you and any of your covered dependents to change group insurance to some form of individual insurance, without medical examination upon the loss of your group insurance.

Coordination of Benefits (COB) – A method used by insurers to avoid duplicate payments under more than one insurance policy. A coordination of benefits clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not more than 100 percent of the cost is covered.

Co-pay – Unlike coinsurance, which is based on a percentage of the cost, a co-pay is a flat fee paid for a specific service, such as \$15 for an office visit. This cost-sharing arrangement is typical of an HMO-based plan. (See *Health Insurance Basics for Micro-businesses*.)

Cosmetic Procedure – Treatment, such as a facelift, which improves your appearance but is not medically necessary.

Cost Sharing – When you must pay some of your health care costs out of your own pocket in order to receive care. This includes deductibles, coinsurance, and co-payments, but not your premium.

Key Health Insurance Terms and Definitions continued

Covered Benefit – A medically necessary service that is specifically provided for under the provisions of your health plan’s Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. Always check the fine print in your health insurance policy.

Credentialing – Process by which a potential or existing provider must meet certain standards in order to begin or continue participation in a health care plan or in a hospital medical staff organization. Credentialing helps determine the quality of personnel by providing standards for evaluating education, training, and competency.

Deductible – The amount you must pay before your health insurance benefits kick in. You must meet your deductible each year.

Dependent – Someone other than yourself who is covered under your health plan. This may be a spouse, child, unmarried partner, or, in rare instances, a parent.

Disallowance – When an insurer declines to pay for all or part of your claim.

Discharge Planning – When after-care services are determined for discharge from the hospital.

Durable Medical Equipment (DME) – Medical equipment, such as a walker, that you own or rent to assist in your home treatment or rehabilitation.

Electronic Medical Record (EMR) – A computer-based record containing your personal health care information. This technology, when fully developed, will meet provider needs for real-time data access and evaluation in medical care.

Elimination Period – The waiting period in a health insurance policy.

Emergency Medical Treatment and Labor Act (EMTALA) – This legislation requires hospitals to provide you with emergency treatment, regardless of your insurance status or ability to pay.

Employee Assistance Program (EAP) – A service, plan or set of benefits that are designed for personal or family problems, including mental health, substance abuse, gambling addiction, marital problems, parenting problems, emotional problems, or financial pressures. EAP began with a primary drug and alcohol focus with an emphasis on rehabilitating valued employees rather than terminating them for their substance abuse problems.

Employee Retirement Income Security Act of 1974 (ERISA) – This legislation regulates the majority of private pension and welfare group benefit plans in the U.S. ERISA exempts most large self-funded plans from State regulation and, hence, from any reform activities undertaken at the state level.

Evidence or Explanation of Coverage (EOC) – The booklet provided to you by your insurer which summarizes the benefits available to you under your plan.

Evidence of Insurability – Proof of a person’s physical condition that affects acceptability for insurance or a health care contract.

Exclusions – Conditions or situations not covered under your health plan. Some common exclusions include cosmetic surgery, dental expenses, and infertility treatment.

Explanation of Benefits (EOB) – The statement sent to you that explains the services provided, the amount you or your insurer was billed, any payments that were made, and the amount you owe.

First Dollar Coverage – Insurance coverage with no “front-end” deductible. Your coverage begins immediately for any covered benefit. It is common for many plans to provide first dollar coverage for preventive care such as annual physical exams and immunizations for children.

Flexible Spending Account (FSA) – An IRS-sanctioned plan that allows you to use pre-tax dollars set aside from your salary to pay for any unreimbursed health care or dependent care services.

Formulary – List of prescription drugs approved by a health plan. Formularies are either “closed,” including only certain drugs, or “open,” including all drugs. Both types typically impose a cost scale requiring you to pay more for brand name drugs, rather than generic.

Gatekeeper – Usually refers to your primary care physician (PCP) who oversees and coordinates all aspects of your health care. In many managed care plans, your PCP must preauthorize a visit to a specialist, unless there is an emergency.

Guaranteed Issue – Requirement that health plans offer coverage to all businesses during some period each year.

Grace Period – Period past the due date of a premium during which your coverage may not be cancelled.

Grievance Procedures – The process by which you can air complaints and/or appeal a treatment denial.

Group Insurance – A single contract issued by your employer, or other group entity, that covers many individuals.

Health Employer Data and Information Set (HEDIS) – A set of HMO performance measures that are maintained by the National Committee for Quality Assurance. HEDIS data is collected annually and provides an informational resource for consumers on issues of health plan quality.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Primarily affecting the small group and individual health insurance markets, this legislation was designed to allow the portability of health insurance between jobs. In addition, it required the creation of a federal law to protect personally identifiable health information.

Hold Harmless Clause – A clause frequently found in managed care contracts whereby the parties agree to indemnify each other for malpractice or corporate malfeasance if either is found to be liable. It may also refer to language that prohibits your doctor from billing you if your managed care company goes bankrupt.

Hospice – Facility or program providing care for the terminally ill.

Identification Card – A card given to you and your dependents which identifies benefit eligibility.

Informed Consent – Refers to requirements that health care providers and researchers explain the purposes, risks, benefits, confidentiality protections, and other relevant aspects of medical care, a specific procedure, or participation in medical research. Informed consent is also required for the authorization of release or disclosure of individually identifiable health care information under HIPAA.

Inpatient Care – Care given to a registered bed patient in a hospital, nursing home, or other medical institution.

Lifetime Limit – A cap on the benefits paid under a policy. Many policies have a lifetime limit of \$1 million, which means that the insurer agrees to cover up to \$1 million in covered services over the life of the policy.

Mandated Benefits – Benefits that health plans are required by law to provide.

Medical Information Bureau (MIB) – A data pool service that stores information on the health histories of persons who have applied for insurance in the past. Most life and health insurers subscribe to this bureau to get more complete underwriting information on health insurance applicants.

Medically Necessary – Services or supplies that are necessary for the symptoms, diagnosis, or treatment of a medical condition. They meet the standards of appropriate medical practice within the medical community in your service area and are not primarily carried out for your convenience or your doctor's.

Mental Health Parity – Legislation designed to make sure that insurers provide the same level of coverage for mental health treatment as that offered for medical and surgical treatments.

National Practitioner Data Bank (NPDB) – The federal government maintains this computerized data bank which contains information on physicians against whom malpractice claims have been paid or disciplinary actions have been taken. Many regulatory agencies require hospitals to use the NPDB prior to credentialing physicians at their facilities.

Network – An affiliation of providers through formal and informal contracts and agreements.

Open Access – Open access means that you can visit any participating network provider without a referral.

Open Enrollment Period – The period during which you may elect to enroll in, or transfer between, available programs providing health care coverage, without evidence of insurability or waiting periods. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

Out-of-Network Benefits – Under most HMO-based plans, you are not reimbursed for any services provided by a hospital or doctor who does not participate in the plan's network. With PPO-based plans, there may be a provision for reimbursement of "out-of-network" providers, but this usually involves higher co-pays and/or lower reimbursements.

Out-of-Network Provider – A health care provider with whom an insurer does not have a contract. You must pay either part or all of the costs of care from an out-of-network provider, depending on the provisions of your health plan.

Out-of-Pocket Expenses – Your portion of health care costs that are not reimbursed by the insurer, including deductibles, co-payments, and coinsurance.

Out-of-Pocket Limit – A cap placed on your out-of-pocket costs, after which benefits increase to provide full coverage for the rest of the year. It is a stated dollar amount set by your insurer, in addition to regular premiums.

Key Health Insurance Terms and Definitions continued

Outpatient Care – Care given to a person who is not hospitalized. Many surgeries and treatments are now provided on an outpatient basis and don't require an overnight stay.

Participating Physician – A physician in the insurer's service area who has entered into a contract.

Plan Document – The document that contains all of the provisions, conditions, and terms of a pension, health, or welfare plan. This document may be written in technical terms and is different from a summary plan description (SPD) that, under ERISA, must be written in language that can be understood by the average plan participant. (See ERISA above.)

Portability – A requirement that health plans must guarantee you continuous coverage without waiting periods if you're moving between plans. Your old health plan must give you a certificate of prior coverage that you pass along to your new plan to guarantee that the new plan cannot exclude any of your pre-existing conditions. (See HIPAA above.)

Pre-Certification (Pre-authorization) – Review of "need" for care before admission. This review determines whether or not your insurer will pay for the service.

Pre-existing Condition – A medical condition that you developed prior to applying for, or receiving, a health insurance policy that may trigger a limitation of your benefits. Some policies can exclude coverage of such conditions, often indefinitely. New statutes in 1997 and 1998 altered the freedom other health plans have enjoyed in setting pre-existing time limits. (See HIPAA above.)

Preventive Care – Health care that emphasizes prevention, early detection, and early treatment, thereby ultimately reducing health care costs. Health care that focuses on keeping you well in addition to helping you when you are sick.

Primary Care – Basic or general health care given by general practitioners, family practitioners, internists, obstetricians, and pediatricians with referral to secondary care specialists, as necessary.

Protected Health Information – Under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form. (See HIPAA above.)

Reasonable and Customary Charges – These charges are those which are most often made by a provider for services rendered in a particular geographic area.

Referral – Permission from your doctor to consult with another physician or hospital.

Report Card – An accounting of the quality of services, compared among providers over time. You can use report cards to choose a health plan or doctor, or check up on the overall program effectiveness of your current plan or provider.

Risk Pool – Legislatively created programs that group individuals together who cannot secure coverage in the private sector.

Second Surgical Opinion – A cost containment technique to help you and your insurer determine whether a recommended procedure is necessary, or whether an alternative method of treatment could accomplish the same result. Some health policies require a second surgical opinion before specific procedures will be covered.

Section 125 Plan – A plan which provides flexible benefits. This plan qualifies under the IRS code which allows employee contributions to meet with pre-tax dollars. (See Flexible Spending Accounts above.)

Self-Funded Plan – Plan that is funded by the employer rather than an insurer.

State Children's Health Insurance Program (SCHIP) – Created in 1997 by the Balanced Budget Act, SCHIP gave each state permission to offer health insurance for children, up to age 19, who are not already insured. SCHIP is a state-administered program and each state sets its own guidelines regarding eligibility and services.

Third Party Administrator (TPA) – An independent organization that provides administrative services including claims processing and underwriting for other entities, such as insurance companies or employers.

Triage – The act of categorizing patients according to the severity of their health. Triage, most commonly used in emergency rooms, is designed to maximize the most efficient use of medical resources and personnel.

Utilization Review – A cost control mechanism by which the appropriateness, necessity, and quality of health care is monitored by both insurers and employers.

Waiting Periods – The length of time an individual must wait to become eligible for benefits for a specific condition after overall coverage has begun.

Wellness – In health care, wellness refers to preventive medicine and the associated lifestyle that promotes general well-being and reduces health care usage and costs.

Listing of State Departments of Insurance

Alabama

Alabama Department of Insurance

201 Monroe Street, Suite 1700
Montgomery, Alabama 36104
Phone: 334.269.3550
Fax: 334.241.4192
www.aldoi.org

Alaska

Alaska Division of Insurance

550 West 7th Avenue, Suite 1560
Anchorage, Alaska 99501-3567
Phone: 907.269.7900
Fax: 907.269.7910
www.commerce.state.ak.us/insurance

Arizona

Arizona Department of Insurance

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7256
Phone: 602.364.2499
Fax: 602.364.2505
www.id.state.az.us

Arkansas

Arkansas Insurance Department

1200 West 3rd Street
Little Rock, Arkansas 72201
Phone: 501.371.2600 / 900.282.9134
Fax: 501.371.2681
www.insurance.arkansas.gov

California

California Department of Insurance

300 South Spring Street, South Tower
Los Angeles, California 90013
Phone: 213.897.8921 /
800.927.HELP (CA Residents only)
Fax: 213.897.9051
www.insurance.ca.gov

Colorado

Colorado Division of Insurance

1560 Broadway, Suite 850
Denver, Colorado 80202
Phone: 303.894.7499 / 800.930.3745
Fax: 303.894.7455
www.dora.state.co.us/insurance

Connecticut

Connecticut Insurance Department

PO Box 816
Hartford, Connecticut 06142-0816
Phone: 860.297.3800 / 800.203.3447
Fax: 860.566.7410
Street Address:
153 Market Street
Hartford, Connecticut 06103
www.ct.gov/cid

Delaware

Delaware Department of Insurance

Rodney Building
841 Silver Lake Boulevard
Dover, Delaware 19904
Phone: 302.674.7300
Fax: 302.739.5280
www.delawareinsurance.gov

District of Columbia

Department of Insurance, Securities & Banking

810 First Street, N. E. Suite 701
Washington, DC 20002
Phone: 202.727.8000
Fax: 202.535.1196
www.disb.dc.gov

Florida

Florida Department of Financial Services

Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399-0326
Phone: 850.413.3140
Fax: 850.488.3334
www.fldfs.com

Georgia

Georgia Department of Insurance

2 Martin Luther King, Jr. Drive
Floyd Memorial Building
West Tower, Suite 704
Atlanta, Georgia 30334
Phone: 404.656.2070 / 800.656.2298
Fax: 404.657.8542
www.inscomm.state.ga.us

Hawaii

Hawaii Insurance Division

Department of Commerce & Consumer Affairs
PO Box 3614
Honolulu, Hawaii 96813
Phone: 808.586.2790
Fax: 808.586.2806
Street Address:
335 Merchant Street, Room 213
Honolulu, Hawaii 96813
www.hawaii.gov/dcca/areas/ins

Idaho

Idaho Department of Insurance

700 West State Street, P.O. Box 83720
Boise, Idaho 83720-0043
Phone: 208.334.4250
Fax: 208.334.4398
www.doi.state.id.us

Listing of State Departments of Insurance continued

Illinois

Illinois Division of Insurance

100 West Randolph Street, Suite 9-301
Chicago, Illinois 60601-3395
Phone: 312.814.2470 / 866.445.5364
Fax: 312.814.5416
www.idfpr.com/DOI/Default2.asp

Indiana

Indiana Department of Insurance

311 W. Washington Street, Suite 300
Indianapolis, Indiana 46204
Phone: 317.232.2385
Fax: 317.232.5251
www.in.gov/idoi/

Iowa

Insurance Division

330 Maple Street
Des Moines, Iowa 50319-0065
Phone: 515.281.5705 / 877.955.1212
Fax: 515.281.3059
www.iid.state.ia.us

Kansas

Kansas Department of Insurance

420 S.W. 9th Street
Topeka, Kansas 66612-1678
Phone: 785.296.3071 / 800.432-2484
Fax: 785.296.2283
www.ksinsurance.org

Kentucky

Kentucky Department of Insurance

PO Box 517
Frankfort, Kentucky 40602
Phone: 502.564.6034 / 800.595.6053
Fax: 502-564-6090
Street Address:
215 West Main Street
Frankfort, Kentucky 40601
<http://doi.ppr.ky.gov/kentucky/>

Louisiana

Louisiana Department of Insurance

PO Box 94214
Baton Rouge, Louisiana 70804
Phone: 225.342.5900 / 800.259.5300
Street Address:
1702 N. 3rd Street
Baton Rouge, Louisiana 70804
www.lidi.state.la.us

Maine

Maine Bureau of Insurance

Department of Professional
& Financial Regulation
State House Station #34
Augusta, Maine 04333-0034
Phone: 207.624.8475 / 800.300.5000
Fax: 207.624.8599
Street Address:
124 Northern Avenue
Gardiner, Maine 04345
www.maine.gov/pfr/insurance

Maryland

Maryland Insurance Administration

525 St. Paul Place
Baltimore, Maryland 21202-2272
Phone: 410.468.2090 / 800.492.6116
Fax: 410.468.2020
www.mdinsurance.state.md.us

Massachusetts

Division of Insurance

Commonwealth of Massachusetts
One South Station, 5th Floor
Boston, Massachusetts 02110
Phone: 617.521.7794
Fax: 617.521.7575
www.mass.gov/doi

Michigan

Office of Financial and Insurance Regulation

PO Box 30165
Lansing, Michigan 48909-7665
Phone: 571.373.0220 / 877.999.6442
Fax: 517.335.4978
Street Address:
611 W. Ottawa Street, 3rd Floor
Lansing, Michigan 48933
www.michigan.gov/dleg

Minnesota

Minnesota Department of Commerce

85 7th Place East, Suite 500
St. Paul, Minnesota 55101
Phone: 651.296.4026
Fax: 651.291.1959
www.commerce.state.mn.us

Mississippi

Mississippi Insurance Department

PO Box 79
Jackson, Mississippi 39205
Phone: 601.359.3569
Fax: 601.359.2474
Street Address:
1001 Woolfolk State Office Building
501 North West Street
Jackson, Mississippi 39201
www.mid.state.ms.us

Missouri

Missouri Department of Insurance

P.O. Box 690
Jefferson City, Missouri 65102-0690
Phone: 573.751.4126
Fax: 573.751.1165
Street Address:
301 West High Street, Suite 530
Jefferson City, Missouri 65101
www.insurance.mo.gov

Montana

Montana Department of Insurance

840 Helena Avenue
Helena, Montana 59601
Phone: 406.444.2040
Fax: 406.444.3497
<http://sao.state.mt.us/insurance/index.asp>

Nebraska

Nebraska Department of Insurance

Terminal Building, Suite 400
941 'O' Street
Lincoln, Nebraska 68508-3639
Phone: 402.471.2201
Fax: 402.471.4610
www.doi.ne.gov

Nevada

Nevada Division of Insurance

788 Fairview Drive, Suite 300
Carson City, Nevada 89701
Phone: 775.687.4270
Fax: 775.687.3937
www.doi.state.nv.us

New Hampshire

New Hampshire Insurance Department

21 South Fruit Street, Suite 14
Concord, New Hampshire 03301
Phone: 603.271.2261 / 800.852.3416
Fax: 603.271.1406
www.nh.gov/insurance

New Jersey

New Jersey Department of Banking & Insurance

20 West State Street, P.O. Box 325
Trenton, New Jersey 08625
Phone: 609.292.7272 / 800.446.7467
Fax: 609.984.5263
www.state.nj.us.dobi

New Mexico

New Mexico Division of Insurance

P.O. Box 1269
Santa Fe, New Mexico 87504-1269
Phone: 505.827.4601 / 800.947.4722
Fax: 505.827.4734

Street Address:

PERA Building, 4th Floor
1120 Paseo de Peralta
Santa Fe, New Mexico 87501
www.nmprc.state.nm/id.htm

New York

New York Insurance Department

One Commerce Plaza
Albany, New York 12257
Phone: 518.474.6600 / 800.342.3736
www.ins.state.ny.us

North Carolina

Department of Insurance

1201 Mail Service Center
Raleigh, North Carolina 27699-1201
Phone: 919.807.6750 / 800.546.5664

Street Address:

Dobbs Building
430 N. Salisbury Street
Raleigh, North Carolina 27603
www.ncdoi.com

North Dakota

North Dakota Department of Insurance

600 E. Boulevard, Fifth Floor
Bismarck, North Dakota 58505-0320
Phone: 701.328.2440 / 800.247.0560
Fax: 701.328.4880
www.nd.gov/ndins

Ohio

Ohio Department of Insurance

50 West Town Street, Suite 300
Columbus, Ohio 43215
Phone: 614.644.2658 / 800.686.1526
Fax: 614.644.3743
www.ohioinsurance.gov

Oklahoma

Oklahoma Department of Insurance

P.O. Box 53408
Oklahoma City, Oklahoma 73152-3408

Street Address:

2401 NW 23rd Street, Suite 28
Oklahoma City, Oklahoma 73107
Phone: 405.521.2828 / 800.522.0071
Fax: 405.521.6635
www.ok.gov/oid

Oregon

Oregon Insurance Division

PO Box 14480
Salem, Oregon 97309-0405
Phone: 503.947.7980 / 888.877.4894
Fax: 503.378.4351

Street Address:

350 Winter Street NE, Room 440
Salem, Oregon 97301-3883
www.cbs.state.or.us/ins

Pennsylvania

Pennsylvania Insurance Department

1209 Strawberry Square
Harrisburg, Pennsylvania 17120
Phone: 717.787.2317 / 877.881.6388
Fax: 717.787.8585
www.ins.state.pa.us/ins

Puerto Rico

Puerto Rico Department of Insurance

PO Box 8330
Santurce, Puerto Rico 00909
Phone: 787.722.8686
Fax: 787.722.0005

Street Address:

Cobian Plaza Bldg.
1607 Ponce de León Avenue
San Juan, Puerto Rico 00910
www.ocs.gobierno.pr

Listing of State Departments of Insurance continued

Rhode Island

Rhode Island Insurance Division

1511 Pontiac Avenue
Cranston, Rhode Island 02920
Phone: 401.462.9520
Fax: 401.462.9602
www.dbr.state.ri.us/divisions/insurance

South Carolina

South Carolina Department of Insurance

PO Box 100105
Columbia, South Carolina 29202
Phone: 803.737.6160
Fax: 803.737.6205
Street Address:
1201 Main Street, Suite 100
Columbia, South Carolina 29201
www.doi.sc.gov

South Dakota

Department of Revenue and Regulation Division of Insurance

445 East Capitol Avenue
Pierre, South Dakota 57501
Phone: 605.773.3563
Fax: 605.773.5369
www.state.sd.us/drr2/reg/insurance

Tennessee

Tennessee Department of Commerce & Insurance

500 James Robertson Parkway, Fourth Floor
Nashville, Tennessee 37243
Phone: 615.741.2218 / 800.342.4029
www.state.tn.us/commerce

Texas

Texas Department of Insurance

PO Box 149104
Austin, Texas 78714-9104
Phone: 512.463.6464
Fax: 512.475.2005
Street Address:
333 Guadalupe Street
Austin, Texas 78701
www.tdi.state.tx.us

Utah

Utah Insurance Department

State Office Building, Suite 3110
Salt Lake City, Utah 84114-6901
Phone: 801.538.3800 / 800.439.3805
Fax: 801.538.3826
www.insurance.utah.gov

Vermont

Vermont Division of Insurance

Department of Banking, Insurance,
Securities & Health Care Administration
89 Main Street, Drawer 20
Montpelier, Vermont 05620-3101
Phone: 802.828.3301
www.bishca.state.vt.us/InsurDiv/insur_index.htm

Virginia

Virginia State Corporation Commission

Bureau of Insurance
PO Box 1197
Richmond, Virginia 23218
Phone: 804.371.9278
Street Address:
1300 East Main Street
Richmond, Virginia 23219
www.scc.virginia.gov

Washington State

Office of the Insurance Commissioner

PO Box 40256
Olympia, Washington 98504-0256
Phone: 360.725.7080
Street Address:
5000 Capitol Boulevard
Tumwater, Washington 98501
www.insurance.wa.gov

West Virginia

West Virginia Offices of the Insurance Commissioner

PO Box 50540
Charleston, West Virginia 25305-0540
Phone: 304.558.3386 / 888.879.9842
Street Address:
1124 Smith Street
Charleston, West Virginia 25301
www.wvinsurance.gov

Wisconsin

Office of the Commissioner of Insurance

PO Box 7873
Madison, Wisconsin 53707-7873
Phone: 608.266.3585
Fax: 608.266.9935
Street Address:
125 South Webster Street
Madison, Wisconsin 53703-3474
www.oci.wi.gov

Wyoming

Wyoming Department of Insurance

106 East 6th Avenue
Cheyenne, Wyoming 82002
Phone: 307.777.7401 / 800.438.5768
Fax: 307.777.2446
<http://insurance.state.wy.us/>



**National Association
for the Self-Employed**
P.O. Box 612067
DFW Airport, TX 75261-2067
800-232-NASE
<http://health.NASE.org>