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Guide to Health Insurance Options for Small Businesses

Cover The Uninsured

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This Health Insurance Guide Is for You

As a small business owner, you might think that offering health insurance coverage to your employees is beyond your reach, but it may be easier than you realize. This Guide is intended to help you find out.

Many employers like you have decided that providing a health insurance benefit to their employees is a sound business decision. Here are just some of the reasons:

➢ Offering health insurance helps attract and retain high-quality, key employees. The U.S. Department of Labor estimates that, on average, recruitment and employee turnover in small businesses account for 30 percent of salary costs.

➢ Evidence shows that insured persons are healthier, and better health increases worker productivity, which can enhance a company's performance.

➢ The health insurance premiums your company pays are fully tax-deductible and are non-taxable income for employees.

➢ Health insurance provides workers and their families with protection from catastrophic financial losses that can accompany serious illness or injury.

This Guide explains the key concepts you need to understand to make an informed decision about health insurance for your company, or, if you are self-employed, for yourself. It answers questions such as: How much does health coverage cost? What types of insurance plans are available to my company? What if an employee or dependent has a pre-existing medical condition?

Important Facts About Health Insurance

Lack of information may keep some small business owners from exploring health insurance options for their employees or themselves. Below is a list of important facts to keep in mind when thinking about health insurance.

❶ Businesses may benefit economically by providing health coverage for workers and their families. Health insurance may help employers:

- Recruit high-quality workers
- Reduce staff turnover
- Reduce the cost of absenteeism
- Limit disability and workers' compensation claims

❷ Employees consider health insurance to be, by far, the most important fringe benefit.

❸ There are tax benefits when you offer health insurance to your workers:

- The health insurance premiums your company pays are fully tax-deductible as a business expense. This tax deduction may be thought of as a discount to the cost of health insurance.
- Employees may make their premium contributions on a pre-tax basis through payroll deductions, which makes coverage more affordable for workers.
- Self-employed persons may deduct 100 percent of the cost of their health insurance premiums from their adjusted gross income.
- Health insurance payments are excluded from base payroll when calculating an employer's Medicare and Social Security payments. An equivalent amount paid in wages would be subject to Medicare and Social Security taxes.

❹ Typically, health insurance costs substantially less when you buy it as a member of a group rather than on your own.

❺ Health insurance coverage gives you access to the price reductions that health insurance companies negotiate with doctors and other health care providers.

❻ Even if an employee or dependent is in poor health, federal law prohibits insurers from denying coverage to the company, the employee or the dependent based on health status, although the cost of insurance may be higher depending on your state of residence.

❼ All states offer children low-cost or free health care coverage to eligible working families. To determine the income limits for this coverage, or to learn more about this type of coverage in your area, call 1.877.KIDS.NOW or visit **www.insurekidsnow.gov**.

❽ Alternatives to traditional health insurance include health savings accounts (HSAs), health reimbursement arrangements (HRAs), and association-sponsored plans. HSAs and HRAs have added tax advantages.

Understanding the Basics: What Small Businesses Need to Know About Health Insurance

Health insurance plans come in many shapes and sizes. Important plan features—such as how much it costs employers, how much it costs employees and how much choice is allowed when selecting physicians—can vary tremendously from plan to plan, making it more likely that at least one plan will meet your company's needs. Such variety can seem daunting when trying to identify the right insurance plan for your business, but it doesn't have to. This Guide can help.

A small business that purchases insurance can gain access to the same hospital and physician discounts enjoyed by larger firms. Insurance companies use the purchasing power gained from all of their customers—large groups, small groups and individuals—to negotiate the best prices.

Although there are exceptions in some states, a small employer that purchases insurance can often pool his employees with thousands of employees in other small firms. In this way, if an employee falls ill, the cost of that illness is spread across the entire small business pool rather than across your business alone.

DO INSURANCE COMPANIES HAVE TO SELL HEALTH INSURANCE TO MY SMALL BUSINESS?

Under federal law, health insurance companies cannot refuse to sell coverage to small businesses (typically defined as 2 to 50 employees) on the basis of health status or other factors related to the use of health care. This is called **guaranteed issue.** In addition, an insurance company cannot cancel a business' policy because someone in the group becomes sick. This is called **guaranteed renewability.** However, insurers may increase **premiums,** which is the amount an insurance plan costs per month. Federal law does not require guaranteed issue and guaranteed renewability for self-employed individuals. Some states do require that insurers offer at least one plan to individuals without regard to their health status.

States may set certain criteria for providing coverage:

➢ Some insurers may require that a minimum percentage of eligible workers participate in a group health plan.

➢ Employers may use other factors—such as full-time versus part-time status—to determine which employees are eligible for insurance coverage.

➢ Neither employers nor insurers can condition eligibility of employees and their dependents on their health status. This is called **nondiscrimination.**

➢ Insurers may require employers to pay a minimum share of their workers' health insurance premiums.

➢ Insurers can refuse to renew coverage for nonpayment of premiums or if the insured commits fraud.

WHAT ARE MY OPTIONS IF I AM SELF-EMPLOYED? IS THIS GUIDE USEFUL TO ME?

Yes, it is. In most states, the laws that govern health insurance sold to the self-employed are different from those that govern insurance sold to small businesses. It is important for the self-employed individual to understand the impact that certain federal laws relating to health insurance have on them. In 2003, federal tax law began allowing self-employed individuals to deduct the full cost of health insurance from their adjusted gross income. However, federal law does not require that all insurance companies sell coverage to all self-employed individuals.

Much of the general information about health insurance contained in this Guide is relevant to the self-employed.

WHAT TAX ADVANTAGES ARE AVAILABLE TO ME AND TO MY EMPLOYEES IF I PURCHASE INSURANCE FOR MY COMPANY?

Tax advantages make the cost of purchasing insurance considerably less. Consider this example: Assume the owner of an eight-person firm (with seven dependents) offers insurance, everyone participates and the total premium annually is $48,000 per year. If the employer pays 70 percent of the premium, without the tax advantages, the employer would pay $33,600 per year. However, after taking the tax advantages into account the true costs are about 40 percent less (assuming the firm is in the 27 percent tax bracket). Here's why: The employer is taxed on

the difference between revenue and expenses. Since the cost of health premiums is an expense, the profit is less, thus saving $9,072 ($33,600 x .27) in federal income taxes in a single year (or 27 percent of your premium payment). When FICA taxes (Social Security and Medicare) and state taxes (assumed at 5 percent) are included, the firm realizes an additional savings of $4,250, or 12.65 percent. See the example below:

Employer's cost of health insurance premium without tax advantages	$ 33,600
Savings in income tax per year *(premium is tax deductible)*	$ 9,072
Savings in FICA and state taxes	$ 4,250
Cost of health insurance premium with tax advantages *(40 percent savings to employer)*	**$ 20,278**

Employees also enjoy tax savings. Their premium costs can be deducted from their wages pre-tax, thereby reducing those costs in a way similar to the employer's example.

WHAT TAX ADVANTAGES ARE AVAILABLE TO AN INDIVIDUAL WHO PURCHASES INSURANCE IN THE INDIVIDUAL MARKET?

A self-employed person who purchases insurance (self-only or family coverage) in the individual market realizes the same three types of tax savings described above. This includes federal income tax savings (at the individual's tax bracket), 15.3 percent FICA tax savings (because the self-employed person must pay the employer's and employee's share) and state income tax equivalent to the individual's state income tax bracket.

WHAT TYPES OF INSURANCE PLANS ARE AVAILABLE TO MY COMPANY?

Health plans take many forms. The two most common plan types available today are preferred provider organizations (PPOs) and health maintenance organizations (HMOs).

Tax advantages can reduce the cost of purchasing health insurance.

➢ **PPOs** encourage you to get care from the doctors and hospitals within the plan's network, but allow you to go outside the network if you are willing to pay more. Many PPOs do not require you to choose a primary care doctor or get a referral to see a specialist. Typically, PPOs require deductibles and have higher copayments than HMOs, but they allow a broader choice of providers.

➢ **HMOs** require you to get care from the doctors and hospitals that are part of their network. Usually, a primary care doctor coordinates all of your care and refers you to specialists. HMOs generally do not require **deductibles** (the amount the patient pays before insurance kicks in), but often do charge a small fee (called a **copayment**) for services like doctor visits and prescriptions. Most HMOs offer a **point-of-service (POS)** option that allows an enrollee to go out-of-network for a higher copayment and possibly a higher premium. An HMO or POS plan is considered an **open access plan (OA)** when patients are allowed to self-refer to specialists for a higher copay.

➢ **Health savings accounts (HSAs)** and **health reimbursement arrangements (HRAs)** are alternatives to traditional insurance coverage that allow employers or employees to set aside pre-tax income to pay for medical expenses. These funding mechanisms are typically combined with a high-deductible health insurance policy, which has a lower premium than the options outlined above. Funds from the account are used to pay the deductible and, sometimes, additional medical expenses. For more details on these options, see the discussion on page 8 and the chart on page 7.

HOW MUCH DOES HEALTH COVERAGE COST?

The cost of health insurance varies widely, depending on the type, size and location of your business, as well as the features of the insurance plan selected. In addition, in many states, the health status of your employees and their families may affect the group's premium when you buy or renew coverage.

The most obvious price consideration is the monthly premium. Typically, this amount is shared between the employer and employee. Insurers determine premiums on an annual basis and may change these rates based on medical inflation, the number of employees and dependents covered, and changes in covered benefits or employee cost sharing. Employees may pay their share of the premium through pre-tax payroll deductions, which effectively discount the employee's premium and make health coverage more affordable to workers.

In many states, insurers may consider health status to determine a firm's

premium through a process called "**medical underwriting**." A firm's premium costs could therefore increase—sometimes substantially—if one or more workers or dependents has a pre-existing medical condition. Nondiscrimination rules prohibit the exclusion of specific (e.g., high-risk or unhealthy) employees or dependents to participate in the health plan based on health factors if they meet participation eligibility requirements.

The monthly premium covers all workers and their dependents, but does not represent the full cost of health care for employees. In addition to their share of the monthly premium, employees pay additional expenses out-of-pocket. See the box entitled, *"How to Estimate the Full Costs of Medical Care: A Simple Illustration."*

WHAT IS EMPLOYEE COST SHARING?

Employee cost sharing refers to the portion of health insurance costs—above and beyond the premium contribution—that employees are expected to pay out-of-pocket. Employee cost sharing expenses include deductibles, copayments and coinsurance.

➢ A **deductible** is the amount that insured persons must pay for covered services before medical expenses are paid by the health plan. Once the annual deductible is met, the plan will begin paying toward an enrollee's medical expenses. Annual deductibles typically range from $100 to $500 per person, but the current trend is toward higher deductibles. Some plans have separate deductibles for pharmacy benefits.

➢ **Copayments** are fixed dollar amounts that insured persons pay each time they seek medical services—such as a $10 payment when they see a primary care physician and a $30 payment if they go to the emergency room. Health plans usually have separate co-pay requirements for prescription drugs, with generic drugs requiring lower copayments than brand name drugs.

➢ **Coinsurance** refers to the percentage of a medical bill that insured persons must pay. The most common arrangement requires enrollees to pay 20 percent and the health plan to pay 80 percent. Increasingly, plans are requiring beneficiaries to pay higher coinsurance amounts—30, 40 or even 50 percent—particularly for services provided outside the plan's network of providers.

Health plans often set annual limits on employees' maximum **out-of-pocket expenditures**. Once the maximum is reached, the plan pays all covered medical expenses for the remainder of the year. However, plans usually place a maximum limit, or cap, on the total dollar amount they will pay out over the insured person's lifetime (usually $1 million or more).

WHAT IS PROVIDER CHOICE?

Provider choice refers to the degree to which you can choose among doctors and other health care providers located in your geographic area. Traditional **health maintenance organizations (HMOs)** use restricted provider networks to contain costs and may offer relatively limited provider choice. Moreover, HMOs usually require a referral to see a specialist. A **point-of-service (POS)** plan is an HMO that allows patients to go out of the HMO provider network without incurring 100 percent of the costs of doing so. Thus, POS plans allow more provider choice than HMOs. An **open access plan** is an HMO or POS plan that allows a patient to self-refer to a specialist, and thus, it too adds a degree of provider choice to these plans. **Preferred provider organizations (PPOs)** allow the broadest access to providers, both by having larger networks (typically) and

How to Estimate the Full Costs of Medical Care: A Simple Illustration

An employee who injured his arm while riding a bicycle seeks medical attention at a nearby walk-in community health center, which is a non-network provider. He has PPO insurance coverage, his premiums have been paid every month and he has already met his annual deductible of $300. He sees a doctor, who X-rays and sets his broken arm and writes a prescription for a pain reliever. Under these circumstances, his health plan requires that he pay 20 percent of the doctor's fee ($350) and the radiology fee ($100), and a $10 co-pay for filling the prescription with a $30 generic drug at a local pharmacy.

The employee's out-of-pocket costs are:

Coinsurance for doctor's bill ......$	70	*($350 x 20%)*
Coinsurance for X-ray ....$	20	*($100 x 20%)*
Copayment for prescription ....$	10	*(of $30)*
Total cost of injury ....$	480	
Total out-of-pocket charge..........$	100	
Total amount insurance pays......$	380	

allowing access to out-of-network providers, but at a higher price than their in-network coverage.

HOW MUCH DO PLANS VARY WITH RESPECT TO THE BENEFITS THEY OFFER?

Many plans cover hospitalizations, office visits, prescription drugs, lab work, X-rays, preventive care, and maternity and well-child care—the services and treatments that people are likely to use. Some plans do not offer specific services such as infertility treatment, routine vision or foot care. Very few plans cover experimental and investigational treatments or cosmetic procedures. Some states require that plans offer certain benefits as a condition of selling insurance in the state. These are known as **mandated benefits**. Health insurance plans may vary with respect to the extent of coverage for a specific benefit. Small business owners should read plan documents carefully to see what is covered and what is excluded.

WHAT IS THE RELATIONSHIP BETWEEN PREMIUMS, EMPLOYEE COST SHARING AND PROVIDER CHOICE?

The chart below is a simplification of the typical relationships among premium amount, employee cost sharing and provider choice. These relationships tend to apply regardless of the size of the business seeking coverage. In general, plans with lower monthly premiums require higher employee out-of-pocket expenses. Conversely, plans with higher monthly premiums require lower employee out-of-pocket expenses. The degree of provider choice is a function of plan type, as described above under the heading "What types of insurance plans are available to my company?"

RELATIONSHIPS BETWEEN PLAN TYPES, PREMIUMS, EMPLOYEE COST SHARING AND PROVIDER CHOICE

PLAN TYPE

FIRM'S MONTHLY PREMIUM: *Very Low, Low, Medium, High, Very High*

EMPLOYEES' OUT-OF-POCKET COSTS *(In addition to insurance premiums)*: *Very Low, Low, Medium, High, Very High*

PROVIDER CHOICE: *Very Low, Low, Medium, High, Very High*

PPO 1 HSA/HRA

PPO 2

HMO 1

HMO 2

POS

OPEN ACCESS

PPO 3

NOTE: Actual plans sometimes defy their traditional plan type labels. The purpose of this chart is to illustrate common relationships among plan type, premiums, out-of-pocket costs and provider choice. Often, specific plans prove the exception rather than the rule.

1 HMOs tend to have smaller provider networks and require patients to get referrals to specialists. Out-of-network care is not covered.

2 POS plans are HMOs that allow patients to go out-of-network for a higher out-of-pocket cost.

3 Open Access plans are POS plans that allow patients to self-refer to specialists.

4 PPO plans tend to have broader networks than HMOs and allow patients to see "non-preferred" (or non-network) providers for a higher out-of-pocket cost.

5 A Health Savings Account is a tax-preferred arrangement, with relatively high cost sharing, built on a PPO platform.

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COMPARISONS OF OTHER HEALTH BENEFIT OPTIONS			
QUESTION	HEALTH SAVINGS ACCOUNT (HSA)	HEALTH REIMBURSEMENT ARRANGEMENT (HRA)	FLEXIBLE SPENDING ACCOUNT (FSA)
WHO IS ELIGIBLE?	Individuals and firms of any size.	Firms of any size. Owners of S corporations, limited liability companies and the self-employed can fund HRAs for their employees but not for themselves. Owners of C corporations can fund HRAs for themselves and their employees.	Firms of any size.
MUST IT BE USED WITH A HIGH-DEDUCTIBLE HEALTH PLAN?	Yes. It must be coupled with a health insurance policy with a minimum deductible of $1,000 for an individual or $2,000 for a family. There is no maximum deductible, but total costs to the insured cannot exceed $5,000 for an individual or $10,000 for a family.	No, but it usually is. The deductible is not set in law as it is with HSAs.	No.
WHAT ARE THE TAX ADVANTAGES?	As long as funds are spent on qualified medical expenses, there are federal and state income tax savings and payroll tax savings (FICA) for employee and employer. Qualified medical expenses are defined in section 213(d) of the Internal Revenue Code.[1]	As long as funds are spent on qualified medical expenses, there are federal and state income tax savings and payroll tax savings (FICA) for employee and employer. Qualified medical expenses are defined by the employer.	As long as funds are spent on qualified medical expenses, there are federal and state income tax savings and payroll tax savings (FICA) for employee and employer. Qualified medical expenses are defined in section 213(d) of the Internal Revenue Code.
WHO FUNDS IT?	Employer and/or employee. If the employer contributes to the employee's account, the contribution must be the same for all employees.	Employer.	Typically, the employee.
WHO "OWNS" IT?	Employee.	Employer.	Employee.
WHAT HAPPENS TO UNUSED FUNDS AT THE END OF THE YEAR?	Rollover is allowed.	Rollover is allowed at the employer's discretion.	Forfeited to the employer.
EMPLOYER FLEXIBILITY?	Federal legislation sets minimum deductible and maximum out-of-pocket amounts. The full amount of the deductible can be funded through the account.	The employer has substantial flexibility in designing an HRA.[2]	The employer can set the contribution limit.
WHAT IF THE EMPLOYEE LEAVES THE FIRM?	The account is owned by the employee and therefore the balance is portable.	The account is owned by the employer and therefore portability of funds is at the discretion of the employer.	Balances are generally forfeited at termination. However, if an employee leaves mid-year and has already spent the entire account, the employer is liable for the balance.

1 Consult a tax adviser to determine the savings that would occur in your specific case. As a general illustration, assume an HSA is funded at $1,000. If the employer funds the entire account, the $1,000 is deductible as a business expense by the employer. The $1,000 is excluded from determining employment or FICA taxes for the employer and employee, and is excluded from the employee's income taxes. Alternatively, assume the employee takes $1,000 out of their wages and funds an HSA. In this case, the employee can claim the $1,000 as an income tax deduction. Neither the employer nor employee would save FICA taxes on the $1,000 since it is included as income.

2 The employer can determine the amount the firm contributes to the HRA; the amount that can be rolled over to the next year; what happens to unused funds when an employee leaves; the timetable for the firm's contribution; whether to place a cap on the amount that can be accumulated over time and the amount of the cap; and the number of HRA plans to be offered (employers can establish different plan designs for different classes of employees).

Alternatives to Traditional Insurance

Health savings accounts (HSAs) and health reimbursement arrangements (HRAs) are alternatives to traditional insurance coverage. HSAs and HRAs allow employees and/or employers to set aside pre-tax income to cover medical expenses. They are similar to **flexible spending accounts (FSAs)**, which also allow the use of pre-tax income for medical expenses. FSAs, however, are usually used as a supplement to traditional insurance, not as an alternative. Also, deposits into HSAs and HRAs may accumulate from year to year, unlike FSAs, which expire at the end of each year and require that unspent funds revert to the employer (commonly known as "use it or lose it").

HSAs must be, and HRAs usually are, combined with high-deductible health insurance policies to provide a two-part health plan. Businesses may deduct contributions to HSAs and HRAs, and their accompanying high-deductible health plans, just like traditional insurance. However, HSAs and HRAs also provide a tax advantage for employee out-of-pocket spending for medical expenses. Such medical expenses can include coinsurance, copayments and the deductible of the accompanying high-deductible insurance policy.

There are some key differences between HSAs and HRAs. For example, contributions to an HSA can be funded by an employer and/or employee. Therefore, an employer with very limited funds to purchase insurance could purchase a high-deductible health insurance plan for employees and encourage them to make regular tax-free contributions to an HSA to fund their health care expenses up to the deductible. In contrast, because an HRA can only be funded by an employer, it does not allow for this shared funding arrangement. The chart on page 7 compares HSAs, HRAs and FSAs.

For more information on HSAs and how they compare with HRAs and FSAs, go to http://www.cahi.org/cahi_contents/resources/pdf/n124HSAFSAHRA.pdf. Contact a local insurance broker for information on how to obtain this type of health insurance.

WHAT ABOUT PURCHASING INSURANCE THROUGH A PROFESSIONAL OR TRADE ASSOCIATION?

Association-sponsored plans allow small business owners to purchase coverage through their membership in a business, trade or professional association for their families and employees. Small businesses may be able to find attractive coverage in some areas by buying through an association. When state-regulated association-sponsored plans can reduce costs, small businesses may be able to better afford health insurance.

Small businesses may have more plans to choose from when they participate in association-sponsored plans, while spending less time and effort identifying and administering health coverage. You should, however, check with your state Insurance Department to make sure the plan is insured with an organization licensed with the state. Go to http://www.naic.org/state_web_map.htm or the Insurance Department for contact information by state.

Beyond Perfect Health: You Do Have Options If an Employee or Dependent Is Ill

In some states your premiums can be higher, sometimes substantially so, if one or more workers or dependents has a medical condition. To follow is more information on how premiums might increase based on health status.

WHAT IF AN EMPLOYEE OR DEPENDENT HAS A PRE-EXISTING MEDICAL CONDITION?

In order to discourage small employers from waiting to purchase insurance until an employee falls ill, most states allow insurers to charge a higher premium to firms with employees that have medical conditions. However, most states provide some protection if an employee already has a **pre-existing medical condition.** A **pre-existing medical condition** is one for which an individual actually received care, treatment or medical advice during the 6-month period before coverage went into effect. After the exclusion period is over, the conditions will be covered and people in your group will not have to satisfy another pre-existing condition exclusion period, even if you switch health plans, as long as they are continuously covered. **Continuous coverage** means coverage that is not interrupted by a lapse of 63 or more days in a row. Many states limit premium increases to 25 percent or less, and some states have even stricter protections against further premium increases if one of your employees falls ill after you purchase coverage.

To help you better understand how premiums might be affected by pre-existing health conditions, the example that follows provides information on how much premiums could increase for a small firm whose employees are not in perfect health and is located in an "average" market.

Rating up premiums on the basis of health status is called **medical underwriting.** Some states (e.g., New York, Massachusetts, Washington) do not permit plans to increase premiums due to health status. Others (e.g., Virginia and Pennsylvania) provide no limits on the extent to which plans can rate-up on the basis of health status. On average, most states provide some limits on how much plans can rate-up. In this

regard, Texas is an "average" state, thus the illustration provided here is for a small firm located in the Houston metropolitan area. The firm consists of seven employees with the following characteristics and health conditions:

GENDER	AGE	COVERAGE	HEALTH CONDITION
Female	33	self only	
Male	23	not covered	
Female	49	self only	fibrocystic breast disease
Male	51	self only	controlled hypertension
Female	27	self only	benign cervical dysplasia
Female	24	self only	
Male	42	employee & spouse	Graves disease

As of the first quarter of 2004, the total monthly premium for this firm—assuming no pre-existing medical conditions—was approximately $1,800. If the firm did not previously have health insurance, the rate-up due to these pre-existing conditions cannot go higher than 67 percent according to Texas law. Thus, the actual premium offered to this firm would range from:

$1,800 — no rate-up, up to
$3,006 — full rate-up

Rating-up premiums on the basis of health status through **medical underwriting** is determined by the health plan and depends on many factors, including actual and expected medical claims, and market conditions.

If the firm already has insurance, and is renewing with the same plan, the premium can increase no more than 15 percent due to health status. However, for renewals in Texas, no limits are placed on premium increases due to general medical inflation and/or changing demographics of the firm.

It is important to note that the severity of illness is taken into account during rate-ups. Thus, the increase for a relatively minor, easily managed chronic illness would be less than for a major, life-threatening illness. However, this adjustment based on illness severity could be counterbalanced by the size of the group being insured. Smaller businesses will incur greater rate-ups than larger businesses for the same illness because there are fewer insured people to spread the risk across.

IF I FIND GROUP COVERAGE UNAVAILABLE OR UNAFFORDABLE, ARE THERE ANY OTHER OPTIONS AVAILABLE TO MY EMPLOYEES, OUR DEPENDENTS AND ME?

You and your employees could choose to purchase coverage separately in the individual health insurance market and each be responsible for your own premiums. The individual health insurance market operates differently from the small group market. Healthy people generally can get affordable health insurance in the individual market. However, in many states, people with pre-existing conditions may be denied coverage, charged higher premiums or subjected to a waiting period for coverage of their pre-existing conditions.

Some states operate **"high-risk pools"** for individuals who are denied insurance on the basis of poor health status. Although no one can be turned down for this coverage, the premiums are relatively high and there is usually a one-year waiting period for coverage of pre-existing conditions. In addition, some states require some or all insurers to offer individual health insurance policies on a guaranteed issue basis—which means that nobody can be turned down because of health problems. Contact your state Insurance Department for more information.

All states offer low-cost or free health insurance to eligible *uninsured* children of working parents, and, in some cases, extend this coverage to parents as well. Depending on their wages and other family income, your employees and/or their children may qualify for these programs. Coverage options may include Medicaid and the State Children's Health Insurance Program (SCHIP), but these program names often differ from state to state. To learn more, call 1.877.KIDS.NOW or visit www.cms.hhs.gov/schip/statemap.asp and www.cms.hhs.gov/medicaid/statemap.asp.

Consumer Protection: Overview of Federal and State Health Insurance Regulations

WHAT SHOULD I KNOW ABOUT FEDERAL PROTECTIONS, LAWS, REGULATIONS AND RESOURCES WHEN PURCHASING INSURANCE?

There are two important federal laws that affect the provision of health insurance to small business employees. They are the **Health Insurance Portability and Accountability Act (HIPAA)** and the **Consolidated Omnibus Budget Reconciliation Act (COBRA).**

HIPAA is a 1996 federal law that includes important health insurance protections for small businesses and their employees. In employer-based health plans, HIPAA does the following:

➢ It guarantees availability of all small group plans to all small employers. With limited exceptions, it requires that all health plan policies be renewed, regardless of the health status or claims experience of a firm.

➢ It limits benefit exclusions for pre-existing medical conditions to no more than 12 months from the effective date of coverage for those who have been diagnosed or treated within the previous six months. Regardless

of enrollees' coverage history, health plans that sell to small employers are not allowed to impose a pre-existing condition exclusion period for newborn babies or newly adopted children, for pregnancy or on the basis of genetic information.

➢ It requires that pre-existing condition exclusion periods be reduced, day for day, for group health plan participants by the amount of prior, creditable health insurance coverage they have had. Almost all types of major medical insurance are "creditable," no matter what the source (public, private, group, individual).

➢ It prohibits insurers from discriminating against employees and dependents based on their health status. Thus, insurers cannot deny eligibility to your employees or any enrolled dependents, or charge anyone in your group more for coverage than any similarly situated person.

➢ It requires that special enrollment opportunities be offered to employees and their dependents following a change in family status or loss of other health insurance coverage.

HIPAA provides the following protections for self-employed individuals:

➢ Under limited circumstances, there is guaranteed access to at least some insurance products in the individual market with no pre-existing condition exclusion periods for so-called "HIPAA-eligible individuals." HIPAA eligibility refers to persons with at least 18 months of prior creditable coverage with no break of more than 63 consecutive days and who:

- are leaving employer-sponsored group coverage;
- have exhausted COBRA (see below) or any other continuation coverage that is available;
- are not eligible for any other group coverage; and
- have not lost group coverage due to fraud or failure to pay premiums.

➢ With limited exceptions, HIPAA provides guaranteed renewability of health plan policies to self-employed persons.

➢ A person who "loses" individual coverage has no federal right to guaranteed access in the individual market.

HIPAA, a federal law, guarantees availability of all small group plans to all small employers.

COBRA, in effect since 1986, permits employees and their dependents to continue participation in their employer-sponsored group health plan for a limited period of time after their job ends. If the employer has 20 or more workers, its employees may be eligible for COBRA continuation coverage when they retire, quit, are fired or begin working reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parents' plan rules. An employee may choose to continue in the group health plan for a limited time and pay the full premium, including the share the employer previously paid on the employee's behalf plus 2 percent to help pay the employer's administrative costs. COBRA continuation coverage generally lasts 18 months for previous employees and 36 months for dependents in certain circumstances.

WHAT SHOULD I KNOW ABOUT STATE PROTECTIONS, LAWS, REGULATIONS AND RESOURCES WHEN PURCHASING INSURANCE?

Although state laws that regulate health insurance vary across the country, virtually all states address the following key issues:

➢ Insurers pool small employers so individual firms do not bear the full cost of employees' illnesses.

➢ The Insurance Department monitors insurers' business practices and requires them to maintain adequate financial reserves to pay claims.

➢ Virtually all states require fair marketing practices and have established external grievance requirements to give consumers options if they believe a denied claim or service should have been paid or provided.

Companies licensed to sell health insurance to small businesses must comply with certain state laws and regulations. These provisions apply to small group health plans and to individual plans, and they apply if the cost of the benefit is treated as a business tax deduction, or if the employer pays any portion of the cost through reimbursement, payroll deduction or wage adjustment.

The laws and regulations that govern the business of health insurance in the states change from time to time. Thus, small business owners should contact the state Insurance Department with specific questions.

GLOSSARY

Association-sponsored plans
Professional or trade association-sponsored plans allow small business owners to purchase health insurance for their employees through membership in business, trade or professional organizations.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) is a federal law allowing employees and their dependents to continue participation in an employer-sponsored group health plan for a limited period (generally 18 months) after employment ends. Participants pay the full premiums associated with the plan, plus 2 percent to cover administrative costs.

Coinsurance
Coinsurance is the percentage of a medical bill that an insured person must pay, after deductibles and/or co-pays are met. While coinsurance is commonly 20 percent, it can be as little as zero or as much as 50 percent (for out-of-network services, for example).

Continuous Coverage
Coverage that is not interrupted by a lapse of 63 or more days in a row.

Copayment
A copayment, or copay, is a fixed-dollar amount insured persons pay each time they seek care or purchase covered items, such as office visits or prescription drugs. Copays sometimes apply to inpatient hospital stays. Health plans usually have separate copay requirements for prescription drugs.

Deductible
A deductible is the amount that insured persons must pay for covered services before medical expenses are paid by the health plan. Some plans have separate deductibles for pharmacy benefits.

Employee cost sharing
Employee cost sharing refers to the portion of health insurance costs—above and beyond the premium contribution—that employees are expected to pay out-of-pocket. Employee cost sharing expenses include deductibles, copayments and coinsurance.

FSA
A flexible spending account (FSA) is funded by the employee from pre-tax income and is used to pay for medical expenses. The entire annual amount of an FSA must be made available to the employee at the beginning of the year. However, unspent balances must be forfeited to the employer at the end of the year.

Guaranteed issue
Federal law prohibits insurance companies from denying health coverage to small businesses (usually defined as 2 to 50 employees) on the basis of health status or other factors related to the use of health care.

Guaranteed renewability
Federal law prohibits insurance companies from canceling a business' insurance because someone in the firm becomes sick.

High-risk pools
In some states, high-risk pools provide a health insurance option for individuals whose poor health creates a barrier to obtaining employer-based coverage. Premiums in high-risk pools are relatively high, and there is often a waiting period. However, many states have nondiscrimination laws that eliminate the need for these pools.

HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law that includes important health insurance provisions, including nondiscrimination, guaranteed renewability, guaranteed issue and limits to benefit exclusions due to pre-existing medical conditions.

HMO
A health maintenance organization (HMO) is an insurance plan that requires a person to get care from providers who are part of the HMOs network. Usually, a primary care provider coordinates care and controls access to specialists. Most HMOs offer a point-of-service (POS) option for additional fees.

HSA
A health savings account (HSA) is an alternative to traditional insurance coverage. HSAs must be paired with a high-deductible health insurance policy, the contribution to which is tax-deductible. HSA funds may be used to pay out-of-pocket costs (deductibles, coinsurance, co-pays). The employer, the employee or both may fund the plan. HSA accounts are owned by the employee, are fully portable and remaining balances roll over year to year.

HRA
A health reimbursement arrangement (HRA) is an alternative to traditional insurance coverage. HRAs are usually paired with a high-deductible health insurance policy, the contribution to which is tax-deductible. HSA funds may be used to pay out-of-pocket costs, including deductibles, coinsurance and co-pays. The employer must fund the HRA, and consequently may decide if benefits are portable or if they roll over from year to year.

Maximum out-of-pocket expenditures
This out-of-pocket limit is the maximum amount of cost sharing an insured individual or family would have to pay in a given year. Once a maximum out-of-pocket limit is reached, the insurer pays all additional covered medical expenses for the year, up to the plan's limit.

Medical underwriting
Medical underwriting is a pricing practice used by insurance companies to adjust premiums (usually upward) based on a group's health status or medical claims experience.

Nondiscrimination
Neither insurers nor employers are permitted to condition eligibility of employees and their dependents on their health status.

Open access plan
An open access (OA) plan is an HMO or POS plan in which patients are allowed to self-refer to specialists for a higher co-pay.

Point-of-service
A point-of-service (POS) plan is an option added to many HMOs allowing enrollees to seek care outside of the HMOs network for a higher co-pay and, possibly, a higher premium.

PPO
A preferred provider organization (PPO) is an insurance plan that encourages enrollees to get care from providers within the plan's network, but allows access to providers outside the network if one is willing to pay more. Many PPOs do not require the insured person to choose a primary care doctor or get a referral to see a specialist.

Pre-existing medical condition
Pre-existing medical conditions, such as asthma, diabetes or cancer, may increase the cost and, in some cases, the availability of insurance, subject to federal and state laws and a carrier's policies.

Premiums
The premium is the amount an insurance plan costs per month. Premiums may vary as a function of market conditions, plan types, health status of enrollees, number of enrollees and degree of employee cost sharing. Typically, the employer and employee each contribute to the premium payment.

Provider choice
Different plan types (HMOs, PPOs, POS plans and OA plans) vary with respect to the degree of choice enrollees have as to which doctors or other health care providers they wish to see. HMOs have the least provider choice, as they require participants to see professionals only within the plan's relatively narrow network, whereas PPOs tend to have broader networks of preferred providers and allow access to non-network providers, but at a higher cost.

Rate-up
A rate-up is the extent to which premiums are increased, usually annually. Premium rate-ups are typically expressed as a percentage increase. For example, a premium that increases from $1,000 per year to $1,100 per year has a rate-up of 10 percent.

A PowerPoint presentation to accompany this guide is available at **www.CoverTheUninsured.org/materials.**