Health Insurance

A Small Business Guide

The Key

Health insurance is a key benefit of employment. Most organizations with more than 100 employees have a group health insurance plan. Yet many smaller firms do not. A large proportion of New York State’s uninsured individuals are employed in small businesses.

This publication provides information to help small-business owners make informed decisions on health insurance plans for their employees.

Why do Small Businesses Offer Health Insurance?

Small businesses offer health insurance:

- to keep employees healthy and productive;
- to help attract and retain employees;
- because employees “need it;”
- because employees “demand it;” and
- because the owners/managers want the coverage for themselves and their families.
Why Don’t Small Businesses Provide Health Insurance?

Small-business owners say the high cost of premiums heads the list of reasons why they do not provide health insurance. Often small businesses have a difficult time getting the right help in understanding the insurance market. They may not receive satisfactory assistance from insurance representatives and consultants.

What Affects Coverage?

Small businesses may not seem like ideal clients for insurers selling group coverage. The costs of marketing, installation and maintenance are relatively high. There is also a greater relative risk of “adverse experience” when fewer individuals are being covered as part of a group. In any given year, only a few individuals in a group of thousands are likely to be frequent users of health services. They may not always be the same individuals, but the proportion tends to remain stable and predictable. This is an example of the pooling principle that underlies insurance: many individuals pay premiums to cover the claims generated by a few. In a small group, i.e. one that is comprised of between two to 50 employees or members, not including spouses and dependents, experience is likely to be more erratic.

COMMUNITY RATING. New York State requires that the premium rates for all health insurance policies sold to small groups be calculated using a community rating methodology that is designed to help stabilize rates. The community rating requirement means that an insurer offering health insurance to small groups must set the premium rate for a given health insurance policy using the pooled experience of all persons covered by that policy. For example, the premium charged to a small group may not be based on the age, sex, health status or claims experience of that specific group. This requirement extends to coverage issued by health maintenance organizations (HMOs).

OPEN ENROLLMENT. In addition to the community rating requirement, all health insurance policies sold to small groups, including HMO coverage, must be offered on an open enrollment basis. The open enrollment requirement means that an insurer must accept all persons who apply for coverage, without taking into account an applicant’s health status. Depending on the circumstances, however, there may be a period of up to one year during which pre-existing conditions are not covered. Refer to “Contract Provisions” on page 7 of this guide for further details concerning pre-existing conditions and waiting periods.
Health Insurance Plans

**BASIC COVERAGE.** A basic hospital and medical insurance plan covers necessary hospitalization for a predetermined number of days. Typically, it includes room and board charges, routine nursing and physicians’ services provided in the hospital, x-rays, laboratory tests, in-hospital anesthesia, operating room charges, drugs, and surgical supplies. Usually, emergency room charges are covered as well.

Basic plans have significant limitations. They almost always have deductibles and co-payments and may also restrict the length of covered hospital stays or set limits on total payments.

**MAJOR MEDICAL.** Major medical plans protect against the high costs of serious or prolonged illness. Benefits may be payable after basic plan benefits are exhausted. In New York State, a major medical plan must provide at least $100,000 of coverage.

Payments may be paid directly to a participating hospital, physician or other provider based on established charges or prior agreement.

Reimbursement to the insured individual can be based on “reasonable” charges, a percentage of reasonable charges or a stated dollar amount. This type of coverage is generally called a fee for service “indemnity” plan.

**SELF-INSURING.** To save costs, some employers are self-insuring their employees by assuming the responsibility of paying directly for claims. In the case of self-insuring plans, the employer controls the money that would otherwise go to premium payments and thus avoids State premium taxes.

There are also disadvantages. The employer is responsible for claims administration, although this may be contracted out to a health insurance company. For some employers, self-insuring will not result in any lower costs compared with purchasing a policy from an insurance company. Most importantly, the employer assumes the risk of unexpected increases in claims costs. To protect against this risk, self-insured groups seek “stop-loss” insurance. Stop-loss insurance will indemnify the employer for claims greater than a specified amount. Self-insured plans are not regulated by New York State. As a result, the mandated coverage imposed on insurers by state law need not be provided.

**MULTIPLE-EMPLOYER WELFARE ARRANGEMENTS (MEWA).** Before purchasing coverage from a MEWA, make sure that the plan offered meets the applicable federal and state laws and regulations concerning licensure, reserve requirements, plan benefit provisions, and premium rates.
Service Arrangements to Consider

HEALTH MAINTENANCE ORGANIZATIONS (HMOs). HMOs provide comprehensive health care benefits to the voluntarily enrolled group of members. Members pay premiums in advance to the HMO according to a set schedule. Premiums are charged independently of the amount of covered services any particular member may receive.

Under an HMO, members are provided services only by physicians and other providers employed or approved by the HMO. Except in an emergency or with an appropriate referral, members are fully responsible for paying all charges when they seek care outside the HMO.

There are three types of HMOs:

- **GROUP MODEL**, which contracts with one or more large multi-specialty group practices;

- **STAFF MODEL**, which has physicians who are salaried employees of the HMO; and

- **INDEPENDENT PRACTICE ASSOCIATION (IPA)**, made up of independent physicians who provide care for employees based on negotiated rates.

PREFERRED PROVIDER ORGANIZATIONS (PPOs). A PPO is a contractual agreement between providers of health care; i.e. physicians and hospitals and employers, unions, insurance carriers or third-party administrators to provide health care services at established fees. Providers are selected based on their willingness to discount their charges, their availability in certain geographic areas, and the perception of the quality and efficiency of their practice.

To encourage patients to use the preferred provider, there is either full payment of covered services or reduced deductibles and co-payments. Patients are free to use a non-PPO provider if they are willing to pay higher out-of-pocket costs.

POINT-OF-SERVICE PLANS. The point-of-service option provides the same benefits as an HMO plan. It provides more flexibility because it permits you to seek treatment from providers included in your plan’s network or to “opt out” of network and select your own provider without a referral. If you stay within the network, you receive the full amount of covered health care benefits after satisfaction of any co-payments. If you choose to use physicians outside the network, you will be covered for a substantial part of the cost. As a result, you will generally pay more out-of-pocket expenses including a deductible and coinsurance.
The following legislative and regulatory requirements affect the design, administration, and cost of health insurance plans. Additional information is available from the New York State Insurance Department.

**HCRA (HEALTH CARE REFORM ACT).** The Health Care Reform Act of 2000 introduced a program entitled "Healthy NY" which promotes access to quality health care by providing lower-cost health insurance to those New Yorkers who need it most. The program began January 1, 2001 and has increased the availability of comprehensive health insurance coverage for New York's uninsured workers and their families. The Healthy NY program is designed to assist small business owners in providing their employees and their employees' families with the health insurance they need and deserve. In addition, uninsured workers whose employers do not provide health insurance may also purchase this coverage directly through the Healthy NY program.

Healthy NY is offered by all health maintenance organizations (HMOs) in the state and provides standardized benefits that are made more affordable through State sponsorship. Healthy NY includes coverage for essential health needs including inpatient and outpatient hospital services, physician services, maternity care, preventative health services, diagnostic and x-ray services, and emergency services. Applicants may choose to have an optional limited prescription benefit.

Healthy NY is available to certain businesses with 50 or fewer employees, sole proprietors and eligible uninsured individuals. For information on the program's eligibility criteria and participation rules, please visit www.healthyny.com or call 1-866-HEALTHYNY (1-866-432-5849).

**TEFRA (TAX EQUALITY AND FISCAL RESPONSIBILITY ACT OF 1982, REVISED 1986) AND DEFRA (DEFICIT REDUCTION ACT OF 1984).** Employers of 20 or more full- or part-time employees are responsible for providing the same coverage to working employees age 65 or older (TEFRA) and their non-working spouses age 65 or older (DEFRA) as they provide for employees under 65.

**COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1988, 1989).** Employers of 20 or more employees maintaining a group health plan are required to offer employees and their dependents the option of continuing membership in the group plan at their own expense after they leave employment under certain circumstances. The cost of the COBRA extension can be charged to the employee at 102 percent of the group’s cost for an active employee. Furthermore, the law adds a “portability” feature to coverage wherein an insurer must credit the time a person was covered under a prior health insurance policy toward satisfying any pre-existing condition waiting period imposed by the subsequent policy, as long as the prior coverage was in force at least 63 days before the effective date of the subsequent policy.
OBRA (OMNIBUS BUDGET RECONCILIATION ACT OF 1986). Employers with 100 or more employees who provide a group health plan are required to continue coverage for active employees or dependents who become eligible for Medicare because of a disability.

ERISA (EMPLOYEES RETIREMENT INCOME SECURITY ACT OF 1974). Self-insured plans that are not governed by state insurance law must meet the requirements of ERISA. ERISA requires a “creditable” claims review procedure and notices that state the reason for claim denials.

CONTINUATION OF COVERAGE. New York law requires insurers to offer continuation of group coverage, consistent with COBRA requirements for continuation, to employees and their dependents who do not qualify for continuation under COBRA. Employees who lose their group coverage and are not covered by COBRA are eligible for continuation under the group plan.

NOTIFICATION OF CESSTATION OF BENEFITS FOR TERMINATED EMPLOYEES. Employers with operations in New York State are required to provide a written notice to all terminated employees that specifies the date on which their employee benefits will be cancelled.

Coverage and Cost

SUPPLEMENTAL COVERAGE. In addition to basic and major medical plans, there is a wide variety of possible supplements to insurance coverage. Each has cost implications for the employer.

Popular supplements include dental care, prescription drugs and vision care plans. Coverage may also be provided for long-term care, hospice care and as a supplement to Medicare payments.

FIRST DOLLAR COVERAGE VS. COST SHARING. First dollar coverage pays virtually the entire cost of all covered services with little or no out-of-pocket expense to the insured. Cost sharing means that the employee contributes to the cost of the care, sometimes based on a fixed percentage of the cost or, in a way that is becoming more popular, at a rate connected with salary level. Many employers pay most or the entire premium for employees, but require contributions for all or part of the premium for dependents.

Deductibles and co-payments (co-insurance) are another form of cost sharing. Deductibles require the employee to spend a specified amount before insurance reimbursement begins. Co-payments require the employee to pay a specific percentage or a fixed amount of the plan’s allowable charges.
Many plans have a “catastrophic” or “stop-loss” feature that sets a maximum limit on cost sharing for the policy year. The plan pays the full amount of covered expenses after a predetermined amount of out-of-pocket payments have been made.

**COSTS VS. COVERAGE.** Designing a health insurance plan involves a continued trade-off between the comprehensiveness of coverage and the cost of the plan to the employer and employees. Many carriers offer both “high option” plans, with broad benefits, and “low option” plans, under which coverage is more limited and greater cost sharing is required. All plans offering basic hospital coverage, however, must also provide coverage for state-mandated benefits.

When shopping for affordable group insurance look carefully at the levels of deductibles and co-payments. Also look at the range of coverage, items that are excluded from coverage and coverage maximums or “caps.” A plan with a $100 deductible may actually provide less coverage than one with a $500 deductible. This balancing between deductible and co-payment features is another trade-off.

**Contract Provisions**

While group contracts may seem similar, there are often significant differences that you should examine.

**COVERED EMPLOYEES.** Contracts usually limit coverage to “permanent” full-time employees and part-time employees who work more than a specified number of hours. Employers usually have the option of covering new employees when they are hired or can require waiting period.

**DEPENDENT COVERAGE.** Spouses and dependent children can be covered under a family plan. The eligibility for coverage of adopted or foster children and children of single parents should be defined in specific language. Dependent children are usually covered from birth until the age of 19 with extensions until the age of 25 if they are full-time students. Plans must continue coverage beyond these ages for disabled or handicapped children as long as they are dependent.

**PRE-EXISTING CONDITIONS.** Depending on the circumstances, conditions present prior to the employee’s enrollment date may be excluded from coverage for up to one year. This is known as a pre-existing condition exclusion. These exclusions are subject to reduction or elimination depending on the amount of creditable coverage an insured has accrued, provided such coverage was continuous to a date that was not more than 63 days prior to the enrollment date of the new coverage.
WAITING PERIODS. In lieu of the use of a pre-existing condition provision, some plans may impose a waiting or affiliation period of up to 60 days before coverage takes effect.

LIMITATIONS. Some plans limit the choice of physicians or hospitals to those in a specific geographic region except in the case of accidents and medical emergencies. Supplemental coverage may be required to cover employees and dependents who travel outside that region.

EXCLUSIONS. Most group plans exclude coverage for injuries and illnesses ordinarily covered under workers’ compensation or sustained while serving in the armed forces or resulting from acts of war or riot.

COORDINATION OF BENEFITS. Coordination or non-duplication of benefits may apply when an individual is covered under more than one group insurance contract. Coordination ensures that the total amount of the benefits under all contracts does not exceed 100% of the actual medical expenses.

GRIEVANCE PROCEDURES. Many types of insurance contracts are now required to have a grievance procedure in place to provide for times when the insurer denies access to a referral or determines that a benefit is not covered under the contract. The procedure must be set forth in the insurance contract and must also be provided in a written notice.

EXTERNAL REVIEW. Provides an independent appeal process for insureds who have been denied health insurance benefits on the basis that the services are not medically necessary or are experimental or investigational. Medical professionals who are not affiliated with your HMO or health insurer review the merits of the case and issue a determination. These professionals are called certified external appeal agents. Prior to this law, aggrieved consumers were limited to filing internal appeals through their health plans or filing lawsuits. You are not eligible for external review if you are covered by a self-funded plan.
How to Shop for Insurance

Selecting the health insurance program most appropriate to the needs and resources of your small business is a complex task. There are three groups of insurance professionals who can guide you in making the best decision:

- **AGENTS.** Agents are representatives of insurance companies who are responsible for marketing its products. They usually earn commissions based on their sales.

- **BROKERS.** Brokers are licensed sales people who represent a number of different carriers or plans. They are compensated by the insurance company through which the insurance is placed. The broker is responsible for ongoing servicing of the account for the insurance company.

- **CONSULTANTS.** Insurance consultants can help evaluate a group’s needs, design a plan and recommend the most economical carrier. The consultant is paid by the employer group based on a contract or agreement that outlines the scope, timing and fees of the service.

**CHOOSE A CARRIER CAREFULLY.** Remember, when you select a carrier you should base your decision not only on the plan it offers, but also on its reputation, stability and record in serving the small-business market. You should also consider its administrative policies and procedures. To assist you in choosing a carrier, insurers are required by law to disclose to insureds or, upon request, to potential insureds, information on matters such as coverage parameters; prior authorization requirements; utilization review policies; provider payment methodologies; premium and cost sharing responsibilities; grievance procedures; procedures for obtaining emergency services; and procedures for selecting, accessing and changing providers.

The New York State Department of Insurance also publishes a health insurance complaint ranking that includes information on Department complaints, grievance determinations, and appeals relating to medical necessity. The complaint ranking can be accessed through the Department’s website at: [www.ins.state.ny.us](http://www.ins.state.ny.us).

**FINANCIAL STABILITY OF THE CARRIER.** To find this out, ask for a copy of its rating by A.M. Best & Co., Standard & Poor’s, or Duff & Phelps from the broker, consultant or the insurance company itself. For more information, contact the New York State Insurance Department, which is responsible for licensing carriers and monitoring their operations.
EFFICIENCY AND ACCURACY OF CLAIMS PAYMENT. Review and audit procedures will help to control your costs by denying inappropriate reimbursement.

LEVEL OF PAYMENTS. Most carriers have their own schedules of “usual, customary and reasonable” fees on which they base their reimbursement. Low levels will reduce claims costs, but may also cause dissatisfaction among employees.

HOW PREMIUMS ARE SET. Community rates are those rates charged all insureds covered by a particular contract in a specific region.

There are many elements in an insurance plan that affect its cost and its ability to meet your needs. Plans differ in what they exclude. Under some circumstances, carriers may issue coverage only when a specific percentage or number of eligible employees enroll in the group.

It is important to consider that the lowest price may not represent the best value. Cost and coverage should be balanced and prudence exercised in selecting a carrier.

Managing Your Plan

HOW TO CONTAIN COSTS. While major factors contributing to health care costs are beyond the employer’s control, you can influence others. Employees and their dependents should learn about their coverage and how to use it. Your employees should receive information on how to select and talk to a physician, to ask about fees, and to question the necessity of tests and procedures. They need to understand that more is not necessarily better.

Carriers and sponsors of plans will usually provide informational brochures and will make their representatives available to answer questions. Make sure that information concerning their health insurance coverage is available to your employees in language that is easily understandable. To keep costs down, insurance carriers are introducing a group of strategies that have become known as “utilization review,” “utilization management,” or simply “managed care.” These include:

- Second surgical opinion when an elective, non-emergency procedure has been recommended;
- Pre-admission certification for non-emergency hospital admissions;
- Concurrent review to determine the continued need for inpatient care;
Retrospective review to analyze the practice patterns of physicians and hospitals; and

Claims audits to validate physician and hospital charges.

Your employees and their dependents should also be made aware of potential areas of provider abuse. These include:

- “Unbundling” or separation of a single procedure into multiple parts with separate fees for each part;
- “Phantom” charges for services that were not performed;
- Altering diagnoses so that services will be eligible for reimbursement; and
- Waiving co-payments and inflating fees to make up for the loss of revenue.

CHANGING PLANS AND CARRIERS. A variety of situations such as employee changes, claims experience or benefit agreements may suggest the need to change plans. Most carrier changes, however, happen in an effort to reduce costs. You should be aware that apparent cost savings may not really be what they seem. Carriers may offer higher commissions for new accounts than for renewals. Therefore, a change of carriers may be more advantageous to the broker than to you. Continuous coverage for your employees should be a priority.

THE NEW YORK STATE INSURANCE DEPARTMENT. The New York State Insurance Department regulates health insurers doing business in the state. The Department issues licenses to agents and brokers, monitors the financial condition of insurance companies, and approves health insurance policies and premium rates.

The Consumer Services Bureau investigates complaints against insurers, agents and brokers, and answers consumer inquiries concerning insurance. To contact the Bureau, call 1-800-342-3736. Informational booklets, as well as a variety of other information, may be found and downloaded through the New York State Insurance Department web site at: www.ins.state.ny.us

For additional information concerning insurance coverage please see Property & Casualty - A Small Business Guide. This guide is available free of charge from the New York State Insurance Department and Empire State Development.