Managing Your Health Care

From the Office of
Minnesota Attorney General
Lori Swanson

www.ag.state.mn.us

PUBLICATION INFORMATION

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The Attorney General's Office answers questions about consumer issues. If you have a consumer question or complaint, contact the Attorney General's Office in writing, by phone, or electronically:

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(TTY numbers are for callers using teletypewriter devices.)
www.ag.state.mn.us

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INTRODUCTION

■ Understanding health care has become harder every year. ■ Many of us get the care we need. ■ Unfortunately, at times we can face uncertainty, frustration and confusion when problems develop with our health care plans. ■ These problems often come at a time when we are sick and least able to look after ourselves. ■

■ This brochure provides an overview of some of your legal rights when it comes to your health. ■ It also helps you navigate the system when problems arise. ■ Above all, this brochure will educate you to be an informed and active health care consumer. ■

I. Private Health Coverage

The Relationships Between Patients, Doctors and Health Plans

Different types of private health care coverage are available in today's marketplace. You have somewhat different rights depending on the structure of your plan. For example, you may have private health care coverage through an individual policy or a group policy. These differ a little bit. You purchase an individual policy directly from a **health carrier.** Under a group policy, a "group," typically an employer, either purchases a "**fully-insured**" policy from a health carrier or is "**self-insured**." You, as an employee, then have coverage through the group plan. Let's look at these types of health insurance one at a time.

Individual Coverage

You may purchase an individual policy from a health maintenance organization ("HMO"), insurance company, or nonprofit health services corporation (such as Blue Cross Blue Shield of Minnesota). The health carrier decides whether to sell you a policy based upon an **underwriting** process. In this process the health carrier will review your medical history and that of any **dependents**. In exchange for the premium you pay, the health carrier agrees to cover you and your dependents if you become sick or injured. The health carrier can reject an application for an individual policy based on pre-existing conditions, or place limits on your coverage. (*See* Chapter X for information on what to do in this situation.)

Remember that there are three separate relationships. First, you have a policy issued to you by a health carrier.

■ WORDS IN **BOLD** ARE DEFINED IN THE GLOSSARY BEGINNING ON PAGE 31. ■

TABLE 1

FULLY-INSURED HEALTH PLAN, INDIVIDUAL COVERAGE

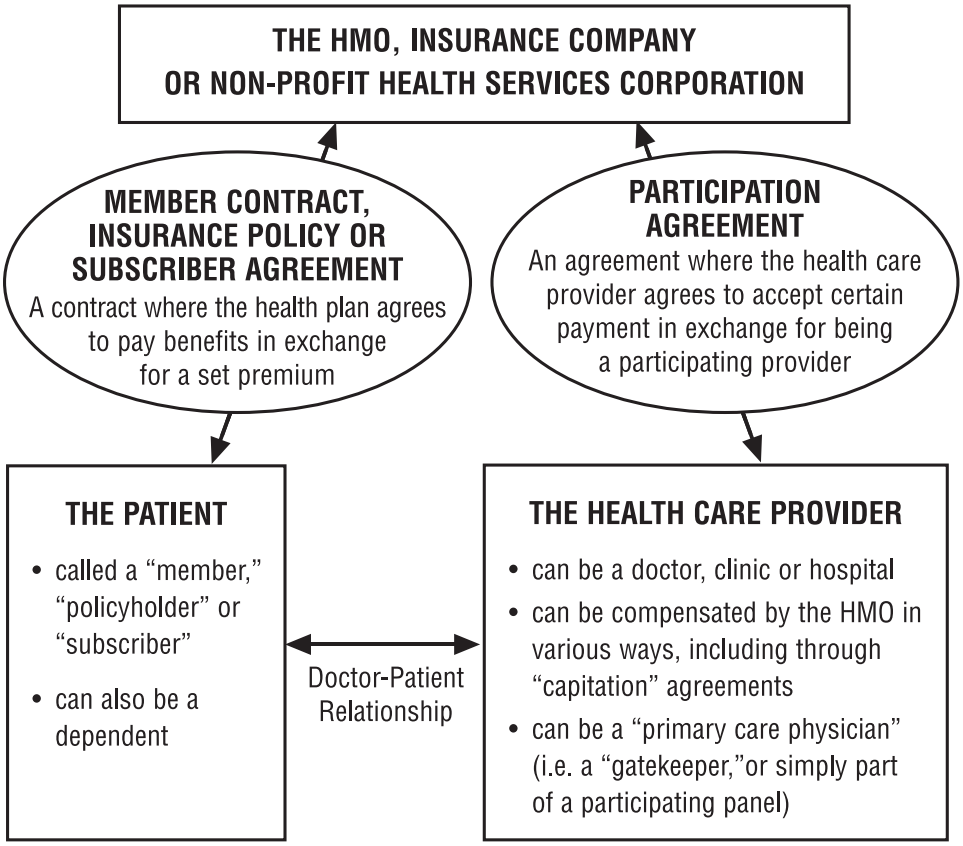
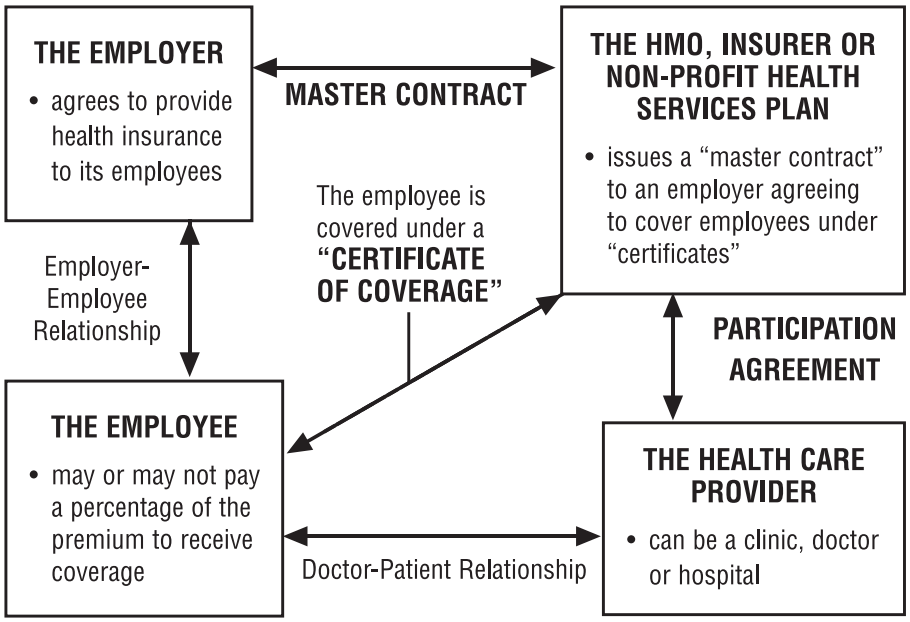


TABLE 2

FULLY-INSURED HEALTH PLAN, GROUP COVERAGE



This legally binding contract will have different names, depending on the type of health carrier that issues it. For example, if you are covered by an HMO, the contract you have typically will be called a "membership contract," and you are considered a "member." If you are covered by an insurance company, the contract is an "insurance policy," and you are the "policyholder." If you are covered by a nonprofit health services corporation, the contract is a "subscriber agreement," and you are the "subscriber."

Second, you have a "doctor-patient" relationship with your medical providers. Third, your medical providers have contracts with the health carrier, typically called **participation agreements**. Health carriers pay their providers in various ways for the care you receive. Payments may be the more traditional **fee-for-service**, or the newer **"risk sharing" agreement**. In a "risk sharing" payment structure, the physician and clinic bear some of the financial risk for your care if you become sick. The relationship between you, the health carrier and the medical provider is diagrammed in Table 1.

Group Coverage

You may be covered under a group policy. The most common group coverage is provided by employers to employees. Group coverage may be one of two types: **fully-insured** or **self-insured**. Federal law says your coverage document must tell you if your plan is self-insured.

Fully-Insured Group Coverage

Fully-insured group coverage is different from individual coverage because the employer is also part of the relationship. A diagram of this type of coverage is found in Table 2.

An employer purchases a fully-insured group policy from a health carrier to cover employees of the organization. The employer may pay all or part of an employee's premium. The policy is called fully-insured because the health carrier assumes the risk of providing coverage to the employees (in a self-insured group plan the employer assumes the risk and financial obligation to provide coverage to employees).

In a fully-insured group plan, the health carrier issues a contract (typically called a master contract or policy) to the employer. In it, the health carrier agrees to provide coverage to the employees subject to various conditions. In turn, the employees and their dependents are covered under what are typically called **certificates of coverage**.

Fully-insured group plans must comply with certain state laws regarding the types of benefits offered, such as covering newborn care.

Self-Insured Group Coverage

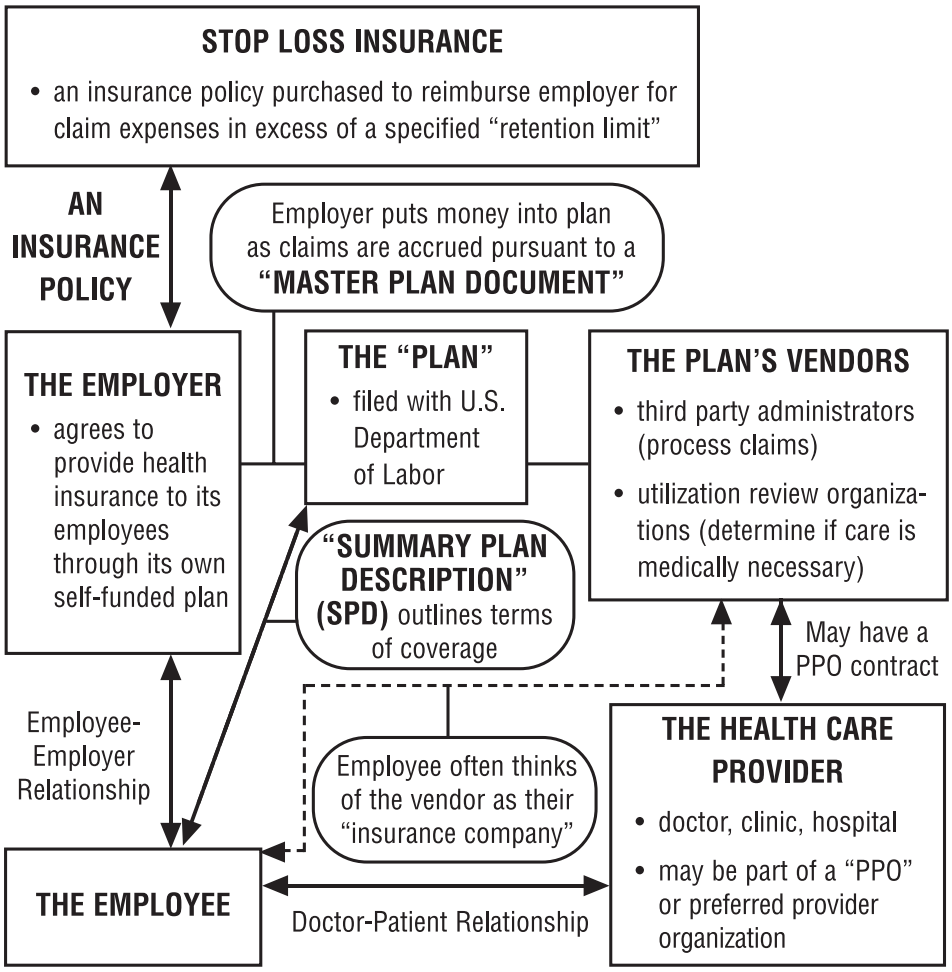
Some employers provide coverage to their employees through a self-insured health care plan. This means the employer pays for its employees' health care with its own money. Many large corporations are self-insured.

A self-insured employer must file a master plan with the United States Department of Labor. The Department assigns the plan an identifying number. The employer then prepares a **Summary Plan Description** ("SPD") for employees that details the terms of coverage. Self-insured health plans are subject to a federal law known as the **Employee Retirement Income Security Act of 1974**, or **"ERISA."** Self-insured health plans are regulated exclusively by the federal government.

Most self-insured employers do not process claims internally. Rather, they usually have agreements with an outside vendor who processes claims for them. These vendors are called **third-party administrators** (or "TPAs"). The third-party administrator may be an HMO, insurance company or nonprofit health services corporation. (Many of these entities also act as "fully-insured" health carriers.) The third-party administrator may also be a company licensed simply to process claims. Some self-insured plans also enter into contracts with separate **utilization review** ("UR") organizations to review the medical necessity of requested treatment. Some also enter into contracts with **preferred provider organizations** ("PPOs") to

TABLE 3

SELF-INSURED PLAN



A WORD ABOUT SHORT-TERM POLICIES

The Attorney General's Office urges consumers to use caution before purchasing short-term health insurance policies that are sometimes used by individuals and families in-between jobs, after college, or for other short-term health insurance needs.

Minnesota law states that **short-term coverage** may exclude any injury, illness, or condition for which the covered person had medical treatment, symptoms, or manifestations before the effective date of coverage. Because of this, some short-term policies broadly define pre-existing conditions, sometimes including any manifestation or symptom experienced at any point prior to the coverage. In other words, an individual may not need to be treated for a condition for it to be considered a pre-existing condition.

For instance, one consumer was denied payment of benefits for tonsillitis because the insurance company deemed the condition a manifestation of previous sore throats. In another case, a senior citizen purchased a short-term policy to fill a coverage gap between her retirement date and start of Medicare coverage. She was denied payment of benefits for heart problems that developed during the coverage because she had a cough and minor chest pains prior to her coverage effective date. A family that purchased a month's coverage between jobs paid medical bills totaling $5,000 because their child was hospitalized for a severe asthma attack triggered by a contracted virus.

Read and understand the terms and conditions of short-term health insurance before purchasing them. Make sure and ask questions about coverage issues, including what qualifies as a pre-existing condition. Ask your insurance agent about other policies that do not include such exclusions.

provide the self-insured plan with access to a panel of physicians to treat the employees and their dependents.

Many people consider the plan's third-party administrator to be their "insurance company." This is because **explanation of benefits forms ("EOB")** and summary plan descriptions frequently list the name of the third-party administrator. Because the third-party administrator is not assuming risk, however, it is not really an "insurance company." Rather, an employer with a self-insured plan has agreed to assume the risk and pay for its employees' health care.

Self-insured employers typically purchase **"stop loss" insurance** coverage to reimburse the employer when treatment for employees exceeds a certain dollar limit. In some cases a self-insured employer may wish to pay an employee's claim but is told by the stop loss insurer that it will not receive reimbursement for the claim. It is important to understand that, although you won't typically have direct dealings with the stop loss insurer, its position may affect whether an employer will pay a particular claim. A typical self-insured relationship is diagrammed in Table 3.

II. Understanding Your Policy

It seems that health care policies get longer each year. It's not uncommon today to find policies over 50 pages long. Faced with a reading assignment this big and complex, it's tempting to just give up. But don't. Your policy is important. So – dive in! Your health is worth the effort.

Most health care policies are put together in a similar way. Most have a "Coverages" section, an "Exclusions" section, a "Definitions" section and a "Conditions" section. By using these three steps, you can turn reading this lengthy document into a fairly manageable task:

1. **Step One: Is There Coverage?** Start by reading the Coverages section. Does the treatment you need appear to be covered? If you encounter important terms, check the Definitions section for more information.

2. **Step Two: Is There an Exclusion?** Next, read the Exclusions section. If you believe you have found coverage, is there an exclusion that takes coverage away? Again, refer to the Definitions section if you need terms defined.

3. **Step Three: What Conditions Apply?** If you determine that there is coverage and that no exclusion takes away coverage, review the rest of the policy to determine whether any conditions apply. Conditions may include requirements that you:

   a. obtain pre-authorization from the health plan for a particular treatment;
   b. pay a deductible or co-payment; or
   c. use a particular health care provider.

If you are covered under an individual or group fully-insured policy, the health carrier must provide a copy of the policy to you. If you have coverage through an employer's self-insured plan, the employer must provide you with a copy of both the summary plan description and the master plan.

Frequently Asked Questions

My insurer wants to cut my hospital stay short. What can I do?

Enlist your physician as your advocate. Talk frankly with your doctor. Express your concerns and ask the doctor to intervene with the health plan. Ask the doctor to explain to the health plan the negative health consequences you could suffer if you leave the hospital. You should also express your concerns directly to your health plan, preferably in writing.

My primary care physician will not give me the referral that I need to see a specialist. What can I do to get a referral?

Some health plans use primary care physicians as "gatekeepers" to control the treatment and referrals you receive. In addition, some health plans pay the gatekeeper a "**capitated**" payment. This means that the gatekeeper receives a flat fee regardless of the amount of treatment you need. The more referrals the patient needs, the less money the gatekeeper makes.

Tell your physician about your concerns and why you believe it is necessary for you to receive a referral to a specialist. Consider putting your concerns in writing. If

FACTS AND FIGURES

■ According to the U.S. Census Bureau, 46.5 million Americans lacked health insurance in 2005, up by 1.5 million from 2003. ■

PREMIUMS, CO-PAYS, DEDUCTIBLES AND ANNUAL MAXIMUMS

Under most policies you will be responsible for certain payments. In recent years, because of the increased cost of health care, some employers and health plans have typically required consumers to pay more in out-of-pocket costs. Look at your policy to determine the payments you must make. Here are some of the main payments to look at:

- **Premium.** This is the amount you pay to obtain insurance coverage. Compare premiums among carriers and among plans of the same carrier.
- **Deductible.** A health care deductible works the same way it does for other types of insurance. For instance, you may be responsible to pay for the first $500 of treatment before your policy kicks in.
- **Co-pay.** This is the amount you pay each time you receive treatment or a prescription drug. For instance, your health plan may require you to pay $10 each time you go to the doctor.
- **Co-insurance.** This is a percentage of the cost that is charged for certain services after the deductible has been paid. For example, a co-insurance level of 20% means that the plan pays 80% of the costs, and you pay the remaining 20% of the cost.
- **Annual out-of-pocket maximum.** This is the maximum amount you will be required to pay each year in co-pays and deductibles.

this doesn't work, you may also wish to consider changing primary care physicians.

Finally, if you still can't get a referral to a specialist, consider locating a specialist on your own and referring yourself. While you may have to pay for the treatment, it may keep your health from being jeopardized.

I want to see a physician outside of my health plan's network. What can I do?

Some health plans allow you to see a physician outside of your network if your primary care physician authorizes it. Explain to your primary care physician why you believe it is necessary to see a physician outside the network and ask for a referral. If the physician refuses, ask why.

Some health plans allow you to go outside the network without a referral but require you to pay a greater share of the cost if you do. Other plans require pre-authorization even with a referral. Read your health plan to find out whether you may go outside the network and get reimbursed later.

Finally, be prepared to convince the health plan why you believe that there is no doctor in the network who can adequately treat your medical condition. For instance, maybe you have a particularly rare or unusual disease which requires specialty care not available in the network. If so, explain this to the health plan.

My medical condition requires me to make repeated visits to specialists. Do I need a referral each time?

Under Minnesota law, health plans must have procedures you can use to apply for a standing referral to a specialist. Check the criteria you must meet in order to obtain a standing referral. Contact your health

plan for more information, then enlist your physician's help to request a standing referral. Minnesota law also allows women direct access to obstetricians and gynecologists for maternity care and annual preventive health examinations, so the health plan cannot require a referral for these services if they are provided within the enrollee's network.

Under what circumstances may a health plan impose a pre-existing condition limitation?

It's common to run into a pre-existing condition limitation when you apply for health coverage from a new health carrier. A pre-existing condition is a medical condition (other than pregnancy) for which you seek medical advice or treatment within six months of the time you apply for health coverage. This means you will not be covered right away for pre-existing conditions.

A health carrier may apply a pre-existing condition limitation for up to 12 months from the date you first become covered. For example, if you received treatment for a heart condition within six months of being covered by a new carrier, the new carrier may deny any claims for care you need due to that heart condition for 12 months after your coverage starts.

If you are a "late entrant," a health carrier may apply a pre-existing condition limitation for up to 18 months. A late entrant is an individual who did not apply for coverage in a timely manner. For example, if you become eligible for coverage after working at a new job for 30 days, you must then apply for coverage or be considered a late entrant.

However, the period of time a health carrier can limit coverage for the pre-existing condition is reduced by the length of time you have had continuous **qualifying coverage**. Under the example above, if you had continuous qualifying coverage for nine months before applying for coverage through the new carrier, the new health carrier would have to give you nine months credit against the 12 month pre-existing limitation period for the nine months that you had qualifying coverage, so the new carrier could only deny claims for your heart condition for three months after enrollment. Continuous coverage means maintaining uninterrupted coverage. A person is considered to have continuous coverage if he or she applies for coverage within 63 days of terminating a qualifying coverage. If you did not maintain uninterrupted coverage or did not apply for coverage until more than 63 days after your previous coverage terminated, then the new carrier could impose the pre-existing condition limitation for the entire 12 month period (or for 18 months if you were a late entrant).

My employer just changed health plans and my doctor is not included in the new health plan. Do I need to stop seeing my old doctor right away?

State law says health plans must have written procedures which allow you to see your old doctor for certain conditions. For example, if you have special needs, such as an acute condition or a life-threatening illness, or special circumstances, such as a second or third term pregnancy, or a major disability that lasts for at least a year, you may continue seeing your doctor for up to four months after becoming covered by a new health plan. If your doctor certifies that you are expected to live less than six months, the new health plan must allow you to see your regular doctor for the rest of your life. This is called "continuity of care." Upon request the health plan must give you a copy of the written procedures for continuity of care.

My health plan says that it won't pay for emergency services I received because I could have waited until the next day for a clinic appointment instead of going to the emergency room. What are my rights?

Minnesota law requires that emergency services be covered whether they were provided by a participating provider or not. These services are covered if you are within or outside your health plan's service area. When considering coverage for emergency services, the health plan must look at the following:

1. a reasonable person's belief that the circumstances required immediate medical care

that could not wait until the next working day or next available clinic appointment;

2. the time of day and day of week the care was provided;
3. the symptoms at the time the patient received the emergency care and not just the after-the-fact diagnosis;
4. the patient's efforts to follow the health plan's procedures for obtaining emergency care, together with any circumstances that precluded using these procedures; and
5. any circumstances that precluded the patient from using the health plan company's established procedures for obtaining emergency care.

III. Tips on Fighting Back

How to Get the Health Care You Need

Let's say you have encountered a problem with your health plan. Maybe you can't get a referral to a specialist. Maybe plan administrators are telling you that treatment is not "medically necessary" or is "experimental." Or maybe they say that the treatment your health care provider recommends is not covered. Here are some general tips to help you navigate the health care maze:

1. **Be a Squeaky Wheel.** The adage that "the squeaky wheel gets the grease" holds true with your health carrier. By complaining to the health plan administrators, government officials and your medical providers, you are more likely to get the attention you deserve.

2. **Be firm.** Let the health plan know that you believe it is in breach of its promises to you. These are legal words that tell the health plan you mean business, you know your legal rights and will enforce them if necessary.

3. **Read Your Contract.** Don't accept the health plan's claim that something is not covered. Read your contract and determine for yourself if the health plan's position is right or wrong (see page 9 for guidance on how to read your health plan). Compare the language in the health plan's denial letter to the language in your contract.

4. **Document Your Dealings.** You can bet that when you call the health plan, they are taking notes on what you say. You should take notes, too. Get names and numbers and write down what you are being told. Then, if you need to refer back to a conversation, it's there.

5. **Put It In Writing.** If you have a complaint against your health plan, put it in writing. This way it will be harder for the health plan to minimize your concerns.

6. **Be Your Own Advocate.** Ask a lot of questions and know your rights. Let the health plan know that you understand your rights.

7. **Get Your Doctor To Be Your Advocate.** Develop a strong relationship with your doctor. When you encounter a problem with your health plan, ask your doctor to write a letter on your behalf disputing the denial with language from the contract whenever possible.

8. **Appeals.** Your health plan has informal appeal and grievance processes. Try using these forums (see page 15 for information on handling an appeal).

9. **Find Out Who Is Behind the "No."** In the case of a self-insured health plan, your employer might want to provide the coverage but maybe its stop loss carrier (which insures the employer) does not. Or maybe your physician wants to make a referral but the HMO is telling her she can't. Find out who is really behind the refusal to let you have the care you need. It will make solving the problem easier.

10. **Enlist an Ally.** Enlist an ally such as a friend, family member, or a lawyer to assist you, especially if you are sick.

11. **Go to the Top.** If you don't get the resolution you need from people lower in the organization, go straight to the top. If an

employer's self-insured plan is telling you "no," get the President or CEO of your company to intervene. The big shots at the top may not even know that the administrator they employ is denying you coverage.

12. **Get Treatment First.** If you need treatment that a health plan won't let you have, consider spending your own money to get the treatment. You can fight the health plan later to get reimbursed. If your health plan won't let you see a specialist, consider finding one and making an appointment on your own, using your own money to go.

IV. Appeals, Grievances and Complaints

Internal Appeals

Most health plans provide a way for you to file an internal grievance or appeal. These procedures are described in your contract with the health plan and may contain multiple steps to follow. If you decide to use these procedures, here are a few steps to keep in mind:

1. Explain clearly why you believe you are right and the health plan is wrong. Where possible, point to language in your contract that supports your position.
2. Include documentation. In particular, ask your physician to write a letter supporting your position, using relevant language from the contract, if possible. The physician should state why he or she believes your position is correct and why the facts of your particular medical condition entitle you to coverage.
3. If you attend an in-person appeal hearing, bring a friend, family member or an attorney to help you.
4. Keep in mind that most grievance and appeal procedures are internal health plan mechanisms. They may be controlled by the same people, or colleagues of the same people, who have already said "no" once. Also, even a so called "independent" hearing officer is often paid by the health plan. This "independent" hearing officer often has a contract with the health plan and conducts appeals at the health plan's premises.

External Appeals

If you are unhappy with the result of the internal appeal or have been told that a utilization review organization has refused to certify certain health care services, you may appeal to an external review entity. You should receive notice from the health plan company about your right to external review when a health plan company denies your request.

You may request external review by filing a written request for external review with the Minnesota Department of Health if the health plan company is an HMO, or with the Minnesota Department of Commerce if the health plan company is an insurance company. There is a $25 filing fee for an external appeal, but that fee may be waived if it is a financial hardship. Once you have filed an external appeal the external review organization will notify you of its process and you may submit whatever documents and argument you want the review organization to consider.

The decision of the external review organization is binding on the health plan company, but not on you. Thus, you could attempt to further challenge the decision by, for example, going to court. The health plan company can challenge the result in court only on the grounds that the decision of the external review

A NOTE ON MENTAL HEALTH CLAIMS

If you or your family members receive treatment for behavioral health issues (mental health, chemical dependency, eating disorders, or autism), you should be aware of the provisions in settlement agreements between the Attorney General's Office and Blue Cross and Blue Shield of Minnesota, HealthPartners and Medica Health Plans. One of the principal provisions in this agreement is the automatic review of any pre-service behavioral health claim denials by an independent administrative review board. The companies are bound to provide coverage if the review board determines that their denial of a claim was improper. If you would like more information about the administrative review board or any other part of the settlement agreements, please contact the Attorney General's Office.

organization is arbitrary or an abuse of discretion. If the health plan company is regulated by the State, it must participate in the external appeals process.

Making a Complaint to a Government Agency

If you are interested in making a complaint to a regulatory or government agency, you should first determine the type of health plan you have. Refer to page 5 to determine if you have a fully-insured or self-insured plan and are covered by an HMO or insurance company. The following agencies accept complaints concerning your health care coverage.

Self-Insured Plans

The United States Department of Labor Employee Benefits Security Administration ("EBSA") regulates self-insured plans. The State of Minnesota does not have authority to directly regulate self-insured plans. If you have a complaint regarding your self-insured plan, you may contact the EBSA as follows:

Employee Benefits Security Administration
Kansas City Regional Office
2300 Main Street, Suite 1100
Kansas City, MO 64108
(816) 285-1800
1-866-444-EBSA (3272)
www.dol.gov/ebsa/

The Minnesota Department of Commerce regulates third-party administrators doing business in Minnesota. If your self-insured plan uses a third-party administrator, you may contact the Minnesota Department of Commerce with a complaint as follows:

Department of Commerce
85 East Seventh Place, Suite 500
St. Paul, MN 55101
(651) 296-2488
1-800-657-3602
www.commerce.state.mn.us

SPECIAL NOTE ON ERISA PLANS

■ The Employee Retirement Income Security Act of 1974 ("ERISA") applies to certain employer-sponsored health plans. ■ ERISA requires these plans to include an appeal mechanism, but it also allows plans to limit the time in which you must file your appeal. ■ You may have as little as 60 days to appeal, and you must exhaust this appeal process before you can go to court. ■ You should carefully read the provisions so you don't miss any deadlines. ■ The provisions should be explained in your health contract.

Fully-Insured Plans

If your health coverage is through an HMO, you may contact the Minnesota Department of Health concerning coverage issues as follows:

Minnesota Department of Health
Managed Care Systems Section
85 East 7th Place
P.O. Box 64882
St. Paul, MN 55164-0882
(651) 201-5100
1-800-657-3916
www.health.state.mn.us

If your health coverage is through a health insurance company, you may contact the Minnesota Department of Commerce concerning coverage issues as follows:

Minnesota Department of Commerce
85 East Seventh Place, Suite 500
St. Paul, MN 55101
(651) 296-2488
1-800-657-3602
www.commerce.state.mn.us

The bureaucracy can be confusing — if you are unsure if your plan is self-insured, fully-insured, through an HMO or an insurance company, contact the Attorney General's Office for help. In addition, you may also contact the Attorney General's Office concerning coverage or other issues as follows:

Minnesota Attorney General's Office
445 Minnesota Street, Suite 1400
St. Paul, MN 55101
(651) 296-3353
1-800-657-3787
TTY: (651) 297-7206
TTY: 1-800-366-4812

Other Types of Complaints

If you would like to make a complaint about a licensed hospital, nursing home, boarding care home, supervised living facility, assisted living or home health agency, you may contact the Minnesota Department of Health, Office of Health Facility Complaints as follows:

Office of Health Facility Complaints
PO Box 64970
St. Paul, MN 55164-0970
(651) 201-4201
1-800-369-7994

If you have a complaint about a health care professional, the State of Minnesota has several Boards that license different medical professions, including the following:

Minnesota Board of Chiropractic Examiners
2829 University Avenue SE; Suite 300
Minneapolis, MN 55414-3220
(651) 201-2850
www.mn-chiroboard.state.mn.us

Minnesota Board of Dentistry
2829 University Avenue SE; Suite 450
Minneapolis, MN 55414-3246
(612) 617-2250
1-888-240-4762 (non metro)
www.dentalboard.state.mn.us

Minnesota Board of Dietetics and Nutrition Practice
2829 University Avenue SE; Suite 555
Minneapolis, MN 55414
(651) 201-2764
www.dieteticsnutritionboard.state.mn.us

Minnesota Board of Emergency Medical Services (for ambulance services)
2829 University Avenue SE; Suite 310
Minneapolis, MN 55414
(651) 201-2800
www.emsrb.state.mn.us

Minnesota Board of Medical Practice
2829 University Avenue SE; Suite 500
Minneapolis, MN 55414-3246
(612) 617-2130
1-800-657-3709 (Minnesota complaints only)

Minnesota Board of Examiners for Nursing Home Administrators
2829 University Avenue SE; Suite 440
Minneapolis, MN 55414
(651) 201-2730
www.benha.state.mn.us

Minnesota Board of Optometry
2829 University Avenue SE; Suite 550
Minneapolis, MN 55414
(651) 201-2762
www.optometryboard.state.mn.us

Minnesota Board of Nursing
2829 University Avenue SE; Suite 200
Minneapolis, MN 55414
(612) 617-2270

Minnesota Board of Pharmacy
2829 University Avenue SE; Suite 530
Minneapolis, MN 55414-3251
(651) 201-2825
www.phcybrd.state.mn.us

Minnesota Board of Physical Therapy
2829 University Avenue SE; Suite 420
Minneapolis, MN 55414
(612) 627-5406
www.physicaltherapy.state.mn.us

V. Prescription Drugs

The costs of prescription drugs have skyrocketed over the years and many people lack health coverage for them. In addition, drug pricing schemes are complex. Prescription drug costs are affected by lots of factors and can vary greatly from one source to another. Pharmaceutical manufacturers negotiate prices with drug purchasers. Discounts are generally greater for large-volume purchasers such as hospitals, employers or managed care companies. By contrast, smaller-volume purchasers, such as individuals, may not have access to such discounts. Here are some things you can do to help reduce your out-of-pocket costs for prescription drugs:

1. Ask your doctor if there is a generic equivalent to a brand-name drug that would be appropriate to treat your health condition. Generic drugs are often less expensive than their brand-name equivalents.
2. Comparison shop. As with any purchase, shop around for the best price. Ask your doctor how you can get the most for your money.
3. If you have health insurance with prescription drug benefits, make sure you understand what your plan covers. In particular, figure out if the health plan's **formulary** includes the drug prescribed for you.

FACTS AND FIGURES

■ According to the Kaiser Family Foundation, in 2005, 63 percent of Minnesotans surveyed indicated that they had health insurance coverage through an employer or union, 7 percent purchased coverage on their own, and 21 percent reported having coverage through a public health insurance program. Overall, 9 percent of Minnesotans, or approximately 444,860 people, were uninsured at the time of the 2005 survey. ■

FACTS AND FIGURES

■ According to a report by the Kaiser Family Foundation, prescription drug spending in the United States is projected to increase 138% from a total of $188.5 billion in 2004 to $446.2 billion in 2015. ■ According to the same Kaiser Family Foundation report, from 1994 to 2005, retail prescription drug prices increased an average of 8.3% per year. ■ According to a report by Families USA, the top seven U.S. pharmaceutical companies had combined revenues of almost $199 billion in 2005. ■

4. If you want a drug that is not on your formulary, there are options that may apply. First, if your plan is an HMO, state regulations require the HMO to offer all medically necessary prescription drugs. So, if the drug you need is not on the formulary but it is medically necessary, the HMO must cover it. In addition, if the drug in question is not on the HMO's formulary but the formulary drug causes an adverse reaction, is contraindicated or the doctor demonstrates that the non-formulary drug must be dispensed as written, the HMO must cover the non-formulary drug. Second, if a health plan provides for prescription drug coverage it also must cover prescribed antipsychotic drugs.
5. If you are a veteran, contact your local Veterans Affairs Office to find out if you qualify for discounts on prescription drugs.
6. Ask your doctor how long you will need to take the medication and in what dosage. This way you can just buy what you need. If you must take a drug for a long time, check to see if you can buy the drug in bulk.

7. Understand and follow the directions for taking your medications. This will make the drugs most effective and help reduce the risk of side effects. Avoid potential problems by telling your doctor what other drugs you take, including herbal remedies and over-the-counter medicines. Don't discontinue or change the dosage of your medication without your physician's approval.
8. Contact the RxConnect/Senior LinkAge Line at 1-800-333-2433 for assistance in determining whether you may qualify for free or discounted prescription drugs through a drug manufacturer patient assistance program. People of all ages may apply for patient assistance programs, but each program is different and most have income and/or asset guidelines. You may also visit the Minnesota Board on Aging at www.mnaging.org for further information about drug manufacturer patient assistance programs.
9. Visit www.MinnesotaRxConnect.com for information on obtaining affordable prescription drugs, including RxPrice Compare, which allows you to compare local prescription drug prices, and information on how to obtain lower cost prescription drugs from Canada and the United Kingdom. If you are unable to access the website, you may call Minnesota RxConnect at 1-800-333-2433.

Medicare Part D Prescription Drug Benefit

On January 1, 2006 a new prescription drug benefit under Medicare, known as Part D, became available for people enrolled in Medicare. The drug benefit is offered through two types of private health plans: 1) stand-alone Prescription Drug Plans ("PDPs") that supplement the original Medicare plan; or 2) Medicare Advantage (Medicare's version of managed care) plans that provide drug coverage and other Medicare-covered benefits.

Importantly, while Medicare requires all plans to offer certain types of drugs, Medicare does not require that all plans offer the same drug formulary. This means that before you sign up for a plan, you should make sure that the plan's formulary covers your drugs in the dosage that you need.

Part D plan benefits and cost structures vary widely. All Part D plans must offer either the standard benefit or a benefit of equal value, and plans may also provide enhanced benefit options for a higher monthly premium. In 2007 the standard benefit requires enrollees to pay: a monthly premium set by the plan; a $265 deductible; 25% cost-sharing up to the initial coverage limit of $2,400; 100% of drug costs until their out-of-pocket spending reaches $3,850 (this is known as the "doughnut hole" gap in coverage); and 5% of their drug costs thereafter. Certain low-income beneficiaries are eligible to receive assistance with their Part D costs.

Additional information and assistance with Medicare Part D is available online, at www.medicare.gov, or by calling 1-800-MEDICARE. You may also contact the Senior LinkAge Line at 1-800-333-2433 for assistance with Medicare Part D.

VI. Medi-Gap and Long-Term Care Insurance

Medicare Supplement Policies

Medigap or Medicare supplement policies can be purchased to help "fill in the gaps" of your Medicare coverage.

In Minnesota there are two standard Medicare supplement policies: "basic" and "extended basic." As the name implies, "extended basic" policies are more comprehensive than basic policies.

An open enrollment period of six months follows when you enroll in Medicare Part B (the portion of Medicare that covers physicians and other professional services). During this period you cannot be denied Medicare supplement insurance due to an existing health condition.

Compare plans before you buy. Consider your health needs and the cost of the plans to make the right choice for your health. If you don't understand what is covered, ask questions. Don't feel pressured to buy. If a salesperson stops by your home unannounced, don't feel pressured to let the person into your home. Do business on your own terms. Check your options carefully before making important decisions about your health care coverage.

The Minnesota Department of Commerce provides a free publication entitled *Medicare Supplemental Insurance: What you need to know* and a list of rates from companies operating in Minnesota. Contact information for the Department is listed later in this chapter.

Long-Term Care Insurance

Long-term care insurance helps you pay the costs of long term care, possibly including an assisted living facility or nursing home. If you're thinking about buying a long-term care insurance policy, you should consider the following steps before doing so.

- **Take Your Time and Shop Around.** Since policies differ in coverage and cost, consider contacting several companies to compare and contrast policies. Also, take your time in reviewing the policies.
- **Check Out the Company and Agent**. Check with the Minnesota Department of Commerce to make sure the company and the agent are licensed and in good standing.
- **Ask Around.** You may want to consider consulting a financial planner, tax advisor, accountant or attorney before purchasing long-term care insurance.

Be sure to review the policy and its requirements. The following information are some of the requirements and provisions that appear in long-term care insurance policies:

- **Minnesota Law Requirements.** Minnesota law requires long-term care policies to contain the following: 1) at least one year of coverage, including nursing home or home health care; 2) Alzheimer's disease coverage (if the policy is initiated before the disease is diagnosed); 3) an inflation protection option; 4) an "outline of coverage" that explains benefits, limitations and exclusions; 5) a "guaranteed renewable" clause that states the policy cannot be canceled unless the premium is not paid; 6) a statement that the policy can be canceled by the consumer within 30 days of its start.

NURSING HOME CARE

■ The Centers for Medicare and Medicaid Services publishes a free booklet entitled *Guide to Choosing a Nursing Home* that contains useful tools such as a checklist for potential nursing homes, information about your rights and a glossary of terms. To obtain this book, contact the Centers for Medicare and Medicaid Services at 1-800-MEDICARE or on the web at www.medicare.gov. ■

- **Duration of Benefits.** A policy must cover at least one year, but can provide up to a lifetime of coverage. A policy might be less expensive if the benefit period is shorter.
- **Elimination Period.** This refers to the number of days you must be in a nursing home or the number of home care visits you must receive before receiving benefits. The number may range from 0 to 100 days.
- **Qualifying for Coverage.** You must meet certain criteria before collecting benefits, which could include the inability to dress, bathe, and eat independently. If a policy has stricter requirements, it is likely to cost less.
- **Assisted Living.** This may be covered at varying levels in different long-term insurance policies. Make sure to carefully read a policy's provisions concerning assisted living.
- **Inflation Protection.** This protects your policy from inflation. The more a policy is protected from inflation, the more likely its premium will be higher.
- **Pre-existing Conditions and Exclusions.** Minnesota law requires pre-existing conditions to be covered after a six-month waiting period. You should be aware that other exclusions in the policy may apply.

Long-Term Care Partnership Program

The Minnesota Long-Term Care Partnership Program is a new effort to encourage people to plan for their long-term needs. Long-term care partnership policies allow you to protect more of your assets if you need to apply for Medical Assistance in the future.

Under the new program, if you purchase a partnership policy and later need to apply for Medical Assistance, you are eligible for asset protection up to the dollar amount of the benefits under your partnership policy. You are allowed to choose which assets to protect. This means that the protected assets are not counted for purposes of determining eligibility for Medical Assistance. They are also protected from estate recovery for Medical Assistance.

To be eligible for the partnership program, you must 1) be a beneficiary of a partnership policy, 2) be a Minnesota resident when your coverage begins, and 3) have exhausted all of your benefits under the partnership policy. Partnership program benefits can be applied when you have exhausted policy benefits at the time of requesting Medical Assistance payment for your long-term care services. They can also be applied when you have exhausted policy benefits while already receiving Medical Assistance payments for long-term care services.

Not all long-term care insurance policies are long-term care partnership policies. If you already have regular long-term care insurance, you can exchange it for a partnership policy. Or you can add a "rider" to your current policy, so your existing insurance policy qualifies as a partnership policy.

Partnership policies are not right for everyone. Traditional long-term care insurance policies must give you an option to purchase inflation protection. Partnership policies must include inflation protection, unless you are 76 or older when you purchase the policy. Inflation protection generally results in a higher premium. When shopping for long-term care coverage, compare policies carefully. Discuss your options with your insurance agent to determine which policy best fits your needs and income.

To learn more about the Minnesota Long-Term Care Partnership Program, you can contact the Minnesota Department of Human Services or visit www.mnltcpartnership.org.

The Minnesota Department of Commerce offers a free publication entitled *Long Term Care Insurance: What you need to know*. The Commerce Department, which licenses insurance companies and accepts complaints concerning long-term care and Medigap insurance companies, can be reached as follows:

Minnesota Department of Commerce
85 East Seventh Place, Suite 500
St. Paul, MN 55101
(651) 296-2488
1-800-657-3602
www.commerce.state.mn.us

VII. Medical Billing

Medical billing is often confusing. Hospitals and clinics generally bill directly to health insurers or HMOs, and certain billing codes are used to identify certain treatments or types of service. In addition, patients are sometimes asked to pay a portion of a bill through a co-pay or all of a bill if they don't have health coverage or if the type of service is not covered under their particular health plan.

If you believe a health care provider is mistakenly attempting to collect charges, you may want to consider the following information.

- Keep all of your records. For instance, if you are being double-billed for something, it is important to have all past bills and communication with the provider on hand.
- Contact the provider and ask them about the charges you believe are incorrect.
- If the problem is not resolved, dispute the information in writing.

Sometimes a provider may use a collection agency or lawyer to collect bills that are not paid. If you would like to make a complaint about a provider involved in questionable billing practices, you may contact the Attorney General's Office. The Attorney General's Office publishes a free brochure called *The Credit Handbook* that discusses your collection law rights and how to dispute a debt. You may obtain this at www.ag.state.mn.us or by calling (651) 296-3353 or 1-800-657-3787. In addition, the Minnesota Department of Commerce regulates and accepts complaints concerning such activity, and can be reached by phone at (651) 296-2488 or 1-800-657-3602.

Charging the Uninsured a Fairer Price and Changing Collection Practices

Although health plans, employers and the government are able to negotiate steep discounts for health care charges, many hospitals and other providers have charged the uninsured their "sticker" or "list" prices, which are much higher. Recently, however, most Minnesota hospitals have signed agreements with the Minnesota Attorney General's Office to offer uninsured patients a fairer price for hospital services and improve the debt collection practices that currently exist in the hospital industry.

The agreements will help those patients who do not have health insurance in the following way:

A NOTE ABOUT COLLECTION PRACTICES

The federal Fair Debt Collections Practices Act ("FDCPA") establishes a standard procedure for "third party" debt collection and provides consumers with certain protections. Within *five (5) days* after the debt collector's initial contact with you, the collector must send you a statement of the total amount owed to the creditor. In that written correspondence, the collector must also inform you what action you can take if you want to dispute owing the money. If you send a letter within *thirty (30)* days disputing that you owe the money, the debt collector cannot make further collection efforts until you receive proof of the debt. The debt collector cannot collect for any debt that cannot be verified. The FDCPA also restricts debt collectors from trying to collect any debt in dispute.

- The hospital will not charge a patient whose annual household income is less than $125,000 for any uninsured treatment in an amount greater than the amount the provider would be reimbursed for that service or treatment from the insurance company which provided that hospital with the most revenue for its services in the previous calendar year.

The agreements also establish standards that hospitals and certain clinics will follow when attempting to collect medical debt from patients.

- Prior to filing any lawsuit against a patient or referring any patient's account to a debt collection agency or attorney, the hospitals and clinics will undertake due diligence to ensure that: (a) the patient owes the debt, (b) all insurance companies that may be responsible to pay the claim have been billed, (c) the patient has been offered a payment plan if the patient cannot afford to pay the entire bill at once, and (d) the patient has been offered any free or discounted care for which the patient may be eligible under the hospital's charity care policy.

- Prior to garnishing any patient's wages or bank account, the hospitals and clinics will undertake the same due diligence to ensure that impoverished patients are not improperly garnished. To ensure adequate judicial supervision over such actions, the hospitals and clinics will not pursue any garnishment without first obtaining a judgment against the patient.

- Hospitals and clinics will adopt a number of other specific debt collection reforms. For instance: (a) they will develop a zero tolerance policy for abusive and harassing debt collection conduct; (b) they will instruct their attorneys not to petition to have a debtor arrested as a result of a debt collection action; (c) they will periodically review their contracts with outside debt collection agencies and attorneys to ensure they are acting in accordance with the law and the hospital's mission; (d) they will ensure that all lawsuits are promptly filed in court, that service of the lawsuit upon the patient is documented, and that no default judgment is obtained against the patient until the patient has been given a fair opportunity to respond.

- Hospitals and clinics will establish a streamlined process for patients to question or dispute bills, including a toll-free number they may call and an address to which they may write. Hospitals and clinics will promptly respond to patient inquiries. Collection notices will list the number for the Attorney General's Office for patients who need assistance.

As of the publication of this brochure, most Minnesota hospitals had signed agreements with the Attorney General. If you are unsure about whether your hospital is covered by such an agreement, please contact us.

FACTS AND FIGURES

■ A RECENT HARVARD UNIVERSITY STUDY FOUND THAT MEDICAL DEBT CAUSES OVER 50 PERCENT OF THE BANKRUPTCIES IN AMERICA, WITH MOST OF THE BANKRUPTCIES FILED BY PEOPLE WHO WERE PART OF THE MIDDLE CLASS AT THE ONSET OF THEIR ILLNESS. THIS MEANS THAT IN MINNESOTA, APPROXIMATELY 7,000 FAMILIES FILE FOR BANKRUPTCY DUE TO MEDICAL DEBT EVERY YEAR. ■

VIII. Protecting Private Information

Federal Law

A number of federal laws and regulations restrict the ways that health plans, pharmacies, hospitals and other entities can use patients' personal medical information. The most important of those laws is the Health Insurance Portability and Accountability Act of 1996, known as HIPAA. HIPAA is designed to provide a minimum standard of privacy protection for consumers across the United States, but it does not replace state laws that provide greater privacy protections. Most health care providers were first required to comply with the federal privacy standards in April, 2003. You may have noticed that your health care provider asked you to sign various notices and consent forms around that time. Here is a summary of some of the key HIPAA provisions:

- **Access To Medical Records.** Under HIPAA, patients generally have the right to view and obtain copies of their medical records and request corrections if they identify errors and mistakes. Access to these records should be provided within 30 days, but the patient may be charged for the cost of copying and sending the records.
- **Notice of Privacy Practices.** Patients must be provided with a notice about their privacy rights and how their personal medical information may be used.
- **Limits on Use of Personal Medical Information.** HIPAA sets limits on how health plans and covered providers may use individually identifiable health information. It does not eliminate the sharing of such information, but it restricts the sharing to the minimum necessary to accomplish the intended purpose of the disclosure. Employees must be trained on new privacy procedures and each covered entity must designate a privacy officer.
- **Restrictions on Marketing.** The final privacy rule sets some new restrictions and limits on the use of patient information for marketing purposes. Unfortunately, it appears the HIPAA restrictions on marketing are fairly weak and may not curb many unfortunate marketing practices, such as health plans hiring telemarketers to contact patients to sell them more health plan services.

The United States Department of Health and Human Services Office for Civil Rights ("OCR") oversees and enforces HIPAA. The State of Minnesota does not have authority to enforce HIPAA. To obtain further information or to file a complaint regarding the privacy practices of a health plan or provider, contact the OCR as follows:

United States Department of Health & Human Services
Office for Civil Rights - Region Five
233 N. Michigan Avenue; Suite 240
Chicago, IL 60601
(312) 886-2359
1-866-627-7748
www.hhs.gov/ocr/hipaa

State Law

Minnesota has a number of state laws restricting the use and dissemination of personal health information by participants in the health care system. Some of these laws provide greater privacy protection than that granted under HIPAA. The general rule under Minnesota law is that a health care provider cannot share your health information with a third party unless you have given written consent or there is a law that authorizes the provider to share your information. Minnesota's health privacy laws are complex, but the law requires providers to give patients notice of when a patient's health records may be disclosed without the patient's consent. This notice should be posted in the provider's place of business or given to you. There are also government resources available to help you address your health privacy concerns. First, the

Minnesota Health Department regulates many health care facilities, such as hospitals and nursing homes, and health maintenance organizations ("HMOs"), such as Medica, Blue Plus, Preferred One and HealthPartners. If you believe that a health care facility or HMO may have violated your privacy rights, you can contact the Department of Health as follows:

Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882
(651) 201-5100
1-800-657-3916
www.health.state.mn.us

Second, the Minnesota Department of Commerce regulates certain health plan companies and health insurance companies, such as Blue Cross Blue Shield of Minnesota. If you believe that an insurance company or health plan company may have violated your privacy rights, you can contact the Department of Commerce as follows:

Minnesota Department of Commerce
85 East Seventh Place, Suite 500
St. Paul, MN 55101
(651) 296-2488
1-800-657-3602

Finally, if your health privacy complaint involves an individual health care practitioner, or if you are otherwise unsure which state agency or board to contact about your concerns, you can contact the Attorney General's Office at (651) 296-3353 or 1-800-657-3787 and we will assist you in identifying the proper regulatory agency.

MEDICAL INFORMATION BUREAU

The Medical Information Bureau ("MIB") is an organization that compiles a central database of medical information. Approximately 15 million Americans and Canadians are on file in the MIB's computers. More than 750 insurance firms use the services of the MIB, primarily to obtain information about life insurance and individual health insurance policy applicants. You are entitled to a free medical record disclosure once a year. You can get a copy by calling the Medical Information Bureau toll-free at: **1-866-692-6901**. For other questions or to correct your report, write to:

Medical Information Bureau
P.O. Box 105
Essex Station
Boston, MA 02112
1-866-692-6901
www.mib.com

IX. Questions About COBRA And Continuation Coverage

If the employee dies, will a surviving dependent be able to continue coverage?

Minnesota law requires fully-insured group plans to continue coverage for the surviving spouse and children. Coverage must continue until the spouse and children are covered by another group policy or the coverage would have ended anyway.

The premiums for the survivors' coverage cannot exceed 102 percent of the cost of the plan for other employees, including any portion paid by the employer.

Under a self-insured plan, the surviving spouse and dependents may continue coverage for up to 36 months, or until they are covered by another plan.

What are the continuation privileges in the event of divorce or legal separation?

If you have fully-insured group coverage, or individual health coverage that provides benefits for spouses and dependent children, coverage continues after divorce or separation. The coverage continues until the former spouse has other coverage or the coverage would have ended anyway. With individual and fully-insured group coverage, the insurer may not charge an additional premium to the former spouse.

The dependent children have coverage until they are covered by another plan or the coverage would have ended anyway. For example, once children reach the maximum age for coverage it may be terminated. (The maximum age for dependents is stated in the policy.) At the expiration of the continuation coverage, the former spouse and dependents have the right to obtain an individual policy from the insurer, within 30 days following notice of the expiration.

With self insured group coverage, the former spouse must pay an additional premium, and the coverage is limited to 36 months.

What benefits are available when the individual policyholder or the employee covered by the fully-insured group coverage plan becomes eligible for Medicare?

If you become eligible for Medicare, your spouse and dependent children may continue with your health coverage for 36 months. If your spouse or child changes insurance plans, or the original plan ends, then the coverage is terminated.

The spouse and dependent children must pay the employer 102 percent of the cost of the premium, including any employer contributions.

What continuation is available to children once they have reached the maximum age of coverage in the policy?

When children reach the maximum age of coverage, as defined in the contract, the child may continue coverage for 36 months by electing continuation.

The coverage for the child would cost 102 percent of the premium, including any employer contributions.

FACTS AND FIGURES

■ According to the Kaiser Family Foundation, in 2005, 63 percent of Minnesotans surveyed indicated that they had health insurance coverage through an employer or union, 7 percent purchased coverage on their own, and 21 percent reported having coverage through a public health insurance program. Overall, 9 percent of Minnesotans, or approximately 444,860 people, were uninsured at the time of the 2005 survey. ■

ADDITIONAL INFORMATION

The Employee Benefits Security Administration ("EBSA") publishes a free guide for federally regulated health plans entitled *An Employee's Guide to Health Benefits Under COBRA*. If you would like a copy of the publication, you may contact the EBSA as follows:

Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/

Can an employee continue his/her group coverage if they become disabled?

If an employee covered by a fully-insured group plan becomes disabled, the employee may continue coverage indefinitely. To do this, the employee must pay the premium directly to the employer. The employee will be required to pay the entire cost of the premium, including any premium formerly paid by the employer.

If a disabled employee is covered by a self-insured plan, the employee may keep coverage for the original 18 months plus an additional 11 months. However, for the additional 11 months the employer may increase the cost of the plan to 150 percent of the plan's total cost of coverage.

Can you continue coverage if you quit your job or if your employer terminates your employment?

If employment ends for reasons other than willful misconduct, an employee covered under a fully-insured group policy is entitled to continue coverage. You may keep coverage for 18 months or until you become insured in another plan. The cost to continue cannot exceed 102 percent of the cost paid by employees still working. The cost includes any portion paid by the employer.

If an employer terminates your employment, for reasons other than willful misconduct, the employer must let you know that you may continue health care coverage. Within 10 days of termination or layoff the employer must tell you that you may continue coverage, what the cost would be, and when payments are due to the employer.

When coverage ends under a health plan, or when the insured has exhausted continuation, may a consumer purchase an individual conversion policy?

A person who has used all possible continuation coverage is entitled to individual coverage from their current insurer without needing to provide evidence of insurability and without interruption of coverage.

X. Government Programs/Assistance

In addition to private health insurance, certain government plans cover some people. Below are descriptions of available plans and resources. If you have web access, most of the below programs are described at www.dhs.state.mn.us/healthcare. If you do not have access to the Internet, you may be able to do so at your local public library. (The following information was current as of March 2007.)

Medical Assistance ("MA")

MA, Minnesota's Medicaid program, is the largest of the public health care assistance programs in Minnesota. It provides medical assistance to low-income senior citizens, children and families, and people with disabilities. MA may also help pay premiums for other health insurance, including insurance through an employer or Medicare. To qualify you must meet eligibility guidelines such as income and asset limits which depend on family size and age. For example, as of the date of this publication, for children ages 2-18 living in a family of four to be eligible, the family must meet an income limit of $ 2,500 per month. For parents in a family of four, the family must meet an income limit of $1,669 per month and have total countable assets of no more than $20,000. Contact your county's human services agency for more information about eligibility requirements. You may also call the MA Info Line at (651) 431-2670 or 1-800-657-3739.

Medical Assistance for Employed Persons with Disabilities ("MA-EPD")

MA-EPD allows working people with disabilities to qualify for MA under higher income and asset limits. To qualify, Minnesotans need to be: 1) certified disabled; 2) at least 16 but under 65 years old; 3) employed in a position earning more than $65 per month and paying applicable federal and state taxes; 4) have no more than $20,000 in countable assets (this asset limit does not apply to pregnant women and children ages 16-21); and 5) pay a monthly premium based on income and household size. If you are married, your spouse's assets do not count toward the asset limitation. The minimum monthly premium is $35. There is no maximum income limit or premium amount. Individuals with unearned income, such as Social Security Disability and/or Supplemental Security Income, are required to pay a small percentage of their unearned income in addition to the monthly premium. Contact your county human service agency or the Disability Linkage Line at 1-866-333-2466 for more information. You may also call the MA Info Line at (651) 431-2670 or 1-800-657-3739.

General Assistance Medical Care ("GAMC")

The General Assistance Medical Care program pays for medical care for low-income Minnesotans who don't qualify for Medicaid or other health care assistance programs, primarily low-income adults ages 21 to 64 without dependent children. To qualify recipients must meet income and asset limits. The asset limit for comprehensive coverage is $1,000 per household. Income limits depend on family size. For example, a single person without children must meet a monthly income limit of $613. A married couple without children must meet a monthly income limit of $826. Enrollees must pay co-pays for certain medical services. People with income over the limit may be eligible for Hospital Only GAMC. Application for this must be made while hospitalized and coverage is subject to a $1000 deductible for each hospitalization. Contact your county human services agency for more information.

MinnesotaCare

MinnesotaCare is a health care program for Minnesotans who do not have access to other health care insurance. There are no health condition restrictions, but applicants must meet eligibility guidelines, including income and asset limits. Children under age 21 and pregnant women are exempt from the asset limit. For example, as of the date of this publication, a family of four needs to meet a monthly gross income limit of $4,586 and have total countable

assets of no more than $20,000 to qualify for MinnesotaCare. Enrollees pay a monthly premium based on income and family size and parents have co-pays for certain services. Some children may be covered for as little as $4 per month. These children may also be subject to waiver of the insurance coverage requirements. Parents can apply for coverage for their children only.

Adults without children may also apply for MinnesotaCare but benefits are limited to a $10,000 yearly cap on inpatient hospitalization costs with a 10 percent co-pay, and a $5,000 yearly cap on physician services, prescription drugs, outpatient services and lab/diagnostic services. Enrollees have co-pays for certain services.

Contact your county's human services agency for more information about MinnesotaCare eligibility requirements. You may also contact the Minnesota Department of Human Services, which administers MinnesotaCare, at:

MinnesotaCare
Elmer L. Andersen Building
540 Cedar Street
St. Paul, MN 55101
(651) 297-3862
1-800-657-3672
www.dhs.state.mn.us/healthcare

Medicare

Medicare is the federal government's health insurance program for people 65 years old and older and certain younger people with disabilities. Medicare Part A covers hospital and nursing home services. Part B covers physician and other professional services. Part D covers outpatient prescription drugs. People who are entitled to Social Security benefits pay no premium to receive Part A coverage, but must pay Part A's annual deductible and co-insurance requirements. Both Part B and Part D have monthly premiums in addition to annual deductibles and co-insurance requirements. See page 19 for further information on Part D.

In addition, Medicare supplement insurance is available to fill in the gaps in Part A and Part B coverage. You can purchase supplemental insurance to pay for items that Medicare generally does not cover.

If you have questions about Medicare eligibility or want to apply for Medicare benefits, contact the Social Security Administration toll-free at 1-800-772-1213 (TTY 1-800-325-0778), or visit www.medicare.gov.

The U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services offers a comprehensive guide to health insurance for people with Medicare entitled *Medicare and You*. The guide is available free of charge, in print or audio cassette format in English or in Spanish, by calling 1-800-MEDICARE or 1-800-633-4227 (TTY 1-877-486-2048), or online at www.medicare.gov.

Medicare Supplemental Programs

DHS administers several programs for Medicare enrollees that can help with Medicare costs: Qualified Medicare Beneficiary ("QMB"), Service Limited Medicare Beneficiary ("SLMB"), Qualified Individuals ("QI") and Qualified Working Disabled ("QWD").

QMB pays your Medicare premiums, deductibles, co-insurance and co-payments. To qualify, you must: 1) be enrolled in or eligible to enroll in Medicare; 2) have no more than $10,000 total countable assets for a single person or $18,000 for two people; and 3) have monthly income of no more than $837 for a single person, $1,121 for a family of two, or $1,405 for a family of three.

SLMB pays your Medicare Part B premium. To qualify, you: 1) must be enrolled in or eligible to enroll in Medicare; 2) have no more than $10,000 total countable assets for a single person or $18,000 for two people; and 3) have monthly income of no more than $1,000 for a single person, $1,340 for a family of 2, or $1,680 for a family of three.

QI also pays for Medicare Part B premiums. To qualify, you: 1) must be enrolled in or eligible to enroll in Medicare; 2) have no more than $10,000 total countable assets for a single person or $18,000 for two people; and 3) have monthly income of no more than $1,123 for a single person, $1,506 for a family of 2, or $1,889 for a family of three.

QWD pays your Medicare Part A premium if you are not eligible for premium free Part A and you meet income and asset limits. Assets may not exceed $4,000 for a single person or $6,000 for two people. Monthly income may not exceed $1,654 for a single person, $2,221 for a family of two, or $2,788 for a family of three.

Contact the *Senior Linkage Line* at 1-800-333-2433 or your local county human service agency for more information.

Minnesota Comprehensive Health Association

The Minnesota Comprehensive Health Association ("MCHA") is a legislatively-mandated health plan for people unable to obtain insurance coverage in the private marketplace due to pre-existing health conditions. MCHA may not turn you away because you have a medical problem. Rather, it is designed to provide health care coverage to people with medical problems. MCHA policies exclude coverage for pre-existing conditions for the first six months if the condition was diagnosed or treated during the 90 days preceding the effective date of coverage, but there are ways to get this waived. If you are rejected for health insurance in the private marketplace due to a pre-existing condition, you should consider contacting MCHA. MCHA is considered a high-risk pool, and therefore its rates are generally higher than those charged in the private marketplace. You may contact MCHA at the following address for more information and an application form or you may contact your insurance agent:

Minnesota Comprehensive Health Association
Customer Service
Mail Route CP555
401 Carlson Parkway
Minnetonka, MN 55305-5387
For deductible plan options:
1-866-894-8053 or 1-800-841-6753 (TTY)
For Medicare Supplement plan options call:
1-800-325-3540 or 1-800-234-8819 (TTY)
www.mchamn.com

MAKING A COMPLAINT TO A GOVERNMENT AGENCY

As you can see from this booklet, it isn't necessarily easy to identify which government agency you should contact regarding a complaint or concern. You need to identify what type of plan you have (i.e., self-insured, fully-insured, etc.). Then, refer to page 15 of this booklet that identifies the different government agencies responsible for regulating the health care industry.

If you have any questions or want to make a complaint to the Attorney General's Office, you may do so as follows:

Minnesota Attorney General's Office
Consumer Division
445 Minnesota Street, Suite 1400
St. Paul, MN 55101
(651) 296-3353
1-800-657-3787
www.ag.state.mn.us

Minnesota Board on Aging

The Board on Aging contains a network of local area agencies on aging that provide several services to older Minnesotans, including health insurance counseling, prescription drug information and more. If you would like to contact the Board on Aging or its local area agencies, they can be reached through the *Senior Linkage Line* or otherwise as follows:

Minnesota Board on Aging
Elmer L. Andersen Building
540 Cedar Street
PO Box 64976
St. Paul, MN 55164-0976
(651) 431-2500
Senior Linkage Line 1-800-333-2433
www.mnaging.org

XI. Glossary of Terms

CAPITATION A payment arrangement whereby a health carrier pays a primary care physician a fixed amount for each patient with deductions for each referral or treatment the patient receives. See also "**risk sharing" agreement**.

CERTIFICATE OF COVERAGE The document that provides evidence of coverage that is issued to a consumer who is enrolled in a group health plan.

CO-INSURANCE The percentage of the cost that is charged to the consumer for certain services after the deductible has been paid. For example, a coinsurance level of 20 percent means that the plan pays 80 percent of the costs, and the member pays the remaining 20 percent of the cost.

CO-PAY An arrangement which requires a covered person to pay a fixed amount each time a covered service is used. For instance, the enrollee might be required to make a $10 co-payment for each office visit or an $8 co-payment for each prescription drug.

DEDUCTIBLE An amount that a covered person must pay before plan payments begin. For instance, the health plan may have a $500 deductible, in which case the enrollee pays the first $500 in medical bills before the plan pays anything.

DEPENDENT A family member of a policyholder who has coverage under the policyholder's health contract.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, OR ERISA This federal law applies to self-insured employee benefit plans.

EXPLANATION OF BENEFITS FORM ("EOB") A form sent by the health plan to the consumer explaining what payments were made on behalf of the consumer and what the unpaid amounts are.

FEE-FOR-SERVICE A payment arrangement whereby a health carrier pays a primary care physician based on the actual services provided.

FORMULARY A list of drugs covered by a plan.

FULLY-INSURED A health coverage agreement under which an HMO, insurance company or nonprofit health services corporation assumes the risk of paying the covered person's health claims.

HEALTH CARRIER An insurance company, health maintenance organization, or nonprofit health service plan corporation that sells health plans.

MANAGED HEALTH CARE A system of financial reimbursement which relies upon strategies designed to influence cost and use of treatment.

NON-PARTICIPATING PROVIDER A physician or clinic that has not signed a contract with a health plan to provide treatment to the health plan's patients.

OUT-OF-POCKET MAXIMUM The total amount of money that the consumer will be obligated to personally incur each year in co-payments and deductibles. For instance, the health plan may have a $3,000 annual out-of-pocket maximum which means that after the deductible and co-pay costs reach $3,000, the enrollee has full coverage.

PARTICIPATING PROVIDER A physician who has a contract with the health plan to provide treatment to the health plan's patients.

PREFERRED PROVIDER ORGANIZATION ("PPO") An organization which, among other things, contracts with health plans to provide a network panel of physicians.

PREMIUM The amount paid to obtain insurance coverage.

QUALIFYING COVERAGE Health benefits or health coverage provided under a private health plan, Medicare Part A or B, a self-insured health plan, or a government-sponsored health plan.

"RISK SHARING" AGREEMENT A payment made in advance by a health plan to a physician or clinic which is a flat, pre-arranged amount. Under a risk-sharing payment structure, the physician receives the same payment from the health plan for a particular patient regardless of the amount of health care the patient needs. The more treatments or referrals the patient receives, the less money the physician or clinic makes. This is different from more traditional "fee-for-service" payments under which a physician makes more money if the patient receives more care. A capitation or risk-sharing agreement operates as a financial incentive to the physician to limit treatment or referrals.

SELF-INSURED A system under which an employer agrees to use its own assets to pay the health claims of its employees. Self-insured health plans are filed with the United States Department of Labor and subject to a federal law called ERISA. Large corporations are more likely to be self-insured than small businesses.

SHORT TERM COVERAGE A form of health insurance consumers can purchase in between jobs, after college, or for other short-term reasons that only require a month or more of coverage. State law allows such policies to contain broad definitions of pre-existing conditions.

STOP LOSS INSURANCE An insurance policy purchased by a self-insured employer to reimburse the employer for claims paid on behalf of covered employees in excess of certain amounts.

SUMMARY PLAN DESCRIPTION ("SPD") The evidence of coverage required under federal law to be issued by a self-insured employer to its employees.

THIRD-PARTY ADMINISTRATOR ("TPA") An entity which processes claims on behalf of a self-insured health plan. In Minnesota, third-party administrators are licensed by the Minnesota Department of Commerce.

UNDERWRITING A process where a health plan reviews a consumer's medical history to decide whether to issue a policy.

UTILIZATION REVIEW ("UR") An organization which evaluates the necessity and appropriateness of medical treatments for purposes of determining medical necessity. In Minnesota, utilization review organizations are licensed by the Minnesota Department of Commerce.

Additional Consumer Information

The Attorney General's Office answers questions about landlord and tenant rights, mobile homes, health care, cars, credit, unwanted mail and phone calls, and numerous other consumer issues. The Attorney General's Office also provides free mediation to resolve disputes between Minnesota consumers and businesses and uses information from consumers to enforce the state's consumer laws.

If you have a complaint, please contact the Attorney General's Office in writing at: Minnesota Attorney General's Office, 445 Minnesota Street, Suite 1400, St. Paul, MN 55101. Citizens can also receive direct assistance from a consumer specialist by calling: (651) 296-3353 or 1-800-657-3787.

TTY numbers are: (651) 297-7206 and 1-800-366-4812. (TTY numbers are for callers using teletypewriter devices.) Visit our web site at: www.ag.state.mn.us.

Consumer publications listed below are available free of charge from the Attorney General's Office.

- The Car Handbook
- Citizen's Guide to Building and Remodeling
- The Credit Handbook
- Conciliation Court
- Guarding Your Privacy: Tips to Prevent Identity Theft
- The Home Buyer's Handbook
- The Home Seller's Handbook
- Landlords and Tenants: Rights and Responsibilities
- The Manufactured Home Parks Handbook
- Minnesota's Car Laws
- The Phone Handbook
- Probate and Planning: A Guide to Planning for the Future
- Pyramid Schemes
- Seniors' Legal Rights

From the Office of
Minnesota Attorney General
Lori Swanson

Consumer Protection
445 Minnesota Street, Suite 1400
St. Paul, MN 55101

www.ag.state.mn.us

Managing Your Health Care