

MANAGING YOUR HEALTH CARE

FROM THE OFFICE OF
MINNESOTA ATTORNEY GENERAL
KEITH ELLISON

www.ag.state.mn.us

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.

This publication contains some words that may need further explanation. You may want to scan the Glossary of Terms located on page 28 before reading ahead.

This brochure is intended to be used as a source for general information and is not provided as legal advice.

Managing Your Health Care is written and published by the Minnesota Attorney General's Office.

This document is available in alternative formats to individuals with disabilities by calling (651) 296-3353 (Twin Cities Calling Area), (800) 657-3787 (Outside the Twin Cities), or through the Minnesota Relay Service at (800) 627-3529.

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Private Health Care Coverage

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.

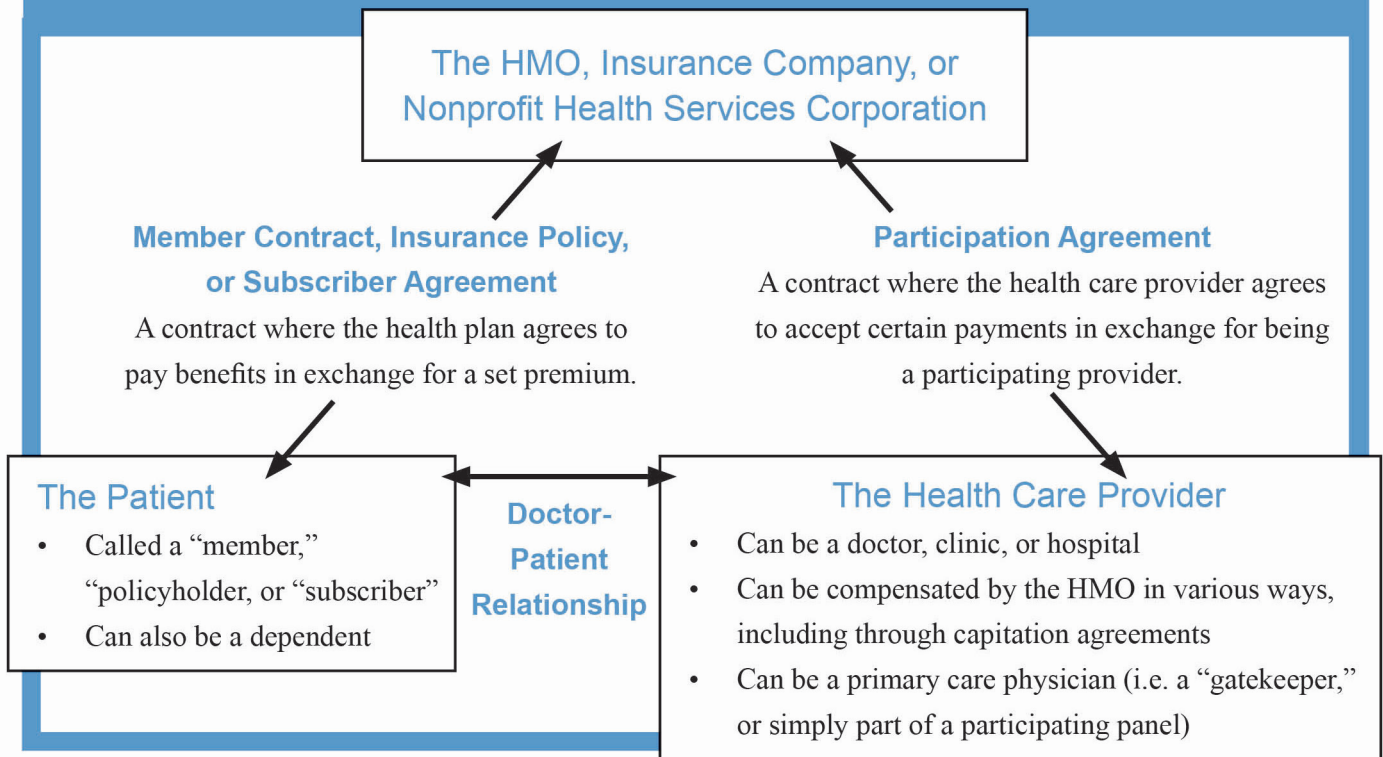
Remember that there are three separate relationships.

First, you have a policy issued to you by a health carrier. 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 One.

Table One: Fully-Insured Health Plan, Individual Coverage



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

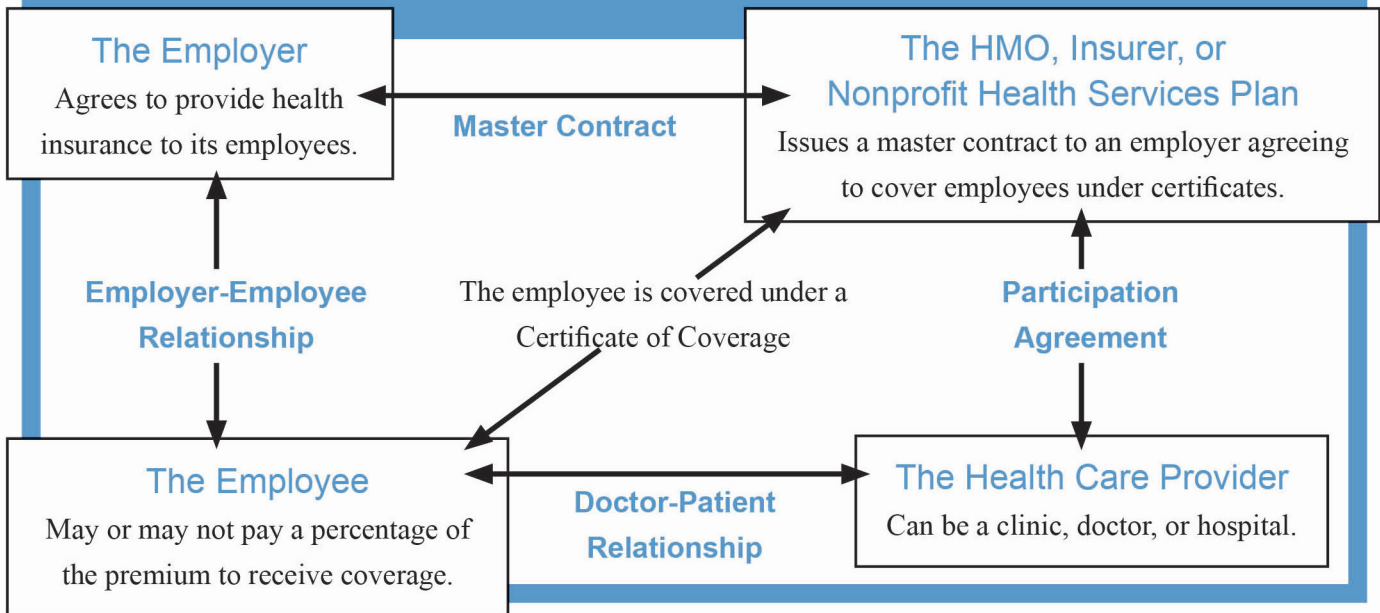
Fully-insured group coverage is different from individual coverage because the employer is also part of the relationship. A diagram of this type of coverage is found in Table Two on the next page.

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.

Table Two: Fully-Insured Health Plan, Group Coverage



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

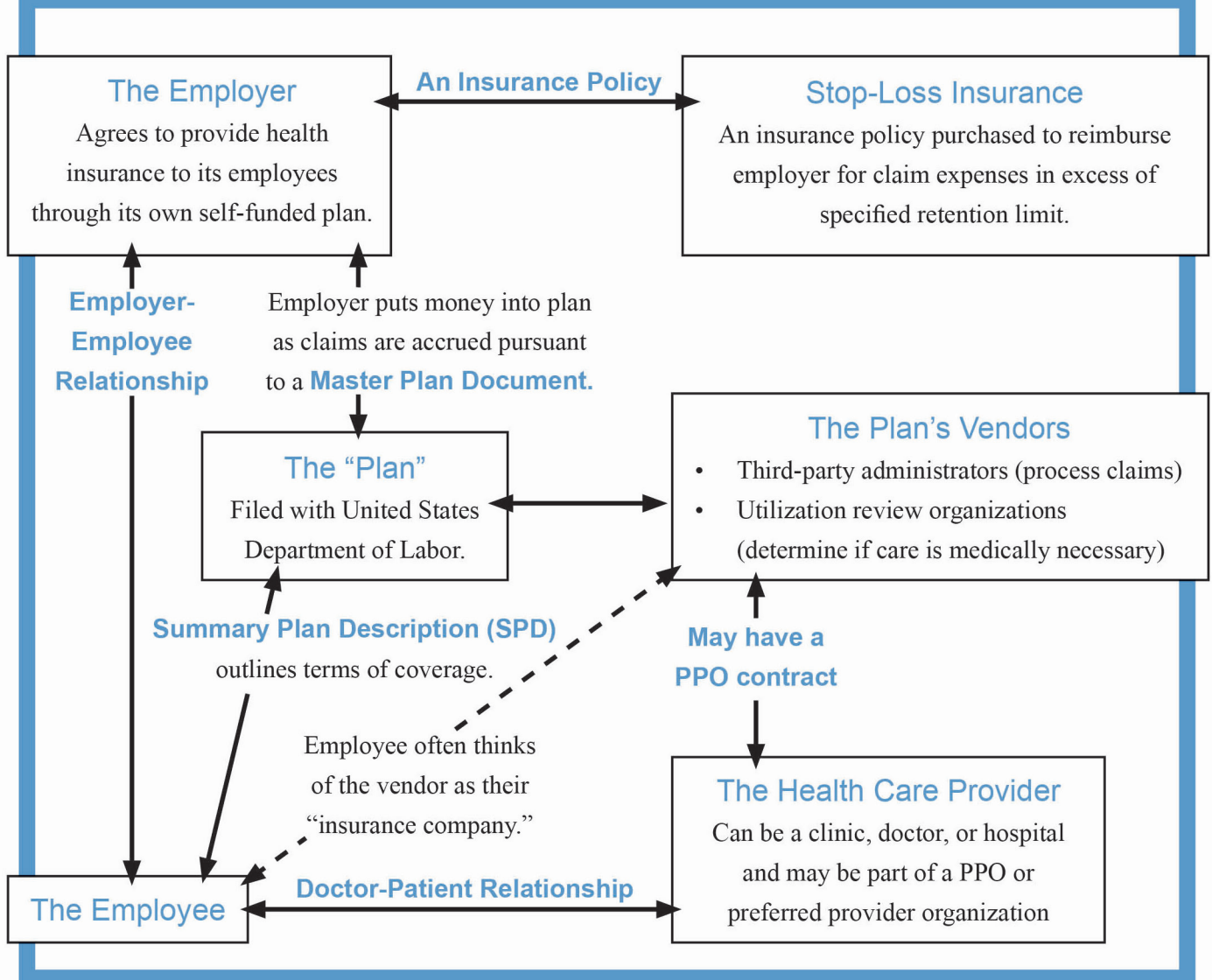
Some self-insured plans are offered through a multi-employer plan, which may be collectively bargained. Those plans, sometimes called Taft-Hartley plans, are also regulated by the federal government under ERISA.

Many people consider the plan's third-party administrator or trustee 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 or a multi-employer plan self-insures by agreeing 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 Three.

Table Three: Self-Insured Plan



A Word about Short-Term Policies

Consumers should 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.

Read and understand the terms and conditions of short-term health insurance policies before purchasing them. Make sure to 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.

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 are composed of sections titled "Coverages," "Exclusions," "Definitions," and "Conditions." By using these three steps, you can turn reading this lengthy document into a fairly manageable task:

- 1. 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 of your policy for more information.
- 2. 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. 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 obtain pre-authorization from the health plan for a particular treatment, pay a deductible or co-payment, or 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.

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 percent means that the plan pays 80 percent of the costs, and you pay the remaining 20 percent 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.

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 for each patient with deductions for each referral or treatment the patient receives.

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 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.

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

Minnesota law says health plans must have written procedures that allow you to see your previous doctor for certain conditions. For example, if you have special needs (such as an acute condition or a life-threatening illness), 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 120 days after becoming covered by a new health plan. If your doctor certifies that you are expected to live less than 180 days, 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 the 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.

My health plan will not approve a service that my doctor says I need. What can I do?

Health plan companies that require authorization for services must have written procedures for reviewing your request. These utilization review procedures allow a health plan to evaluate the necessity and appropriateness of a procedure. Either you or your health care provider can request approval for a service. If the health plan does not approve the service, it must tell you how you can appeal that decision. If the utilization review organization denies

coverage for a procedure, your health provider can request an expedited review. The utilization review organization must give a decision with 72 hours of receiving an expedited appeal.

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 7 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.
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.

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 an 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 organization is arbitrary or an abuse of discretion. If the health plan company is regulated by the State of Minnesota, 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 pages 4-6 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. 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 or (866) 444-EBSA (3272)

www.dol.gov/agencies/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:

Minnesota Department of Commerce

Consumer Helpline

85 East Seventh Place, Suite 280, St. Paul, MN 55101

(651) 539-1600 or (800) 657-3602

www.mn.gov/commerce

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 Section

P.O. Box 64882, St. Paul, MN 55164-0882

(651) 201-5100 or (800) 657-3916

www.health.state.mn.us/hmo

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
Consumer Helpline**

85 East Seventh Place, Suite 280, St. Paul, MN 55101
(651) 539-1600 or (800) 657-3602
www.mn.gov/commerce

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 Minnesota Attorney General’s Office for help. In addition, you may also contact the Attorney General’s Office concerning coverage or other issues as follows:

Office of Minnesota Attorney General Keith Ellison
445 Minnesota Street, Suite 1400, St. Paul, MN 55101
(651) 296-3353 (Twin Cities Calling Area)
(800) 657-3787 (Outside the Twin Cities)
(800) 627-3529 (Minnesota Relay)
www.ag.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.

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
P.O. Box 64970, St. Paul, MN 55164-0970
(651) 201-4201 or (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 Southeast, Suite 300, Minneapolis, MN 55414
(651) 201-2850 or (800) 627-3529 (Hearing/Speech Relay)
www.mn.gov/boards/chiropractic-examiners

Minnesota Board of Dentistry

2829 University Avenue Southeast, Suite 450
Minneapolis, MN 55414
(612) 617-2250 or (888) 240-4762 (non metro)
www.mn.gov/boards/dentistry

**Minnesota Emergency Medical Services
Regulatory Board**

(for ambulance services)
2829 University Avenue Southeast, Suite 310
Minneapolis, MN 55414
(651) 201-2800 or (800) 747-2011 (non metro)
www.mn.gov/boards/emspb

Minnesota Board of Optometry

2829 University Avenue Southeast, Suite 403
Minneapolis, MN 55414
(651) 201-2762
www.mn.gov/boards/optometry

Minnesota Board of Pharmacy

2829 University Avenue Southeast, Suite 530
Minneapolis, MN 55414
(651) 201-2825
www.mn.gov/boards/pharmacy

**Minnesota Board of Dietetics
and Nutrition Practice**

2829 University Avenue Southeast, Suite 402
Minneapolis, MN 55414
(651) 201-2764
www.mn.gov/boards/dietetics-and-nutrition

**Minnesota Board of Examiners
for Nursing Home Administrators**

2829 University Avenue Southeast, Suite 404
Minneapolis, MN 55414
(651) 201-2730
www.mn.gov/boards/nursing-home

Minnesota Board of Nursing

2829 University Avenue Southeast, Suite 200
Minneapolis, MN 55414
(612) 317-3000
www.mn.gov/boards/nursing

Minnesota Board of Physical Therapy

2829 University Avenue Southeast, Suite 420
Minneapolis, MN 55414
(612) 627-5406
www.mn.gov/boards/physical-therapy

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 a lot 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 or pharmacist 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 or pharmacist 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.
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, Minnesota 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 or pharmacist 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 or pharmacist 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 Senior LinkAge Line at (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.

Medicare Part D Prescription Drug Benefit

A prescription drug benefit under Medicare, known as Part D, is 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. Formularies can change from year to year, so check your plan's formulary during the Medicare open enrollment period to make sure your plan still carries the drugs 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. The standard benefit requires enrollees to pay: a monthly premium set by the plan; a deductible; 25 percent cost-sharing up to the initial coverage limit; 100 percent of drug costs until their out-of-pocket spending reaches a set limit (this is known as the “donut hole” gap in coverage); and a small co-pay or 5 percent of their drug costs thereafter, whichever is higher. 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 (800) MEDICARE. You may also contact the Senior LinkAge Line at (800) 333-2433 for assistance with Medicare Part D.

Medigap 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 if you have original Medicare. You don’t need a Medigap policy if you are covered by a Medicare Advantage plan.

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.

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 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; and
 6. A statement that the policy can be canceled by the consumer within 30 days of its start.
 - **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 180 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 an 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 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, 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 280, St. Paul, MN 55101
(651) 539-1500 or (800) 657-3602
www.mn.gov/commerce

Nursing Home Care

The Centers for Medicare and Medicaid Services publish a free booklet entitled *Guide to Choosing a Nursing Home or Other Long-Term Care* 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 (800) Medicare or on the web at www.medicare.gov. The Minnesota Department of Health offers a report card on Minnesota nursing homes on its website at www.health.state.mn.us or nhreportcard.dhs.mn.gov.

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. We also publish a flyer called *Medical Billing Pointers*. You may obtain these publications at www.ag.state.mn.us or by calling (651) 296-3353 (Twin Cities Calling Area) or (800) 657-3787 (Outside the Twin Cities). In addition, the Minnesota Department of Commerce regulates and accepts complaints concerning such activity, and can be reached by phone at (651) 539-1500.

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. Most Minnesota hospitals 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:

- 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 Minnesota Attorney General's Office for patients who need assistance.

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

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 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 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.

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 2003. You may have noticed that your health care provider asks you to sign various notices and consent forms. 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. The records should be provided in the form requested by the patient if it is readily producible in that form.
- **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 privacy procedures and each covered entity must designate a privacy officer.
- **Restrictions on Marketing:** The final privacy rule sets some 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.
- **Health Care Identity Theft:** Because of concern about identity theft, Congress enacted the Fair and Accurate Credit Transaction (FACT) Act of 2003, which applies to financial institutions and other entities that accept payments over time. Under FACT, the Federal Trade Commission (FTC) has enacted a "Red Flag Rule" that requires covered entities, which can include health care companies that offer credit or deferred billing, to develop and implement a written identity theft prevention program. If you think that your private health information has been used for identity theft, you should contact the FTC as follows:

FTC Identity Theft Data Clearinghouse

600 Pennsylvania Avenue Northwest, Washington, D.C. 20580

(877) 382-4357

www.ftc.gov/idtheft

The United States Department of Health and Human Services Office for Civil Rights (OCR) has primary jurisdiction to oversee and 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, Midwest Region
233 North Michigan Avenue, Suite 240, Chicago, IL 60601-5519
(800) 368-1019
www.hhs.gov/hipaa

Medical Information Bureau

MIB Group, Inc. is an organization that compiles a central database of medical information. Approximately 430 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 (866) 692-6901. For other questions or to correct your report, write to:

MIB Group, Inc.
50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734
(866) 692-6901
www.mib.com

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 Department of Health regulates many health care facilities, such as hospitals and nursing homes, and health maintenance organizations (HMOs), such as Medica, Blue Plus, PreferredOne, 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 or (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 280, St. Paul, MN 55101

(651) 539-1500

www.mn.gov/commerce

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 (Twin Cities Calling Area) or (800) 657-3787 (Outside the Twin Cities) and we will assist you in identifying the proper regulatory agency.

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

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.

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 up to 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 up to 36 months by electing continuation. The coverage for the child would cost 102 percent of the premium, including any employer contributions.

Can an employee continue his or 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.

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. In addition to private health insurance, certain government plans cover some people. If you have web access, most of the programs listed are described at www.mn.gov/dhs. If you do not have access to the Internet, you may be able to do so at your local public library.

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 call the EBSA at (866) 444-EBSA (3272) or go online at www.dol.gov/agencies/ebsa.

Government Programs and Assistance

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 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 composition. For example, as of July 1, 2018, for adults without children in the home the income limit is \$1,345 a month or \$16,146 a year for one person. For children ages 2-18 living in a family of four to be eligible, the family must meet an income limit of \$5,752 per month. Contact your county's human services agency for more information about eligibility requirements. You may also call the MA Help Desk at (651) 431-2670 or (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:

1. Be certified disabled;
2. Be at least 16 but under 65 years old;
3. Be 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 and income do not count toward the asset limitation and premium calculation. 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 Disability Hub MN at (866) 333-2466 or online at disabilityhubmn.org for more information. You may also call the MA Help Desk at (651) 431-2670 or (800) 657-3739.

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 limits. For example, as of January 1, 2018, a family of four must not exceed a monthly gross income limit of \$4,100 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 without paying a premium. Adult enrollees have co-pays ranging from \$3 to \$25 for physician services, prescription drugs, outpatient services, and eyeglasses.

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

540 Cedar Street, St. Paul, MN 55101

(651) 297-3862 or (800) 657-3672

www.mn.gov/dhs

Medicare

Medicare is the federal government's health insurance program for people 65 years old and older as well as certain younger people with disabilities. Medicare Part A covers hospital and nursing home services. Part B covers physician and other professional services. Part C includes Medicare Advantage plans run by private companies approved by Medicare that encompass Part A, Part B, and usually other coverage including prescription drugs. 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 15 for further information on Part D.

In addition, if you have original Medicare coverage (not a Medicare Advantage plan), 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 original 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 (800) 772-1213 (TTY: (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 electronic format in English or in Spanish, by calling (800) MEDICARE or (800) 633-4227 (TTY: (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 Disabled and Working Individuals (QDWI). Please note that the dollar amounts, below, are effective from July 1, 2018 through December 31, 2018. The numbers change each year because they are based on the federal poverty guidelines. (The changes are usually small increases.) To get up-to-date dollar amounts after December 31, 2018, please contact the Senior LinkAge Line at (800) 333-2433, your local county human services agency, or the Minnesota Department of Human Services at (651) 431-2000.

Qualified Medicare Beneficiary (QMB)

QMB pays your Medicare premiums, deductibles, co-insurance, and co-payments. To qualify, effective July 1, 2018, 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 \$1,032 for a single person or \$1,392 for a family of two.

Service Limited Medicare Beneficiary (SLMB)

SLMB pays your Medicare Part B premium. To qualify, effective July 1, 2018, 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 \$1,234 for a single person or \$1,666 for a family of two.

Qualified Individuals (QI)

QI also pays for Medicare Part B premiums. To qualify, effective July 1, 2018, you must:

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 \$1,386 for a single person or \$1,872 for a family of two.

Qualified Disabled and Working Individuals (QWDI)

QWDI pays your Medicare Part A premium if you are not eligible for premium-free Part A and you meet income and asset limits. To qualify, effective July 1, 2018, your:

1. Assets may not exceed \$4,000 for a single person or \$6,000 for two people; and
2. Monthly income may not exceed \$2,044 for a single person or \$2,764 for a family of two.

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

540 Cedar Street, P.O. Box 64976, St. Paul, MN 55164-0976

(651) 431-2500 or (800) 882-6262

Senior LinkAge Line: (800) 333-2433

www.mnaging.net

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 12 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 Minnesota Attorney General's Office, you may do so as follows:

Office of Minnesota Attorney General Keith Ellison

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

(651) 296-3353 (Twin Cities Calling Area)

(800) 657-3787 (Outside the Twin Cities)

(800) 627-3529 (Minnesota Relay)

www.ag.state.mn.us

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 (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 a payment from the health plan for a particular patient. This amount is reduced for each treatment or referral the patient receives, which means that the physician or clinic makes less money if more referrals and treatments are provided. 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. Minnesota 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 Organization (URO): 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.

Consumer Questions or Complaints

The Minnesota Attorney General's Office answers questions regarding numerous consumer issues. The Attorney General's Office also provides assistance in resolving disputes between Minnesota consumers and businesses and uses information from consumers to enforce the state's civil laws. We welcome your calls!

If you have a consumer complaint, you may contact the Attorney General's Office in writing:

Minnesota Attorney General's Office
445 Minnesota Street, Suite 1400
St. Paul, MN 55101

You can also receive direct assistance from a consumer specialist by calling:

(651) 296-3353 (Twin Cities Calling Area)
(800) 657-3787 (Outside the Twin Cities)
(800) 627-3529 (Minnesota Relay)

Additional Publications

Additional consumer publications are available from the Minnesota Attorney General's Office. Contact us to receive copies or preview the publications on our website at www.ag.state.mn.us.

- Car Handbook*
- Conciliation Court*
- Credit Handbook
- Guarding Your Privacy: Tips to Prevent Identity Theft
- Home Building and Remodeling
- Home Buyer's Handbook
- Home Seller's Handbook
- Landlords and Tenants: Rights and Responsibilities*
- Managing Your Health Care
- Manufactured Home Parks*
- Minnesota's Car Laws
- Phone Handbook
- Probate and Planning: A Guide to Planning for the Future
- Seniors' Legal Rights
- Student Loan Handbook
- Veterans and Service Members

**Available in Spanish*

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