

REPORT TO INDEPENDENT EXHIBITORS ON HEALTH CARE SOLUTIONS AND POLICY

SEPTEMBER 2008



NATIONAL ASSOCIATION OF THEATRE OWNERS
WASHINGTON, D.C.

www.natoonline.org

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EXECUTIVE SUMMARY

As small business owners, you confront steep challenges locating adequate health care for yourselves and your employees—but there are more options than you might think. This report will help you navigate the array of health plan and health insurance carrier resources and hopefully find the right plan.

Before researching health insurance options and selecting a reputable insurer, you should determine the needs of your employees. It is helpful to discuss options with your employees, while letting them know that you might not be able to afford all forms of coverage or that they might have to bear some of the financial burden. Once you have established your health insurance needs and those of your employees, this report will provide you with the tools and resources to select a reputable health carrier and find the right plan, ranging from consumer-directed health care (CDHC) to managed care.

Managed care is any system that is designed to deliver health care while controlling costs by having a health plan and providers share financial responsibility. Most Americans who have health insurance are enrolled in managed care plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Point-of-Service (POS) plans. Managed care plans usually include a set group of providers and individuals must pay set premiums. Providers within these groups contract with the insurers and agree to accept the plans' rates. Care outside such a group in some cases becomes the responsibility of the beneficiary or might be only partially covered.

Whereas HMO, PPO and POS plans largely rely on negotiating with health care providers to keep down medical costs, small business owners increasingly turn to CDHC as a way to have employees assume more responsibility for controlling costs. CDHC plans take many forms, but most commonly as health savings accounts (HSAs), health reimbursement arrangements

(HRAs) or flexible spending accounts (FSAs). These tax-advantaged accounts are used to pay enrollees' health care expenses, while unused balances in HSAs, and sometimes HRAs, may accrue for future use.

Employees enrolled in CDHC plans are more actively involved in making health care purchasing decisions and will have an incentive to purchase health care more prudently, according to the Government Accountability Office. HSAs can be funded entirely by the employee or by a combination of employer and employee pre-tax dollars, while HRAs are solely employer-funded accounts. FSAs allow employees to contribute some of their own pre-tax earnings to an account to help pay for health care costs, but all account funds must be spent within the plan year.

This report details the differences among the most common health care plans and provides resources and tools to research what plan works best for your business. The information presented here also explores ways to cut health care costs, including details on professional employer organizations, walk-in medical clinics, wellness programs and “mini-medical” plans.

In addition, you will become acquainted with health care reforms and current legislation being considered in Congress. Enacting comprehensive health care reform and finding market-based solutions will increase access and affordability for small businesses throughout the nation. NATO currently supports efforts to enact legislation establishing small business health plans, reforming medical liability laws, creating health care tax deductions and exempting small businesses from state health insurance mandates.

No matter whether you are buying health insurance for the first time or considering changing plans, this report provides the resources and tools to maximize benefits and save money.

INTRODUCTION

Soaring health care costs and ever-rising insurance premiums make it increasingly difficult for small businesses to offer employees and dependents health coverage. Health insurance costs for small businesses have skyrocketed 129 percent over the last eight years, with workers in the country's smallest companies paying an average of 18 percent more in premiums for the same benefits as those in the largest firms, according to data from the National Federation of Independent Businesses. Consequently, more and more small business owners are looking to their employees to share a greater part of the costs associated with providing health care or they are simply unable to offer health benefits. So, even when a small business owner offers health coverage, their employees might not be able to afford signing on.

As a result, small business workers and dependents made up roughly 60 percent of the 45 million people in America without health insurance in 2007. While Census Bureau figures released August 26, 2008, show the number of uninsured people unexpectedly dropped from 47 million the year before, the drop is most likely due to the fact government health programs boosted enrollment to cover an additional 2.7 million individuals.

Premiums for employer-sponsored health insurance increased an average of 6.1 percent in 2007, less than the 7.7 percent increase reported

last year but still higher than the increase in workers' wages (3.7 percent) or the overall inflation rate (2.6 percent), according to the 2007 Employer Health Benefits Survey conducted by the Kaiser Family Foundation and Health Research and Education Trust. The 6.1 percent average increase in 2007 was the slowest rate of premium growth since 1999, when premiums rose 5.3 percent. Since 2001, premiums for family coverage have increased 78 percent, while wages have gone up 19 percent and inflation has gone up 17 percent, the survey found. The average premium for family coverage in 2007 was \$12,106, and workers on average paid \$3,281 out of their paychecks to cover their share of the cost of a family policy.

While the 60 percent of firms offering health benefits to at least some of their workers in 2007 was statistically unchanged from the previous year's offer rate of 61 percent, it remains significantly lower than it was in 2000, when 69 percent of firms offered health benefits, according to Kaiser/ HRET. Furthermore, only 45 percent of the smallest firms with three to nine workers offered health benefits to employees in 2007, down from 58 percent in 2001. The percentage of businesses with fewer than 200 employees that offer insurance dropped to 59 percent last year, down from 66 percent in 2002. Meanwhile, 99 percent of all large firms with at least 200 workers offered their employees health benefits.

For more information view the Kaiser/HRET survey at www.kff.org/insurance/7672.

Percentage of Firms Offering Health Benefits, by Firm Size 1999-2007									
	1999	2000	2001	2002	2003	2004	2005	2006	2007
3-9 Workers	56%	57%	58%	58%	55%	52%	47%	48%	45%
All Small Firms (3-199 Workers)	65	68	68	66	65	63	59	60	59
All Large Firms (200 or More Workers)	99	99	99	98	98	99	98	98	99
All Firms	66	69	68	66	66	63	60	61	60
Source: <i>Employer Health Benefits: 2006 Annual Report</i> , The Kaiser Family Foundation and the Health Research and Educational Trust									

CHAPTER 1

THE BASICS OF HEALTH INSURANCE

As medical care advances and treatments increase, health care costs also increase. The purpose of health insurance is to help you pay for care. It protects you, your employees, and dependents financially in the event of an unexpected serious illness or injury that could be very expensive. In addition, people are more likely to get routine and preventive care if they have health insurance.

HOW DO YOU GET INSURANCE?

Most people get health insurance through their employers or organizations to which they belong. This is called group insurance. People who do not have access to this insurance may choose to purchase their own individual health insurance directly from an insurance company. Many people get health insurance through government programs that operate at the national, state, and local levels.

GROUP INSURANCE

Group health insurance is typically offered by employers. Or, if you are a member of a union, professional association, or other group, you may be able to get group coverage through that organization.

Some employers allow employees to choose between several plans, including both indemnity insurance and managed care. Other employers offer only one plan. Some group plans offer dental and/or vision benefits as well as medical benefits. So it is important to compare plans to find the one that offers the benefits you and your employees need most. Once you enroll in a health insurance plan, you usually cannot change to another plan

until the next open season, usually set once a year.

When group health insurance is an employee benefit, the employer usually pays a portion or all of the premiums. This means your employees' costs for health insurance premiums will be lower than they would be if the employees paid their entire premium alone. When a person gets group insurance through membership in an organization, he or she usually will benefit from being a member of a large group. The person may pay less for premiums than an individual would pay. However, the organization often does not pay a share of the premium, meaning he or she may be responsible for paying the entire premium.

INDIVIDUAL INSURANCE

If you are self-employed, you may not have access to group insurance. You may, however, be able to purchase individual coverage directly from an insurance company. When you buy your own health insurance, you should shop around to find a plan that fits your needs at a price that you are willing to pay. Most self-employed workers are able to deduct their health insurance premiums from their federal taxable income, providing them with an important tax saving. Most states also offer similar tax preferences. If you are self-employed and buy individual health insurance, you should consult a tax advisor to find out if you are eligible for this deduction.

This information is available from the Agency for Healthcare Quality and Research. For more information, visit www.ahrq.gov/consumer/insuranceqa/index.html.

CHAPTER 2

WHICH TYPE OF GROUP INSURANCE IS RIGHT FOR YOU

When choosing what health insurance is right for your business, you should carefully compare costs and coverage. The Agency for Healthcare Quality and Research, a branch of the U.S. Department of Health and Human Services, says to compare:

- Premiums.
- Coverage/benefits.
- Access to doctors, hospitals, and other providers.
- Access to after hours and emergency care.
- Out-of-pocket costs (coinsurance, copays, and deductibles).
- Exclusions and limitations.

As an employer, you need to be sure your employees understand their coverage. They need to know what services are covered, what steps they need to take to get the care they and their family members need, and when they need prior approval to ensure coverage for care.

Despite some differences, indemnity and managed care plans share various features. For example, both indemnity and managed care cover an array of medical, surgical, and hospital services. While most plans offer some coverage for prescription drugs, some plans also have at least partial coverage for dentists and other providers.

The major difference between indemnity (non-network based coverage) and managed care plans (network-based coverage) concerns choice of doctors, hospitals, and other providers; out-of-pocket costs for covered services; and how bills are paid. The following descriptions of these plans can be found by visiting www.ahrq.gov.

INDEMNITY INSURANCE

This type of coverage offers more flexibility in choosing doctors and hospitals. Usually, you can choose any doctor you wish, and you can change doctors at any time. Although you usually will not need a referral to see a specialist or go for x-rays or tests, you may need paperwork, such as your medical records, from your primary care physician. Be sure to ask your doctor if there's any paperwork that you will need to take with you.

If you have indemnity insurance, your plan only pays part of your medical bills. You are responsible for the rest. Your out-of-pocket costs are likely to be higher for certain services than with some managed care plans. Usually, you will need to spend a certain amount each year before your plan begins to pay benefits. This amount is called a deductible. Deductibles might range from \$100 to \$300 per year per covered person or \$500 or more per year for a family.

If you have an indemnity plan, you may have more paperwork to do. Some doctors will submit the claim for you. Once the doctor receives payment from the insurance company, he or she will bill you for the difference. With other doctors, you will have to pay the entire bill and file a claim with your insurance company to be reimbursed. Indemnity insurance pays a portion of the bill—usually 80 percent—after the deductible has been met, although this may vary. You pay the remainder, usually 20 percent of the total bill. This is called coinsurance.

Indemnity policies typically have an out-of-pocket maximum. This means that once your expenses reach a certain amount in a given calendar year, the fee for covered benefits typically will be paid in full by your insurance plan. If your doctor bills you for more than the reasonable and customary charge, you possibly may have to pay a portion of the bill. If you have Medicare coverage, there are limits on how much a physician may charge you above the usual amount.

There also may be lifetime limits on benefits paid under the policy. Most experts recommend that you look for a policy with a lifetime limit of at least \$1 million. Anything less may not be sufficient.

MANAGED CARE

More than half of all Americans who have health insurance are enrolled in a managed care plan. Managed care plans usually cover a wide range of health services. With these plans, costs are lower when patients use the doctors and other providers who participate in the plan (network providers).

In most cases, you will not have to fill out any insurance forms or submit any claims to the insurance company when you use in-network providers. Usually, you will pay a copay (typically \$10 to \$20 for an office visit) each time you go to the doctor or hospital or fill a prescription. Your copay may vary depending on whether you see your primary care doctor or a specialist and whether you receive a generic or brand name prescription drug.

Most managed care plans have a list of drugs that they cover, called a formulary. Your copay for prescription drugs will probably depend on whether you are getting a generic drug, a brand name formulary drug, or a brand name drug not on the plan's formulary. For example, the copay might be \$10 for a

generic drug, \$25 for a formulary drug, and \$40 for a brand name non-formulary drug.

Some managed care plans have a mail-order pharmacy option. This means that you send your doctor's prescription for routine maintenance drugs (for example, blood pressure medicine, drugs to control blood sugar, and other drugs used on a regular basis) to the mail order pharmacy. In most cases, you will receive a three-month supply of your medication by return mail. You still pay a copay, but your cost may be lower than it would be at a local retail pharmacy.

If you choose to enroll in a managed care plan instead of an indemnity plan, you may have lower out-of-pocket expenses for health care, as long as you see doctors who are part of the plan (in-network providers). There are three main types of managed care plans:

- (1) Health Maintenance Organizations (HMOs)
- (2) Preferred Provider Organizations (PPOs);
- (3) Point-of-Service Plans (POS).

All three types of managed care plans have contracts with doctors, hospitals, and other providers. They have agreed on certain fees with these providers. As long as you get your care from a plan provider, you typically will be responsible only for any cost-sharing your plan requires.

Health Maintenance Organization

HMOs have long been known for a focus on prevention and wellness. Traditionally, HMOs required that you receive most of your care from one primary care physician (PCP) who is aware of your total health picture. If you belong to an HMO, usually you must receive all of your medical care from network providers, except in emergencies. HMOs usually have flat copayments rather than deductibles and co-insurance and no lifetime limits on coverage.

After enrolling in an HMO, you typically will need to select a PCP who will be responsible for coordinating all of your care. PCPs may be family practice doctors, internists, pediatricians, obstetricians-gynecologists, or general practitioners. If you become ill, your PCP will see you first, unless it is an emergency, and will give you a referral if he or she thinks you need to see a specialist. Usually, your HMO will not provide coverage for a specialist without this referral. In most cases, you must see a specialist who participates in your HMO. Sometimes, in special circumstances, HMO patients may be referred to providers outside the HMO network and still receive coverage.

If you need to be admitted to the hospital and it is not an emergency, you may have to obtain precertification from your plan. In most cases, your physician or hospital will take care of this. Non-emergency hospital care may not be covered without precertification. In case of an emergency admission, you or a family member, your doctor, or your hospital will need to contact your plan within a certain timeframe (usually within 48 hours of admission) to obtain written confirmation of coverage for the hospital stay.

Today, some HMOs do not follow this "primary care model." So, if you are considering a traditional HMO, it is important to compare the features and requirements among the various HMO plans that are available to you.

Preferred Providers Organizations and Point-of-Service Plans

PPOs and POS plans combine features from both fee-for-service and HMOs. PPOs and POS plans offer more flexibility than HMOs in choosing physicians and other providers. POS plans have primary care physicians who

coordinate patient care, but in most cases, PPOs do not. Premiums tend to be somewhat higher in PPOs and POS plans than in traditional HMOs.

Generally, the greater the emphasis on in-network care, the lower the premiums and the more comprehensive the benefits will be. Consumers and employers make tradeoffs, deciding which is more important: a greater choice of providers or a lower premium. If you are enrolled in a PPO or POS plan, your out-of-pocket expenses will be less if you use a provider who is part of the plan (a network provider). However, you will still get some reimbursement if you receive a covered service from a provider who is not in the network. In this case, your reimbursement will be at a lower level than if you used an in-network provider.

If you choose to go out of network for your care, you may have to meet a deductible before your plan begins to pay benefits. Also, you may have to pay the bill yourself and submit paperwork to the plan for reimbursement of covered expenses. If you are in a PPO, you will not need a referral to see a specialist or get other types of care, but you may need to take some paperwork with you.

Be sure to ask your doctor if you will need a written order or other documentation when you are referred to a specialist, laboratory, or other provider. When you go out of the plan's network for care, PPOs and POS plans work like fee-for-service plans and charge you coinsurance. For PPOs, this coinsurance may be different than the coinsurance charged for in-network providers. Also, you may have to pay the total cost of care right away and then file a claim with your insurance company to get the allowable reimbursement for out-of-plan care.

Chapter 3

Consumer-Driven Health Care

Consumer-directed health care (CDHC) plans allow individuals to have greater control over their health care. The major types of consumer-directed coverage are:

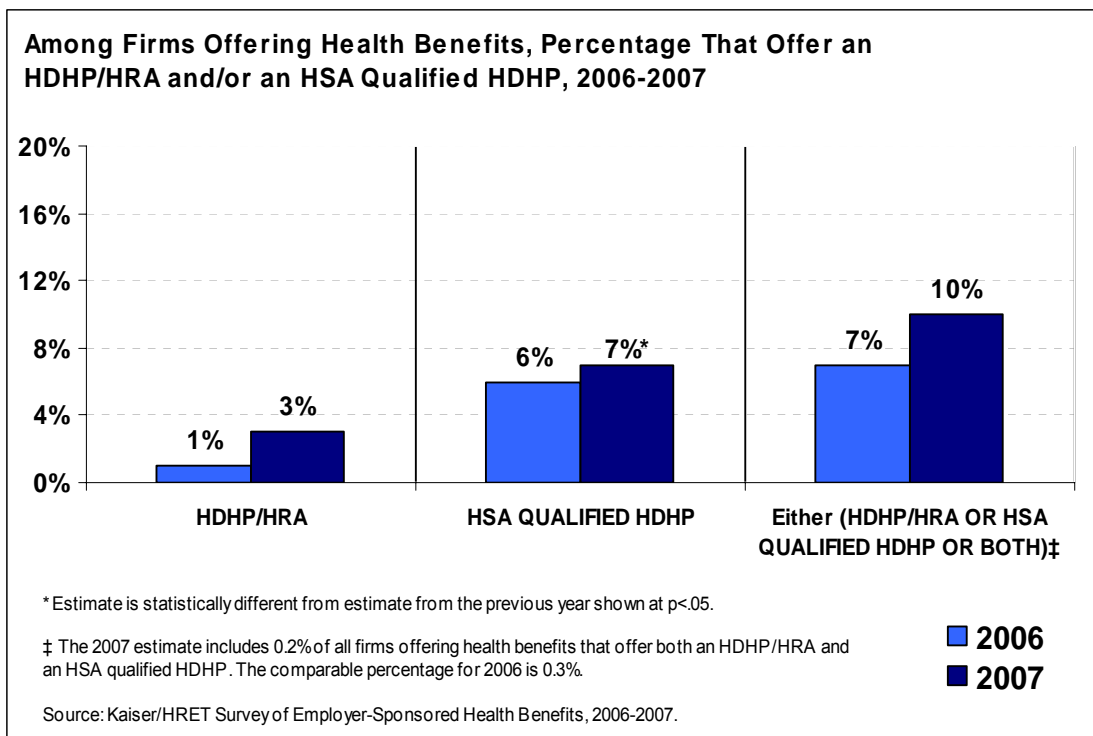
- Health Savings Accounts (HSAs)
- Health Reimbursement Arrangements (HRAs).
- Flexible Spending Arrangements (FSAs).

An estimated 3.8 million workers are enrolled in CDHC plans, about equally divided between HDHPs that qualify for an HSA and plans with an HRA, according to Kaiser/HRET. These plans feature an HDHP and a tax-preferred saving option, from which employees can pay for their out-of-pocket medical expenses.

“Such plans are often described as consumer-driven because people pay directly for a greater share of their health care and may have an incentive to minimize cost. They also may offer tools to help consumers choose providers based on cost and quality,” Kaiser states.

HEALTH SAVINGS ACCOUNTS

A health savings account is a type of medical savings account that allows you to save money to pay for current and future medical expenses on a tax-free basis. In order to be eligible for an HSA, you must be covered by a high-deductible plan, not have any other health insurance (including Medicare), and not



be claimed as a dependent on someone else's tax return.

You can use this account to pay for your qualified health expenses, including expenses that the plan ordinarily doesn't cover, such as eyeglasses and hearing aids. Expenses paid out of the HSA that are eligible expenses under your high-deductible health plan will count toward the plan's deductible.

During the year, you can make voluntary contributions to your HSA using before-tax dollars. In some cases, employers may set up and help fund HSAs for their employees. An HSA earns interest. If you have a balance in your HSA at the end of the year, it will "roll over," allowing you to build up a cushion against future health expenses. An HSA allows you to accumulate funds and retain them when you change plans or retire.

For more information on HSAs visit the U.S. Treasury Department at www.treas.gov/offices/public-affairs/hsa. For more information on health insurance companies offering HAS-eligible plans in your state, visit www.HSAInsider.com. To compare different company policies in most states, visit www.ehealthinsurance.

HIGH-DEDUCTIBLE HEALTH PLANS

High-deductible health plans that can be used with HSAs are now being offered by many insurers. As of 2008, individuals contributing to an HSA must be covered by a health plan with an annual deductible of not less than \$1,100 for self-only coverage and \$2,200 for family coverage.

The deductible generally applies to all expenses, including prescriptions and doctor office visits, but in some cases, preventive care does not count toward meeting the deductible. However, most plans will cover

2008 HDHP and HSA Amounts	
Individual Coverage	2008
HDHP Minimum Annual Deductible	\$1,100
HDHP Maximum Out-of-Pocket Amount	\$5,600
HSA Maximum Annual Contribution Level	\$2,900
Family Coverage	2008
HDHP Minimum Annual Deductible	\$2,200
HDHP Maximum Out-of-Pocket Amount	\$11,200
HSA Maximum Annual Contribution Level	\$5,800*
55 & Older Catch-up Contributions	\$900
*The maximum contribution is the lesser of the indexed amount of the HDHP deductible amount. Source: Internal Revenue Service; http://www.irs.gov/formspubs/article/0,,id=178009,00.html .	

preventive services, such as routine office visits, before you have met your deductible.

Under a high-deductible plan, out-of-pocket expenses in 2008 cannot exceed \$5,600 for self-only coverage and \$11,200 for family coverage. These dollar amounts are adjusted annually to account for inflation, and they include deductibles, copays, and other amounts, but not premiums.

After the deductible has been met, some plans will have a coinsurance of 10 to 15 percent of expenses but only up to the out-of-pocket limit in the plan. After you meet the out-of-pocket limit, the plan will pay 100 percent of expenses. Other plans will pay 100 percent after the deductible has been met.

Some insurers have negotiated discounted prices with participating physicians and hospitals, resulting in substantial savings to consumers who purchase high-deductible health plans. If you are considering this type of coverage, be sure to inquire about discounted prices.

HEALTH REIMBURSEMENT ARRANGEMENTS

Health reimbursement arrangements (HRAs) may be established by employers to pay employees' medical expenses. An HRA must be set up by an employer on behalf of its employees, and only the employer can contribute to it. The employer decides how much money to put in an HRA, and the employee can withdraw funds from the account to cover allowed expenses. HRAs often are established in conjunction with a high-deductible health plan, but they can be paired with any type of health plan or used as a stand-alone account.

Federal law allows employers to determine whether employees can carry over all or a portion of unspent funds from year to year. Also, employers can decide whether account balances will be forfeited if an employee leaves the job or changes health plans.

Visit the U.S. Office of Personnel Management at www.opm.gov/hsa/hra.asp. For more information on HRAs, visit www.or.regence.com/agent/product/docs/healthReimbArrangFAQ.pdf. For plan options available through NFIB, visit www.affinityhealthplans.com/nfib/hra.php.

FLEXIBLE SPENDING ARRANGEMENTS

Flexible spending arrangements (FSAs) are set up by employers to allow employees to set aside pre-tax money to pay for qualified medical expenses during the year. Only employers may set up an account, and employers may or may not contribute to the account. Also, there may be a limit on the amount that employers and employees can contribute to a health flexible spending

arrangement. Health FSAs can be offered in conjunction with any type of health insurance plan, or they can be offered on a stand-alone basis. In the past, health FSAs were subject to a use-it-or-lose-it rule. Now, employers may give employees a two-and-half month grace period at the end of the plan year to use up funds in the account. After that time, remaining funds from the previous plan year are forfeited.

If you have a health FSA arrangement, you should try to anticipate your health care expenses for the coming year to avoid losing any money that you contribute and don't spend.

Additional information on HSAs, HRAs, FSAs and HDHPs can be found at www.cahi.org/cahi_contents/resources/pdf/n124HSAFSAHRAJan07pdf.pdf and www.irs.gov/publications/p969/ar02.html.

HSA/HRA/FSA COMPARISON TABLE

	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)	Flexible Spending Account (FSA)
Eligible Plans	Must be offered with a high deductible health plan	No restrictions (usually offered with a high deductible health plan)	No restrictions
Minimum Deductible	\$1,100 Single \$2,200 Family	No restrictions	No restrictions
Out-of-Pocket Maximum	\$5,600 Single \$11,200 Family	No restrictions	No restrictions
Eligible Contributors	Employer, employee or both	Employer	Employer, employee or both (usually employee only)
Maximum Contribution	\$2,900 Single \$5,800 Family	Employer Decision	Employer Decision
Pre-tax contributions	Yes	Yes	Yes
Year-to-Year Balance Carryover	Yes	Employer Decision	No; except COBRA
Portable, employee-owned	Yes	Employer Decision	No
Tax-free withdrawals for qualified health care expenses	Yes	Yes	Yes
Earns Interest	Yes	No	No
Withdrawals for non-qualifying medical expenses	Yes. Withdrawals for non-qualifying medical expenses are subject to income taxes and a 10% penalty. Individuals who are over age 65 are not subject to 10% penalty.	No	No

LEADING HSA ADMINISTRATORS

HSA Administrators																															
Interest	Varies depending on investment chosen	5%	<table border="1"> <tr><td>\$0-\$499:</td><td>1%</td></tr> <tr><td>\$500-2.5K:</td><td>1.73%</td></tr> <tr><td>\$2.5K-5K:</td><td>2.13%</td></tr> <tr><td>\$5K-15K:</td><td>3.15%</td></tr> <tr><td>Over 15K:</td><td>4.41%</td></tr> </table>	\$0-\$499:	1%	\$500-2.5K:	1.73%	\$2.5K-5K:	2.13%	\$5K-15K:	3.15%	Over 15K:	4.41%	<table border="1"> <tr><td>\$0-\$1K:</td><td>1.8%</td></tr> <tr><td>\$1K-\$5K:</td><td>2.3%</td></tr> <tr><td>\$5K-\$10K:</td><td>2.7%</td></tr> <tr><td>\$10K-\$15K:</td><td>3.2%</td></tr> <tr><td>Over \$15K:</td><td>4.2%</td></tr> </table>	\$0-\$1K:	1.8%	\$1K-\$5K:	2.3%	\$5K-\$10K:	2.7%	\$10K-\$15K:	3.2%	Over \$15K:	4.2%	<table border="1"> <tr><td>\$0-\$1K:</td><td>1%</td></tr> <tr><td>\$1-\$5K:</td><td>2%</td></tr> <tr><td>Over \$5K:</td><td>3%</td></tr> </table>	\$0-\$1K:	1%	\$1-\$5K:	2%	Over \$5K:	3%
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\$500-2.5K:	1.73%																														
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\$5K-\$10K:	2.7%																														
\$10K-\$15K:	3.2%																														
Over \$15K:	4.2%																														
\$0-\$1K:	1%																														
\$1-\$5K:	2%																														
Over \$5K:	3%																														
FDIC Insured (funds in Interest-bearing account)	NO	Yes	Yes	Yes	Yes																										
Securities Investment Options (Brokerage Account)	Consumers can direct their account balances among several Wells Fargo mutual funds	YES (For accounts over \$2,000)	Investment options are available. Choose from over 7,000 mutual funds, 3,000 of which are no-load.	Investment options are available. Choose from over 7,000 mutual funds, 3,000 of which are no-load.	Any stock, bond or mutual fund																										
Set Up Fee	\$0	\$10	\$18	\$0	\$15																										
Monthly Maintenance Fee	\$4.25	\$3	\$2.25 (Waived on balances of \$3,000 or more)	\$2.50 (Free first 90 days; waived if balance is over \$2,500 or with any direct deposit)	\$2.50																										
Closing Fee	\$0	N/A	\$25	N/A	\$20																										
Brokerage Account Fee	\$0	N/A	\$0	N/A	\$0																										
Checks	NO	YES (\$1.50 / 6 checks)	YES (\$7.95/ 50 checks)	YES (no charge for first order)	NO																										
Debit Cards	YES (no charge for first two cards; \$10 thereafter)	Yes	YES (no charge for first two cards)	YES (no charge for first two cards)	YES (no charge for first card, \$5 thereafter)																										
Auto Reimbursement	NO	NO	NO	NO	YES (e-checks and e-deposits)																										
Balance Requirements	\$100 to open	\$25 monthly deposit required	\$25 initial deposit	None	None																										
Statements/ Reporting	Quarterly and Year End	Monthly (online); mailed upon request	Monthly and Year End	Monthly and Year End	Quarterly, Year End and real-time access to account status																										
Portable	YES	YES	YES	YES	YES																										

Source: ehealthinsurance.com

Important Notices and Disclaimer: This HSA administrator comparison matrix is a summary for informational purposes only. The information in the matrix has been provided by the HSA administrators identified above. Because this information changes frequently, check with the relevant HSA administrator to confirm its accuracy. You should also review your chosen HSA administrator's enrollment documents for a more detailed description of current requirements, fees and investment options. Only the terms and conditions listed in your enrollment documents are binding.

CHAPTER 4

CHOOSING A HEALTH CARE PROVIDER

Providing workers with health insurance does not have to be an “all-or-nothing” proposition. The Small Business Administration (SBA) encourages small business owners to research available health plan and carrier options and select a reputable insurer that can provide a competitive advantage in recruiting and retaining skilled employees.

Small business owners also should determine the needs of their employees when shopping for health insurance. It is important to discuss the array of options, and let your employees know that you might be unable to afford all forms of coverage and that they might have to shoulder some of the financial burden. By including your employees in the decision-making process, they will appreciate being involved and having the opportunity to share their opinions, according to the U.S. Chamber of Commerce.

FINDING THE RIGHT PLAN

Business owners and employees who suffer from chronic health issues or visit the doctor at the first sign of illness should consider plans with a low deductible. Premiums for these individuals will be higher, but they will not be hit with having to pay for the initial \$1,000 to \$5,000 of medical costs, according to NFIB. For people who simply want health insurance to protect them from the financial burden associated with injuries and disease, HDHPs are a good option because they have lower monthly premiums.

While HDHPs can help your business save money, employees might have reservations about the high deductibles. Employers can mitigate these concerns by pairing the HDHP

Educational Websites
<ul style="list-style-type: none">● Entrepreneur.com: Insurance Center www.entrepreneur.com/insurance A long list of articles related to health insurance issues for small businesses.● AllOptions.com: Small Business Health Insurance http://insurance.alloptions.com/small-business-health-insurance.asp This site will find multiple quotes from different vendors based on the prospective customer's inputs.● Website 101: Small Business Health Insurance & Healthcare Article Library http://website101.com/Health_Insurance A site with dozens of articles specific to small business health insurance issues.● HealthDecisions.org: Agents & Brokers www.healthdecisions.org/Broker/LearningCenter This site provides in-depth tools for consumers and industry professionals to help with health care coverage decisions.● MedlinePlus: Health Insurance www.nlm.nih.gov/medlineplus/healthinsurance.html A government site that helps educate prospective health insurance buyers. <p>Source: www.work.com/health-insurance-shopping-web-sites-839</p>

with an HSA or HRA, or with a slight salary increase to offset the deductible cost. NFIB says employees might actually be ahead fiscally from such a salary increase, because few workers ever use all or even most of their benefits provided through a comprehensive, employer-sponsored health plan.

SELECTING A HEALTH CARRIER

SBA says businesses should contact an independent insurance agent or broker who can (1) explain the range of available coverage options, including managed care plans and CDHC; (2) put forward alternative plans and quotes; and (3) sell and service the policy.

Since you will have an ongoing relationship with your agent, it is important that you contact only experienced, reputable providers or agents. Avoid simply comparing prices since each insurance company quote that an agent or broker provides might be for different coverages. You should request the entire proposal from the insurer, including customer service and claims paying capabilities.

In reviewing the proposals, SBA says you should ask your agent or broker the following questions:

- Is the insurance carrier reputable and financially strong?
- Will the policy be renewed every six months or annually?
- Is the plan easy to administer? Is there a toll-free number to call to make changes or have questions answered?
- What are the penalties employees should know about? Are there any “hidden” deductibles, such as a separate inpatient hospital deductible?
- Will the insurer underwrite the policy as a group, as individuals or both?
- Does the managed care plan provide enough of a financial incentive to encourage employees to select network providers?

It also is a good idea to ask other small business owners in your area which provider or agent they use. NFIB says you should inquire about their experience with a provider regarding:

- Prices;
- Deductibles and co-pays;
- User-understandability of options (are they understandable as written in the policy description, or does each option have to be explained in detail?);
- Receptivity of agent to answer questions before and after a contract is written;
- Cost increases over previous few years;
- Cost containment options (such as disease management programs);

- Speed of claims payments for covered illnesses or accidents; and
- “Hassle-level” of payments (*i.e.*, do you and your attorney need to threaten action just to get a response?).

NFIB also points out another way to assess the overall services of a provider is to question doctors’ offices in your area about which providers have been the most and least reliable in overall servicing of claims. The claims administrator for a doctor’s office will be familiar with all major providers covering local patients and businesses, says NFIB.

Another option is to contact your state department of insurance for a list of local providers that offer group plans for small businesses. There is a chance that your state has associations that provide small businesses with favorable rates and coverage.

At the end of the day, a health insurance plan should not be purchased based on cost alone. NFIB says businesses should take into account all facets of the policy rather than just a few central features.

Contact your local SBA for additional resources or call the Small Business Answer Desk at 1-800-8-ASK-SBA. Also, visit your local Chamber of Commerce at www.chamberofcommerce.com.

Maximize Benefits and Save Money

Health Insurance In-Depth has a website that provides an online educational health insurance course at no cost. The five-lesson course is designed to educate consumers on how to maximize the benefits of health insurance policy, while saving money at the same time. The site also helps consumers uncover and design the type of policy that will fit their budget.

For more information on this educational tool, visit www.healthinsuranceindepth.com/health-insurance-course.html.

CHAPTER 5

SMART TIPS FOR BUYING HEALTH INSURANCE ONLINE

by Karen Auby

eHealthInsurance

Thanks to the Internet, buying a health insurance plan for yourself or your family is simpler than ever before. You'll find lots of valuable information online and hundreds of sites that want to sell you a health insurance plan. But buying health insurance isn't like ordering a book. Purchasing health insurance is a serious endeavor, and you'll have to provide some personal information to complete your application. So who can you trust? How can you shop smart? Here are a few tips to keep in mind:

Shop with a licensed agent

When shopping for health insurance online, selection and assistance are important. Many health insurance companies sell their plans directly to consumers, as well as through licensed agents. But by limiting your scope to a single health insurance company, you may be limiting your options.

A licensed health insurance agent can sell plans from a variety of insurance companies, provide you with personal advice and assistance and work with the insurance company on your behalf to help expedite a decision on your application. An agent can be an individual or a company with multiple agents working to find the best plan to meet your needs. Licensed health insurance agents must follow stringent guidelines mandated by the insurance companies they represent and your state department of insurance. And buying through an agent won't cost you any more than going directly to the insurance company. Make sure any online health insurance agent you work with provides easy access to their state license number.

Make sure they have quality phone support

You may never need to call your licensed online agent, but you want to make sure that they're available when you need them. A reputable agent should never hide their phone number in the fine

print. It may not be on the homepage, but you should be able to find it within one or two clicks. You'll want to be sure you're working with an insurance agent who's available for you not only when you're shopping, but also down the road after you've made your purchase. Courteous, helpful telephone assistance and easy accessibility are a great indicator that you've found a quality health insurance partner.

Look for seals of approval or quality ratings

Quality insurance companies and reliable licensed agents will typically promote the approvals or high ratings they've received from consumer advocacy groups such as the Better Business Bureau, TRUSTe or A.M. Best. When choosing an online health insurance agent, look for a Better Business Bureau Online logo. The BBBO provides reliability reports for online business, which include specific company information and reports of any consumer complaints. Your online agent should also have the approval of an Internet privacy protection organization like TRUSTe. Some of the health insurance companies you see online are big names, but others, you might not have heard of before. Look for A.M. Best ratings for health insurance companies you have questions about. A high A.M. Best is the benchmark for quality in the insurance industry.

Shopping for health insurance online might seem a little intimidating at first, but it's the best and easiest way for you to get the information, assistance and selection you need, and to make valuable connections with licensed agents. Follow these tips while you shop for health insurance online and you'll be doing what you can to protect your personal information and make the most of your time and money.

For more information, visit
www.nfib.com/object/IO_20674.html.

HEALTH PLAN INTERNET RESOURCES

Major health insurance carriers and licensed health insurance agencies operate websites that compare plans and rates and allow you to apply online, receive notification within days, and pay no fees. The following websites are among the best resources on the Internet.

Company	Website	Services
Aetna	www.aetna.com/employer	A health insurance industry giant's site regarding small business.
Bank of America: Small Business Health Insurance	www.bankofamerica.com/insurance	Site allows the user to choose a state, and the browser will return small business insurance packages based on location.
Blue Cross/Blue Shield: Employer Health Care Coverage Information	www.bluecross.com/bluefinder	Blue Cross/Blue Shield companies are collectively the largest health insurance provider. This site has their business information and products.
BuyerZone: Group Health Insurance Price Quotes	www.buyerzone.com/benefits/health_insurance	Site asks five basic insurance questions, and the engine returns five different small business insurance quotes.
eHealthInsurance	www.ehealthinsurance.com	This Internet-based agent sells insurance packages for small business owners.
HealthInsurance.com: Business Owners	www.healthinsurance.com/hi/web/basics/Business_Owners	An online insurance site that is a collaboration by two of the largest insurance firms in the industry.
Insurance.com: Small Business Health Insurance Quotes	http://www.insurance.com/Health.aspx	This online broker allows a user to search for small business health insurance by zip code.
MedHealthInsurance: Small Business Health Insurance	www.medhealthinsurance.com/smallbusiness.htm	Another broker that collects information from the potential customer, and then finds the best value out of its portfolio of vendors.
MostChoice: Group Health Insurance	www.mostchoice.com/group-health-insurance.cfm	This broker says it will find the best insurance deal based on your needs.
Wells Fargo: Small Business Group Health Insurance Overview	www.wellsfargo.com/biz/products/insurance/health/overview	The small business health insurance site of American banking giant Wells Fargo.

Source: www.work.com/health-insurance-shopping-web-sites-839

CHAPTER 6

CUT HEALTH CARE COSTS

Professional Employer Organizations (PEOs)

More and more small businesses are turning to professional employer organizations (PEOs) to manage their human resources functions, ranging from payroll to health care. A PEO hires a client company's workers and becomes the employer of record for tax and insurance purposes. PEOs benefit from pooling employees from multiple clients, which leverages greater purchasing power and lowers health insurance premiums.

The National Association of Professional Employment Organizations (NAPEO) says there are more than 700 PEOs operating in the United States, covering some 2 to 3 million workers. PEO services typically require a one-time startup fee and then an ongoing percentage of payroll, which can fluctuate from less than 5 percent to more than 15 percent, depending on the services and the average worker salary (Sloan, Julie – "Cure Your HR Ills" – FORTUNE magazine, March 28, 2007).

For more information, visit NAPEO at www.napeo.org. Information on PEO providers and PEO licensing by state can be found at www.staffmarket.com.

MINI-MEDICAL PLANS

For small business owners currently unable to fully insure their workers, limited benefit or "mini-medical" plans offer a possible alternative. NFIB says mini-medical plans,

which have lower costs than traditional health plans, provide basic coverage for doctor visits, lab work, some surgery and prescription drugs. Drawbacks of these plans include having no major medical benefits or coverage for catastrophic illness and injuries.

California Broker has an in-depth article on mini-medical plans at www.calbrokermag.com/Magazine/story/sep2005/alternativehealth.htm.

You can learn more about mini-medical plans by visiting NFIB at www.nfib.com/agla or by visiting broker and provider websites, including www.ehealthinsurance.com and www.healthbenefitsdirect.com/minimedical.aspx.

WALK-IN MEDICAL CLINICS

Walk-In Medical Clinics are an increasingly more common health care alternative for necessary but routine medical services and treatment of minor medical conditions.

Although urgent medical clinics have been around for decades, updated in-store clinics are cropping up in supermarkets, drug stores and other retail outlets throughout the country. The clinics treat patients on a walk-in basis and often are open seven days a week and include evening hours.

According to the California Healthcare Foundation, the number of such retail outfits grew from 60 in January 2006 to 280 at the beginning of this year. It is estimated that by 2012 there will be 5,000 clinics in operation. In general, the clinics are staffed by nurse

practitioners or physician assistants, and often are supervised by physicians.

In April 2007, Wal-Mart announced plans to boost its number of in-store health clinics throughout the nation. At the World Health Care Conference in Washington, D.C. last month, the retailer revealed plans to open an additional 400 in-store clinics over the next three years and possibly 2,000 within the next five to seven years, reports the American Medical Association (AMA).

Currently, Wal-Mart has clinics in 75 stores in 12 states. At the conference, Wal-Mart President and CEO Lee Scott said the clinics provide affordable access at the local level to quality health care for customers and communities, according to AMA.

WELLNESS PROGRAMS

Wellness programs are gaining popularity among employers and employees as a way to help stabilize health care costs and create a healthy work environment. Preventable chronic illnesses, such as diabetes and heart disease, affect more than 33 percent of America's workforce and account for nearly 75 percent of the country's total health care costs.

A new report from The Guardian Life Insurance Company of America found that smaller companies trail larger businesses in the implementation of wellness programs despite the fact that 82 percent of small employers said they see value in them.

Wellness programs can positively impact a company's finances and collectively reduce medical spending by helping employees change behaviors that contribute to the cost of health care. The report also found that 68 percent of small employers want their insurance carriers to assist in implementing

wellness and prevention programs to help minimize absenteeism and health care costs.

For more information on the Guardian survey, *Benefits and Behavior: The Voice of American Business Owners and Benefit Decision Makers Today*, visit

www.guardianlife.com/company_info/press_releases/june_05_2007.html.

Wellness Program Resources

The Centers for Disease Control and Prevention (CDC) sponsors websites that provide information, resources and step-by-step toolkits to help business owners improve the health of employees.

The Community Guide

This online guide provides recommendations for programs and policies to promote health. www.thecommunityguide.org

CDC Healthier Worksite Initiative

This website addresses workforce health promotion and provides useful resources for creating programs that reduce costs to employers and improve employee health and morale. Although the site was designed as a resource for wellness program planners in state and federal government, it is also helpful for non-government workplaces. www.cdc.gov/nccdphp/dnpha/hwi/index.htm

Wellness Proposals

A North Carolina-based agency that has partnered with the country's leading wellness companies. It provides wellness program information and a free-of-charge service that can receive up to 30 different wellness proposals. www.wellnessproposals.com.

CHAPTER 7

TOP THINGS TO KNOW AND CONSIDER ABOUT HEALTH INSURANCE

Provided by Blue Cross/Blue Shield of Arizona

Insurance can protect you against significant financial loss.

The purpose of insurance is to protect you against significant loss resulting from car accidents, fire, liability, and illness or personal injury. Health insurance coverage can keep you from having to pay the full cost of certain medical expenses in the event of illness or injury. Health insurance can cost a lot but having no coverage can cost a lot more. Medical bills from a minor illness can deplete your savings; a major illness can leave you bankrupt. In this respect, health insurance is a good value.

Health insurance is a contractual agreement between you and your health insurance company.

Employers and individuals agree to pay a monthly premium in exchange for the insurance company providing coverage and payment of at least some of the expenses incurred for certain medical conditions. Like most contracts, there are restrictions and stipulations. Not all medical expenses, conditions, or situations are covered by the insurance company. It is important for you to know what is covered and what is not covered in your contract with your health insurance company.

There is a difference between health care coverage and health care.

The health insurance company provides health care coverage (payment for medical expenses covered by the contract). The physician provides health care (treatment for medical conditions). Health insurance companies do not provide health care.

However, the insurance company may have a contract with the physician (an agreement that the physician will provide care to the customers of the health insurance company in exchange for a specified reimbursement).

Not all health insurance companies are alike.

Some are not-for-profit and return the money they earn into benefits and services for customers; some are for-profit plans with shareholders and stock values. Some have very large networks of physicians; some have smaller networks of physicians. Some have established standards for customer service; some do not. Some have been in business for decades; others are relatively new. It is a good idea to find out as much as you can about your insurance company and how it operates.

Not all health insurance products are alike.

A Preferred Provider Organization (PPO) contains a contracted network of physicians. However, a PPO "member" can choose between going to a physician within the network (and receiving a discount on medical services) or going to a physician that is not in the network (and paying more to receive these same services). Some PPOs offer copays: a \$5, \$10, or \$20 set fee for a physician office visit or a prescription. Most copays are priced less than a meal for a family at a fast food restaurant.

Other PPOs require the member to pay coinsurance (for example the member may pay 20% of the medical costs in-network and the health insurance company will pay 80%, or the member may pay 30% of the medical

costs out-of-network and the health insurance company will pay 70%). Coinsurance amounts vary. Other health insurance products include HMOs, open-access HMOs, point-of-service products (POS), and Health Savings Accounts (HSAs).

The lowest premium isn't always the cheapest coverage.

What is covered by your health insurance may be more important than what you pay up front for it. Ultimately, the best health insurance coverage for you will provide the benefits you may need at a price you can afford.

The premium dollar an individual or employer pays consists of several key components.

These components include medical costs, administrative costs, and the reserve dollars required for the health insurance company to remain financially solvent.

The premium dollar amount can fluctuate based on the costs of each premium component.

When medical costs increase due to high utilization (use of medical services), escalating drug costs, or higher physician and hospital reimbursement, the premium amount may also increase. When administrative costs increase due to mandated benefits from the legislature or additional legal requirements, the premium amount may also increase.

When reserve requirements are set higher due to the potential losses incurred in consumer lawsuits, the premium amount may also increase. There are many pressures today on the premium amount. Understanding the components of the premium and the impact of consumer behavior and legislation is very important in helping to control premium costs.

Knowing up-front how your health insurance company operates and what is covered or not covered in your health insurance coverage may help you in the long run.

Some people wait until they or their dependents are sick before they find out more about their health insurance company and their health care coverage. Knowing up-front how your benefits work can help you feel more confident and more secure when you use them.

CHAPTER 8

SMALL BUSINESS HEALTH CARE REFORM

Small businesses, such as independent exhibitors, are an integral part of our nation's economy. Critical to economic recovery and strength, small businesses continue to be leaders in innovation and create new jobs at a higher rate than large companies.

Congress needs to move forward aggressively in enacting comprehensive health care reform aimed at increasing access and affordability for small businesses throughout the nation. NATO joins NFIB in supporting market-based solutions that put more control in the hands of the public than the government.

For more information, visit www.nfib.com/page/healthcare.html.

SMALL BUSINESS HEALTH PLANS (SBHPs)

Small Business Health Plans (SBHPs) could reduce the number of uninsured Americans by giving small businesses the same accessibility, affordability and cost in the health insurance marketplace currently enjoyed by big business and unions.

SBHPs would provide small business owners the opportunity to band together across state lines through bona fide trade and professional associations, like NATO, to negotiate better premiums with insurers, lower administrative costs, and improve their risk profile. As a result, small businesses would have more favorable premiums and a larger selection of plans to choose from. While some states allow small businesses to purchase limited health

“Small Business Health Plans will give us, and other small businesses, a viable option in providing our employees with health benefits. It will introduce more competition to a marketplace that in some areas has reached a near monopoly.”

Ray Hallett
Hallett Cinemas LLC

insurance coverage through associations, they must comply with complex state laws and regulations. Large and medium-sized companies and labor unions that self-insure their employees and members, however, are exempt from these requirements under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA allows large organizations to preempt state regulations, thus avoiding the burdensome job of complying with different rules, regulations and benefit mandates in each of the 50 states.

Regulation of SBHPs under similar federal standards would level the playing field by affording small employers greater purchasing clout, administrative efficiencies and the same economies of scale that large businesses, like General Motors and Wal-Mart, now experience, according to NFIB. Federal regulation of SBHPs would permit them to operate across state lines, and build on the successful ERISA structure that has contributed to affordable private health care for more than 150 million Americans.

For more information on SBHPs, visit www.sbhpsnow.com.

MEDICAL LIABILITY REFORM

Reforming our country's medical liability laws should lower overall health care costs. Medical liability reform would bring a greater level of equality to the legal system and slash unnecessary litigation and legal costs, while protecting the rights of people with legitimate claims. The medical liability crisis jeopardizes both the affordability and availability of health care for small businesses. In many states throughout the country, large jury awards have forced insurance premiums to rise at exorbitant rates and have resulted in severe shortages of specialists, such as obstetricians and emergency room doctors.

Like NFIB, NATO supports medical liability reform legislation that caps non-economic damages, abolishes joint and several liability (in which two or more persons are liable for the same injury), implements a sliding scale for attorneys' contingency fees and reforms the "collateral source rule" (a rule of evidence that prohibits the admission at trial of evidence that a victim's damages were compensated from some other source).

HEALTH CARE TAX DEDUCTIONS

Under the current tax code, the self-employed are unable to deduct the cost of health insurance premiums from the wage base for FICA (Social Security and Medicare) taxes. Corporations on the other hand can deduct such costs as a business expense. As a result of not being able to deduct premiums as a business expense, the self-employed are forced to pay 15.3 percent in additional taxes compared with other business entities.

A standard deduction is supported by a group of Republicans, led by President Bush and Sen. Jon Kyle (R-AZ), according to a *Wall Street Journal* editorial. In a plan unveiled by

the White House in 2007, President Bush outlined a proposal that would replace the current health insurance tax system with a standard deduction for health insurance. Under the proposal, families buying health insurance would pay no income or payroll taxes on \$15,000 of income, while individual Americans purchasing health insurance would pay no income or payroll taxes on \$7,500 of income. The *Journal* says the deduction "would go a long way toward creating a more affordable private insurance market."

For more information, visit the White House at www.whitehouse.gov/infocus/healthcare. Additional information is available at the Coalition Supporting Equity for Our Nation's Self-Employed at www.setaxequity.org.

HEALTH INSURANCE MANDATES

One way to lower the cost of health care is to allow small businesses access to coverage that is tailored to fit their needs. As a rule, all health insurance is subject to federal health care laws, including federally mandated benefits. Small businesses, however, are subject to state-mandated benefit laws, while ERISA generally exempts large businesses from such regulations. Under this patchwork of laws, which became common during the 1990s, insurers are required to provide coverage for certain diseases and health services that vary from state to state.

More information on state mandates is located in Chapter 9.

CHAPTER 9

STATE HEALTH CARE LAWS

The National Conference of State Legislatures (NCSL) says states are leading the way in health care reform—fueled by the increasing number of uninsured Americans, the declining number of employers offering insurance to their employees, the improved fiscal conditions in the states and the lack of federal action. Among the tools states are using to reform health care are market-based initiatives, Medicaid, SCHIP expansions, and public-private partnership to increase access and affordability of insurance, according to NCSL.

Covering all uninsured children is the main goal of many states, according to NCSL. Other states, however, have adopted incremental reforms to focus on the eight in 10 uninsured Americans in working families—many of whom work for small businesses that cannot afford coverage.

For more information on what states are doing to stem the rise in health care costs, view the table on page 23 and visit NCSL’s States and Small Business Health Insurance: An Overview at www.ncsl.org/programs/health/SmallBusiness.htm#NH08.

STATE MANDATES

The federal government and the states have enacted legislation with health coverage mandates for the past 30 years. The Council for Affordable Health Insurance (CAHI) released a report in 2008 that found the number of state health insurance mandates have grown from more than 1,800 nationwide in 2007 to more than 1,900 in 2008.

Mandates are laws requiring that a health insurance policy or health plan cover (or offer to cover) specific providers or procedures. CAHI also notes, “While mandates make health insurance more comprehensive, they also make it more expensive because insurers are required to

pay for care consumers previously funded out of their own pockets.”

CAHI estimates that mandated benefits currently increase the cost of basic health coverage from a little less than 20 percent to more than 50 percent, depending on the state and its mandates. “Mandating benefits is like saying to someone in the market for a new car, if you can’t afford a Cadillac loaded with options, you have to walk. Having that Cadillac would be nice, as would having a health insurance policy that covers everything one might want. But drivers with less money can find many other affordable car options; whereas when the price of health insurance soars, few other options exist,” CAHI said in a press release on the issue.

<p>State Health Care Laws and Regulations Council for Affordable Health Insurance (CAHI)</p>
<p>Health Insurance Mandates in the States 2008 (includes a comprehensive table of mandates in each state) www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf</p>
<p>General Accounting Office (GAO)</p> <p>Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Business www.gao.gov/cgi-bin/getrpt?GAO-03-1133</p>
<p>Kaiser Family Foundation (KFF)</p> <p>State Health Facts (up-to-date data on managed care enrollment, state consumer protection laws, and state benefit requirements) www.statehealthfacts.kff.org</p>
<p>Health Insurance In-Depth</p> <p>State Health Insurance Laws and State Health Insurance Regulations www.healthinsuranceindepth.com/individual-state-guides.html</p>

**EXAMPLES OF STATE PROGRAMS TO SUBSIDIZE HEALTH INSURANCE
FOR SMALL BUSINESSES AND INDIVIDUALS**

Arkansas' Safety Net Benefit Program aims to increase health insurance coverage through a public/private partnership that will provide a "safety net" benefit package to approximately 50,000 uninsured individuals over 5 years.

Arizona's premium tax credit establishes a health insurance premium discount program for uninsured small businesses (2-25 employees) and individuals with incomes of less than 250% of the Federal Poverty Level (FPL). This allows small businesses and individuals to apply for a discount certificate to the Department of Revenue.

Kentucky's Insurance Coverage, Affordability and Relief to Small Employers (ICARE) program is a four-year pilot program that targets small employers (2-25 employees) who have been uninsured for at least 12 months and have an average salary that does not exceed 300 FPL.

The employer pays at least 50 % of premiums and the state pays \$40 per employee, per month. The incentive will be reduced each year by \$10.

Small employers who offer insurance and pay 50% or more of the premium with at least one employee in the group with a high-cost medical condition will receive an incentive to remain insured—\$60 per employee, per month, which will be reduced each year by \$15. Premiums must be discounted for a healthy lifestyle.

Maryland's Working Families and Small Business Health Coverage Act targets small business by offering subsidies for coverage and expanding Medicaid eligibility to some adult populations. In order to be eligible for the subsidy, employers must establish a Section 125 payroll deduction and offer a wellness benefit.

Montana's Small Business Health Care Affordability Act targets small businesses (2 to 9 employees) by creating a new purchasing pool—The State Health Insurance Purchasing Pool. Insurance purchased through this pool will be subsidized on a sliding scale.

Tax credits are extended to small businesses currently offering health insurance to their employees.

Program is funded by a tobacco tax.

New Mexico's New Health Plan Initiative provides low-cost basic health insurance through an employer-based benefit program in conjunction with the state.

Covers uninsured adults up to 200% FPL through employer-sponsored coverage.

Financed through employer contribution, employee contribution (based on income), and Medicaid (matched from unused SCHIP dollars).

Benefits similar to basic commercial plans.

New York's Program provides publicly funded or other type of financed reinsurance for private coverage to assume a portion of an insurer's high-cost claims.

State subsidizes the cost for expensive people with the goal of lowering premiums for all, based on the knowledge that 20% of people account for 80% of health care spending.

State requires all HMOs to offer product.

Small firms with low-wage workers, low income self-employed, uninsured workers without access to employer sponsored insurance may enroll.

Oklahoma's Employer/Employee Partnership for Insurance Coverage (O-EPIC) aims to cover an additional 50,000 residents with incomes at or below 185% FPL. The O-EPIC Premium Assistance Program will pay part of the health plan premiums for eligible employees working for qualified Oklahoma small businesses (with 25 or few employees). It is funded through state general fund revenues generated by a tobacco tax, Medicaid matching funds, and employer/employee contributions.

The Oregon Health Plan (OHP) is a limited benefit package. The program covers only a limited number of uninsured adults who are not eligible for traditional Medicaid programs or the Children's Health Insurance Program. Most adults who get OHP Standard must pay monthly premiums. OHP Standard does not have copayments. Eligibility requirements for program include:

An adult (19 years or older)

<p>Not getting Medicare</p> <p>An Oregon resident</p> <p>A U.S. citizen or a non-citizen who meets the immigration status requirement</p> <p>Individuals currently without major health insurance coverage and who have been without coverage for six months. The six-month waiting period is waived in some cases.</p> <p>Under the income limit set at the FPL</p> <p>Under the resource limit set at \$2,000</p> <p>Paid up on OHP premiums billed in the past</p>
<p>Pennsylvania's Health Investment Insurance Act (Act 77 of 2001) uses the state's tobacco settlement to provide health insurance to a number of uninsured individuals between the ages of 19 and 64. The program provides health insurance for adults meeting certain income requirements and who do not have health care coverage. This program—adultBasic—is administered by the Pennsylvania Insurance Department and offers basic benefits, including preventive care, physician services, diagnosis and treatment of illness or injury, in-patient hospitalization, out-patient hospital services and emergency accident and medical care. Participation in the adultBasic Program is based on certain eligibility requirements, which include having no other health care coverage (including Medicaid or Medicare) or lack of prior coverage under any other insurance plan for 90 days prior to enrollment, except for a person (and their spouse) who has been laid off from his/her job and has a family income below 200% FPL. This program also covers children.</p>
<p>Rhode Island WellCare is an affordable health insurance product being offered as a choice to employers with 50 or fewer employees and to Direct Pay subscribers (Rhode Islanders who do not get insurance through an employer). State-approved "Wellness Benefit Plans" are priced about 18% less than comparable plans on the market. What marks these benefit plans are their cost-sharing initiatives—including enrollee pledges to remain at a healthy weight, complete a health risk assessment, and others.</p>
<p>Tennessee's Cover Tennessee is a market based public/private partnership plan for small employers and uninsured workers with incomes below 250% of FPL. Cover Tennessee is basic, major medical coverage for \$150 a month with the cost shared equally by the individual, employer, and state government.</p>
<p>Texas's 2007 Medicaid reform legislation pending federal approval, would create a fund to cover some healthcare costs and provides money for premiums and provides assistance for private insurance enrollment and employer-sponsored plans.</p>
<p>Washington Basic Health Plan is a state-sponsored program that provides affordable health care coverage to low-income Washington residents through private health plans. Administered by The Health Care Authority that also oversees the Basic Health Plus (for children under age 19) and the Maternity Benefits Program (for pregnant women). To be eligible for Washington Basic Health Plan an individual must meet income requirements, must not be eligible for free or purchased Medicare; not institutionalized at the time of enrollment; and not attending school full-time in the United States on a student visa. Monthly premiums are based on age, income, family size, and health plan chosen. No copayments are levied for preventive care services. Washington Basic Health includes a \$150 annual deductible and a \$1,500 annual out-of-pocket maximum for enrollees.</p>
<p>West Virginia's Small Business Plan allows small businesses to tap into the buying power of the Public Employees Insurance Agency (PEIA) through a public/private partnership between PEIA and insurance companies. PEIA is the largest self-insured plan, providing insurance to public employees, state universities, and colleges.</p> <p>Allows participating carriers to access PEIA's reimbursement rates, enabling the new small business coverage cost to be reduced significantly.</p>
<p>Source: The National Conference of State Legislatures</p>

Chapter 10

HEALTH CARE REFORM ON CAPITOL HILL

The last time Congress debated comprehensive health insurance reform was in the 1990s during a period of escalating health care and health insurance costs, declining numbers of individuals with private coverage, and state experimentation and innovation. Congress has again turned its attention toward the growing number of people without health insurance, and in turn the growing number of small business owners, their employees, and dependents who are unable to afford health coverage.

Unlike in the 1990s, however, now frustration with the political in-fighting that has blocked health care reform has led business and labor groups to form advocacy coalitions.

DIVIDED WE FAIL CAMPAIGN

In early 2007, AARP joined forces with the Business Roundtable and the Service Employees International Union to launch the “Divided We Fail” campaign. The National Federation of Independent Businesses joined the campaign in November 2007. While other coalitions advocate particular approaches to health care reform, “Divided We Fail” does not advocate any one plan. Instead, the campaign seeks to end the partisan gridlock on Capitol Hill that has stifled meaningful health care reform. The campaign encompasses advertising in national outlets and in primary states, online initiatives, and traditional grassroots activities to engage the public, businesses, and elected officials in the health care debate.

So far, 344 of the 535 Members of Congress, including presidential candidates John McCain and Barack Obama, have either signed the congressional pledge or written a letter of approval supporting “Divided We Fail.”

HEALTH CARE REFORM COALITIONS

Divided We Fail: a coalition including AARP, NFIB, SEIU and the Business Roundtable. It seeks to end partisan gridlock impeding health care reform.

www.aarp.org/issues/dividedwefail

Fixed For America: NFIB’s campaign for small business health care reform.

www.fixedforamerica.com

Better Health Care Together: a coalition of corporate leaders, including Wal-Mart Stores Inc, and non-profit policy groups. The coalition’s goal is to reform the health care system by 2012.

www.betterhealthcaretogether.org

The Coalition to Advance Healthcare Reform: a coalition of more than 50 companies, including grocery store chains and health care companies. The coalition seeks market-based solutions.

www.coalition4healthcare.org

Health Care for America Now: a coalition of unions, including the AFL-CIO, and liberal-leaning policy groups. The coalition’s goal is to build public support for affordable health care for everybody.

<http://healthcareforamericanow.org>

OBAMA VS MCCAIN

Both McCain and Obama have proposed health care reform proposals that would take different approaches.

McCain’s plan would remove the onus of providing health care from employers. He would end tax breaks on employer-provided health insurance and provide a refundable tax credit of \$2,500 per person (\$5,000 per family) to help them purchase individual policies.

McCain also would allow families to purchase health insurance across state lines.¹

Obama would allow individuals and small businesses to purchase health care through a national public insurance plan similar to that available to federal employees. He would partly supplement the national plan with a tax on employers who do not provide coverage.

Obama also would provide a refundable tax credit of up to 50 percent on premiums paid by small businesses on behalf of their employees, and would reimburse employer health plans for a portion of the catastrophic costs they incur above a threshold if they guarantee such savings are used to reduce workers' premiums.²

LEGISLATION IN CONGRESS

A number of health insurance reform proposals have been introduced in the 110th Congress, particularly in the area of health coverage for small businesses. The bills, among other things, would enable small businesses to organize insurance-purchasing pools across state lines.

It is unlikely any of these proposals will be passed this year, but the stage is set to make small business health care reform one of the driving issues of the next Congress when it convenes in January 2009. Below are a few of the health care bills that have gained the most traction in the 110th Congress.

For more information on these bills, visit www.thomas.gov

¹ McCain's health plan can be viewed by visiting www.johnmccain.com and clicking "Issues."

² Obama's health plan can be viewed by visiting www.barackobama.com and clicking "Issues."

H.R. 6582, THE CHOICE ACT

In July, House Small Business Committee Chairwoman Nydia Velazquez (D-NY) and Rep. Joe Pitts (R-PA) introduced H.R. 6582, the Small Business Cooperative for Healthcare Options to Improve Coverage for Employees (CHOICE) Act of 2008. The measure, which has bipartisan support, would encourage the development of small business cooperatives for health care options to improve coverage for employees, including through a small business tax credit.

Velazquez says the bill would minimize risks for insurance companies by letting small firms pool their employees with those of other businesses in voluntary health cooperatives. Among other initiatives, the bill would give small businesses with up to 100 employees an incentive to join such a coop with a refundable tax credit of 65 percent of the cost of insurance. The bill states self-employed individuals would save \$5,000 per year on health coverage costs, while small firms would save more than 34 percent.

S. 2795, THE SHOP ACT

S. 2795 was introduced by Senators Dick Durbin (D-IL), Norm Coleman (R-MN), Olympia Snowe (R-ME) and Blanche Lincoln (D-AR) on April 2, 2008. The purpose of the bill is to expand health insurance access and reduce costs through the establishment of a national health insurance purchasing group, the implementation of nationwide adjusted community rating standards, and financial assistance through tax credits for small employers that choose to sponsor health insurance plans in states that enact (or already have in place) adjusted community rating. The national health insurance purchasing group—called the SHOP program—would guarantee

access to health insurance for all small employers and self-employed individuals. In addition, plans sold through the SHOP program would be priced based on adjusted community rating principles, wherein workers' individual or collective health status cannot be used to set the price for a small employer's group.

The SHOP Act would let small businesses with up to 100 workers join together in a statewide or nationwide pool to get lower health insurance prices. The bill would provide small businesses with an annual tax credit of up to \$1,000 per employee if they pay for 60 percent of their employee's premiums. The measure also would offer self-employed individuals with a \$1,800 tax credit to buy health insurance.

For more detailed information on the SHOP Act, visit Senator Durbin's website at <http://durbin.senate.gov/showRelease.cfm?releaseId=301776> and NFIB's analysis at www.nfib.com/page/SHOPAct.html.

S. 2818, THE SMALL BUSINESS HEALTH PLANS ACT OF 2008

S. 2818, introduced by Senators Mike Enzi (R-WY), Ben Nelson (D-FL), and Judd Gregg (R-NH) was referred to the Senate Health, Education, Labor, and Pensions (HELP) Committee on April 3, 2008. The bill's main provisions would establish regulatory relief from state insurance regulation for plans offered through trade and professional associations and establish a framework of incentives to encourage states to adopt a single federally described set of insurance laws and regulations. The sponsors hope that reducing state regulation of certain health insurance plans and reducing the variation in regulation of all other plans will result in lower-cost offerings and more choices for

sponsors of health insurance in the small group market. Those regulatory reforms would move states that have already established community rating or adjusted community rating principles toward greater individual underwriting. Under such practices, younger, healthier, or low-risk individuals may find their health insurance costs declining relative to older or higher risk individuals who will have to bear a greater share of their own projected risk.

In 2006, the Congressional Budget Office provided a cost estimate of S. 1955, an earlier version of the Small Business Health Plans Act. The agency concluded that its provisions would increase federal revenues from payroll and income taxes, and reduce net federal spending for Medicaid. The increase in revenues of \$25 million in the first year of implementation (assumed at that time to be 2007) would result from a reduction in the total amount spent on employer-sponsored health insurance. Medicaid spending would be reduced by \$15 million in the same year. Over five years (2007-2011), revenues were estimated to be increased by just over \$1 billion, and Medicaid spending reduced by \$235 million.

HEALTH IT LEGISLATION

Legislation has been introduced in the House designed to spur the adoption of health information technology (health IT), such as a nationwide electronic health records system, to increase the quality of the health care and reduce medical costs.

The Pro(TECH)T Act

On July 23, 2008, the House Committee on Energy and Commerce approved by voice vote H.R. 6357, the Protecting Records, Optimizing Treatment, and Easing Communication through Healthcare

Technology Act of 2008 or the Pro(TECH)T Act. Introduced in June by Energy and Commerce Chairman John Dingell (D-MI), the bipartisan legislation aims to strengthen the quality of health care, reduce medical errors and costs, and further protect the privacy and security of health information in the electronic age.

Specifically, the legislation promotes the nationwide adoption of a Health Information Technology (HIT) infrastructure and establishes incentives for doctors, hospitals, insurers, and the government to exchange health information electronically across the country. Additionally, H.R. 6357 makes permanent the Office of the National Coordinator for Health Information Technology (ONCHIT) at the U.S. Department of Health and Human Services and encourages the use of an electronic health record for each person in the United States by 2014. It provides \$560 million in grants and loans to providers, particularly small and rural providers and those serving medically underserved areas, to acquire electronic medical record systems.

“Your grocery store can immediately determine what brand of cereal you bought last year, but your cardiologist cannot quickly find what prescriptions your family doctor wrote for you last week. That is a problem for the cost and quality of health care. It is time to bring health care into the 21st century...”

— Representative John Dingell

The Subcommittee on Health approved H.R. 6357 on June 25, 2008, by voice vote. H.R. 6357 builds on a discussion draft released by Congressmen John Dingell (D-MI) and Frank Pallone (D-NJ), along with Congressmen Joe Barton (R-TX), Ranking Member of the Committee on Energy and Commerce, and

Nathan Deal (R-GA), Ranking Member of the Subcommittee on Health, on May 22, 2008. On June 4, 2008, the Subcommittee held a hearing in which witnesses from the Administration and representatives from consumer, technological, and privacy groups provided feedback on the draft legislation.

Another bill, H.R. 6179, was introduced in the House by Congressmen Dave Camp (D-MI) and Sam Johnson (R-TX).

House Committee on Small Business Hearing on Health IT

On July 31, 2008, the House Committee on Small Business held a hearing on the adoption of health information technology. Committee Chair Nydia Velazquez (D-NY) said that implementing an electronic health records system could cost a physician more than \$44,000, with additional costs to maintain the system. Witnesses also told the Committee that legal and privacy concerns also present barriers to more wide-spread use of electronic health records, including specialty practices who cannot find health IT products specifically designed for them to meet their needs to protect patient records under the Health Insurance Portability and Accountability Act (HIPAA). The witnesses urged the Committee to provide financial incentives to promote health IT use, and to strengthen laws protecting health record security.

For additional information on H.R. 6357, visit http://energycommerce.house.gov/HealthIT_2008/index.shtml. More information on H.R. 6170 can be found at <http://camp.house.gov/press/PressRelease.aspx?NewsID=1877>.

Health Care Reform Legislation in the 110th Congress

Bill	Introduced	Sponsor	Summary	Status
National Health Insurance Legislation				
H.R. 15	1/4/2007	Rep. John Dingell	National Health Insurance Act 2007 - Requires that medical services, hospital services, and other personal health services be made available to eligible individuals in all U.S. health-service areas as rapidly as possible. Sets forth minimum income requirements for eligibility.	Referred to the Subcommittee on Health
H.R. 676	1/24/2007	Rep. John Conyers	United States National Health Insurance Act of 2007 - Establishes the United States National Health Insurance (USNHI) Program (the Program) to provide all individuals residing in the United States and in U.S. territories with free health care that includes all medically necessary care, such as primary care and prevention, prescription drugs, emergency care, and mental health services.	Referred to the Subcommittee on Health
H.R. 1200	2/27/2007	Rep. Jim McDermott	American Health Security Act of 2007 - Establishes the State-Based American Health Security Program to provide every U.S. resident who is a U.S. citizen, national, or lawful resident alien with health care services. Requires each participating state to establish a state health security program.	Referred to the Subcommittee on Military Personnel
H.R. 1841	3/29/2007	Rep. Pete Stark	AmeriCare Health Care Act of 2007 - Adds a new title XXII to the Social Security Act (SSA) entitled "AmeriCare Health Benefits." Makes all U.S. residents eligible for AmeriCare benefits, including prescription drugs and biologicals. Requires the development of an AmeriCare enrollment mechanism that includes automatic enrollment at birth and the issuance of AmeriCare cards for identification and claims processing purposes. Provides that an individual may elect not to be enrolled for benefits under AmeriCare if the individual has health benefits coverage under a group health plan at least equivalent to AmeriCare coverage.	Referred to the HELP Committee
H.R. 3000	7/11/2007	Rep. Barbara Lee	Josephine Butler United States Health Service Act - Establishes the United States Health Service as an independent executive branch entity to provide health care and supplemental health services to all individuals within the United States. Requires the President to appoint members to a National Health Board to exercise the authority of the Service. Establishes an Office of the Inspector General for Health Services.	Referred to the HELP Committee
Expanding Existing Public Programs				
H.R.2034/ S. 1218	4/25/2007	Rep. John Dingell Sen. Ted Kenned	Medicare for All Act - Amends the Social Security Act to add a new title XXII (Medicare for All) under which: (1) each eligible individual is entitled to benefits which include the full range and scope of benefits available under the original fee-for-service program under parts A (Hospital Insurance) and B (Supplementary Medical Insurance) of title XVIII (Medicare), with parity in coverage of mental health benefits, subject to appropriate cost sharing; (2) each enrollee is free to choose his or her own doctor and private health plan; and (3) benefits are similar to or no less than the health benefits coverage under FEHBP.Establishes the Medicare for All Trust Fund.	Referred to the Subcommittee on Health
Expanding Privately Sponsored Coverage				
H.R. 227	1/4/2007	Rep. Cliff Sterns	Health Care Tax Deduction Act of 2007 - Amends the Internal Revenue Code to allow individuals a tax deduction from gross income for health insurance premiums and unreimbursed prescription drug expenses paid for the benefit of the taxpayer, the taxpayer's spouse and dependents.	Referred to the House Committee on Ways and Means
H.R. 241	1/5/2007	Rep. Sam Johnson	Small Business Health Fairness Act of 2007 - Amends the Employee Retirement Income Security Act of 1974 (ERISA) to provide for establishment and governance of association health plans (AHPs), which are group health plans whose sponsors are trade, industry, professional, chamber of commerce, or similar business associations, and which meet certain ERISA certification requirements. Sets forth rules governing AHPs, including requirements relating to certification, sponsors and boards of trustees, participation and coverage, nondiscrimination, contribution rates, notice of voluntary termination, correction actions, and mandatory termination. Establishes the Association Health Plan Fund to be used by the Secretary of Labor to make payments to an insurer to maintain coverage for a plan if there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of coverage	Referred to the HELP Committee
H.R. 914/ S. 397	2/8/2007	Rep. Paul Ryan	Tax Equity and Affordability Act of 2007 - Amends the Internal Revenue Code to: (1) allow individual taxpayers a refundable tax credit for health insurance costs paid for the benefit of the taxpayer, the taxpayer's spouse, and dependents; (2) require business taxpayers who receive payments for certain employee health insurance coverage to file informational returns; (3) direct the Secretary of the Treasury to make advance payments of health insurance tax credit amounts to health insurance providers; (4) limit the tax exclusion for employer-provided health care coverage.	Referred to the House Committee on Ways and Means
H.R. 1802	3/29/2007	Rep. Darlene Hooley	Keeping Small Businesses Healthy Act of 2007 - Amends the Internal Revenue Code to allow certain small business employers (100 or fewer employees) a refundable tax credit for up to 60 percent of the health insurance costs paid for their employees.	Referred to the House Committee on Ways and Means

Bill	Introduced	Sponsor	Summary	Status
H.R. 2132	5/3/2007	Rep. Thomas Allen	Small Business Health Plans Act of 2007 - Amends the Public Health Service Act to direct the Secretary of Health and Human Services to establish a small business health benefits program (SBHBP) under which small employers may offer health insurance coverage to employees and their dependents. Outlines program elements and coverage requirements, including that small employers are provided access to qualified health pooling arrangements under which their employees may elect coverage substantially similar to the federal employees benefit program coverage.	Referred to the HELP Committee
H.R. 2302	5/14/2007	Rep. Steve King	Health Insurance Affordability Act of 2007 - Amends the Internal Revenue Code to allow a deduction from gross income for premiums paid under a high deductible health plan by an individual eligible for a deduction for amounts paid into a health savings account, for months when such taxpayer is not covered under any other plan.	Referred to the House Committee on Ways and Means
H.R. 2626	6/7/2007	Rep. Tom Price	Comprehensive HealthCARE Act of 2007 - Amends the Internal Revenue Code to allow a tax credit and a deduction for qualified health insurance. Imposes a tax on any employer who fails to contribute to any health insurance provider elected by an employee in lieu of the employer's group health coverage. Requires the Office of Personnel Management (OPM) to revise government contribution amounts such that the amount of contribution does not change based on the health benefits plan in which the individual is enrolled.	Referred to the Subcommittee on Health
H.R. 2737	6/15/2007	Rep. Leonard Boswell	Health Care Relief Act of 2007 - Amends the Internal Revenue Code to allow: (1) a refundable tax credit up to \$1,000 for the health insurance coverage costs of a previously uninsured taxpayer, the taxpayer's spouse, and dependents; and (2) certain small business employers a business tax credit for amounts paid under a new health plan for employee health insurance coverage.	Referred to the House Committee on Ways and Means
H.R. 3515	9/10/2007	Rep. John McHugh	Health Insurance Tax Relief Act of 2007 - Amends the Internal Revenue Code to: (1) allow individual taxpayers a refundable tax credit for health insurance costs paid for the benefit of the taxpayer, the taxpayer's spouse, and dependents; (2) require business taxpayers who receive payments for certain employee health insurance coverage to file informational returns; and (3) direct the Secretary of the Treasury to make advance payments of health insurance tax credit amounts to health insurance providers.	Referred to the House Committee on Ways and Means
H.R. 3516	9/10/2007	Rep. John McHugh	Affordable Health Care for Americans Act of 2007 - Amends the Internal Revenue Code to allow a tax deduction from gross income for the health insurance costs of an individual taxpayer, the taxpayer's spouse, and dependents (available whether or not a taxpayer itemizes deductions).	Referred to the House Committee on Ways and Means
H.R. 3975	10/25/2007	Rep. Steve Chabot	Health Insurance Affordability Act of 2007 - Amends the Internal Revenue Code to allow individual taxpayers a tax deduction for health insurance costs.	Referred to the House Committee on Ways and Means
H.R. 5348	2/12/2008	Rep. James Langevin	American Health Benefits Program Act of 2008 - Amends the Social Security Act (SSA) to establish under a new title XXII (American Health Benefits Program) a program to provide comprehensive health insurance coverage to all Americans who are: (1) not covered under certain federal health insurance programs; and (2) not eligible for employer-provided insurance coverage. Requires provision of such coverage in a manner similar to that in which coverage has been provided to Members of Congress and federal government employees.	Referred to the Subcommittee on Health
H.R. 5784	4/14/2008	Rep. Kay Granger	Affordable Health Care Expansion Act of 2008 - Amends the Internal Revenue Code to: (1) allow individual taxpayers a refundable tax credit for health insurance costs paid for the benefit of the taxpayer, the taxpayer's spouse, and dependents; (2) require business taxpayers who receive payments for certain employee health insurance coverage to file informational returns; and (3) direct the Secretary of the Treasury to make advance payments of health insurance tax credit amounts to health insurance providers.	
H.R. 5923	4/29/2008	Rep. John Shadegg	Patients' Health Care Reform Act - Amends the Public Health Service Act to provide for the establishment and governance of: (1) HealthMarts, which are nonprofit organizations that offer health benefits coverage to employers, employees, and individuals through contracts with health insurance issuers; and (2) individual membership associations (IMAs), which are organizations that offer health benefits coverage to members through health insurance issuer contracts. Requires the Secretary of Health and Human Services to pay 50% of a state's costs to provide health benefits coverage under a high-risk pool, a reinsurance pool, or other risk-adjustment mechanisms used to subsidize the purchase of private health insurance.	Referred to the Subcommittee on Health
S. 99	1/4/2007	Sen. John Kerry	Small Business Health Care Tax Credit Act - Amends the Internal Revenue Code to allow certain small business employers a partially refundable business tax credit for the health insurance costs of employees who are not otherwise covered by a spouse's insurance or by a federal health insurance program.	Read twice and referred to the Committee on Finance

Bill	Introduced	Sponsor	Summary	Status
S. 733	3/1/2007	Sen. Russell Feingold	Promoting Health Care Purchasing Cooperatives Act - Authorizes the Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality (AHRQ), to award grants for the development of health care purchasing cooperatives by two or more self-insured employers. Sets forth requirements for cooperatives, including that they: (1) are nonprofit, wholly owned, and democratically governed by its member-employers; (2) exist solely to serve the membership base; (3) assist members in pooling their health care insurance purchasing power; (4) provide data to improve the ability of the members to make data-based decisions regarding their health plans; and (5) conduct activities to enhance quality improvement in the health care community. Requires the Secretary to carry out an identical grant program for eligible groups of two or more employers that have 99 employees or less and purchase health insurance for their employees.	Read twice and referred to the HELP Committee
S. 1019	3/28/2007	Sen. Tom Coburn	Universal Health Care Choice and Access Act - Provides for health promotion and disease prevention activities, including requiring the Secretary of Health and Human Services to convene an interagency coordinating committee to develop a national strategic plan for prevention. Amends the Internal Revenue Code to: (1) allow participants in high deductible health care insurance plans an increased tax deduction for contributions to a health savings account; and (2) allow individual taxpayers a refundable tax credit for health insurance costs paid. Requires states to establish and operate a qualified high risk pool or a state-designated alternative that ensures access to private health insurance for medically uninsurable individuals.	Read twice and referred to the Committee on Finance
S. 1783	7/12/2007	Sen. Michael Enzi	Ten Steps to Transform Health Care in America Act - Directs states to implement mechanisms to automatically enroll uninsured individuals in health coverage. Requires each health insurance issuer in a state to offer a certified qualified core plan that provides coverage required by the state with a standard premium. Amends the Internal Revenue Code to allow individuals a standard deduction or a refundable tax credit for health insurance. Requires the Secretary of Health and Human Services (HHS Secretary) to provide for the establishment in each state of a single market for all health plans offered in the state.	Read twice and referred to the Committee on Finance
S. 1875	7/25/2007	Sen. Jim DeMint	Healthy Tax Reform Act - Amends the Internal Revenue Code to: (1) allow uninsured individual taxpayers and their spouses and dependents a refundable tax credit for a limited amount of their health insurance costs; (2) direct the Secretary of the Treasury to establish a program for payment of health insurance costs by advancing health insurance tax credit amounts to insurance providers during the taxable year; (3) limit the availability of certain tax preferences for individuals eligible for the health insurance tax credit; and (4) repeal the alternative minimum tax after 2006.	Read twice and referred to the Committee on Finance
S. 1886	7/26/2007	Sen. Richard Burr	Every American Insured Health Act - Amends the Internal Revenue Code to: (1) allow uninsured individual taxpayers and their spouses and dependents a refundable tax credit for a limited amount of their health insurance costs; (2) direct the Secretary of the Treasury to establish a program for payment of health insurance costs by advancing health insurance tax credit amounts to insurance providers during the taxable year; and (3) limit the availability of certain tax preferences for individuals eligible for the health insurance tax credit.	Read twice and referred to the Committee on Finance
S. 1899	7/30/2007	Sen. Ben Cardin	Universal Health Coverage Act of 2007 - Requires each U.S. citizen or national or alien lawfully admitted to the United States for permanent residence to have qualified health coverage, unless such individual is opposed for religious reasons to health coverage. Defines "qualified health coverage" to include federal health plans, group health plans, and other appropriate coverage. Requires the Secretary of Health and Human Services to develop at least three types of low-cost health insurance plans for each state and the District of Columbia that shall be made available, on a guaranteed-issue basis, to all individuals with incomes below 400% of the federal poverty line.	Read twice and referred to the Committee on Finance
S. 2795/ H.R. 5918	4/2/2008	Sen. Richard Durbin	Small Business Health Options Program Act of 2008 or the SHOP Act - Amends the Public Health Service Act to require the Secretary of Health and Human Services to designate an office within the Department of Health and Human Services (HHS) to administer a health insurance program for small businesses and self-employed individuals to purchase health insurance coverage meeting certain requirements.	Read twice and referred to the Committee on Finance
S. 2818	4/3/2008	Sen. Michael Enzi	Small Business Health Plans Act of 2008 - Amends the Employee Retirement Income Security Act of 1974 (ERISA) to provide for the establishment and governance of small business health plans, which are group health plans sponsored by trade, industry, professional, chamber of commerce, or similar business associations that meet ERISA certification requirements. Requires the Secretary of Labor to: (1) apply the rules and standards of this Act to Alternative Market Pooling Organizations, such as unions, churches, and other groups; and (2) consult with the domicile state regarding the Secretary's exercise of authority over such plans. Allows other existing plans to be treated as small business health plans under certain circumstances.	Read twice and referred to the HELP Committee

Bill	Introduced	Sponsor	Summary	Status
S. 2835	4/9/2008	Sen. Jim DeMint	Amends the Internal Revenue Code to allow: (1) taxpayers who do not itemize their deductions to deduct from gross income the costs of health insurance and long-term care insurance; and (2) payments from health savings accounts for non-group high deductible health plan premiums.	Read twice and referred to the Committee on Finance
S. 2948	4/30/2008	Sen. Sherrod Brown	Small Business Empowerment Act - Directs the Secretary of Health and Human Services to establish a national program to make quality, affordable health insurance available to small employers and self-employed individuals in a manner that will spread risk on a national basis, modeled on the federal employees health benefit program.	Read twice and referred to the HELP Committee
Grants to States				
H.R. 506	1/17/2007	Tammy Baldwin	Health Partnership Through Creative Federalism Act - Requires the Secretary of Health and Human Services to establish a State Health Coverage Innovation Commission to: (1) request states to submit proposals for state health care expansion and improvement programs, which may include reform options such as tax credit approaches, expansions of public programs, or other appropriate alternatives; (2) review state applications and submit to Congress a list of state applications that the Commission recommends for approval; (3) report to the public concerning progress made by states; and (4) make recommendations to the Secretary and Congress for minimizing the negative effect of state programs on national employer groups, provider organizations, and insurers because of differing state requirements under the programs.	Referred to the Subcommittee on Health
H.R. 3507/ S. 2031	9/7/2007	Rep. John Tierney Sen. Bernard Sanders	Requires a state plan to provide: (1) coverage of all eligible state residents, without regard to employment status, income, health status or preexisting condition, or location of residency within the state; and (2) health benefits that are at least actuarially equivalent to the standard Blue Cross/Blue Shield preferred provider option service benefit plan under the Federal Employees Health Benefit Program. Allows one or more contiguous states in a geographic region to file a joint application for such grants. Authorizes Interstate Compacts of states to conduct joint health care programs under a grant.	Referred to the HELP Committee/Read twice and referred to the Committee on Finance
S. 325	1/17/2007	Sen. Jeff Bingaman	Health Partnership Act - Requires the Secretary of Health and Human Services to establish a State Health Innovation Commission. Requires the Commission to: (1) provide states with reform options for state health care expansion and improvement programs; (2) establish minimum performance measures and goals with respect to coverage, quality, and cost of state programs; (3) review state applications and determine whether to submit a state proposal to Congress; and (4) submit to Congress a list of state applications that the Commission recommends for approval. Deems such proposals to be approved unless a joint resolution has been enacted disapproving such proposal. Sets forth rules for congressional consideration of such proposals.	Read twice and referred to the HELP Committee
Comprehensive Reforms That Utilize Multiple Approaches				
H.R. 2351	5/16/2007	Rep. Marcy Kaptur	Health Coverage, Affordability, Responsibility, and Equity Act of 2007 - Permits a state to apply to the Secretary of Health and Human Services (the Secretary) for waivers of such provisions of law as may be necessary for the state to implement policies that make comprehensive, affordable health coverage available for all state residents.	Referred to the HELP Committee
H.R. 3163		Rep. Brian Baird	Healthy Americans Act - Requires each adult individual to have the opportunity to purchase a Healthy Americans Private Insurance Plan (HAPI). Makes individuals who are not enrolled in another specified health plan and who are not opposed to coverage for religious reasons responsible for enrolling themselves and their dependent children in a HAPI plan offered through their state of residence. Sets forth penalties for failure to enroll.	Referred to the HELP Committee
S. 158	1/4/2007	Sen. Susan Collins	Access to Affordable Health Care Act - Amends the Internal Revenue Code to allow: (1) tax credits to small businesses for qualified employee health insurance expenses; (2) tax credits for qualified health insurance; (3) deductions for long-term care premiums; and (4) tax credits for individuals with long-term care needs. Requires the Secretary of Labor to award grants to states to assist in planning, developing, and operating qualified small employer purchasing groups for health insurance. Directs the Small Business Administration to award grants to states, local governments, and nonprofit organizations to provide health insurance information to small employers.	Read twice and referred to the Committee on Finance
Source: www.thompson.gov				

CHAPTER 11

ONLINE HEALTH INSURANCE RESOURCES

General Information

- **The Agency for Healthcare Policy and Research (AHRQ)**

www.ahrq.gov

AHRQ provides information to help people make informed decisions about health care.

- **The Centers for Disease Control and Prevention (CDC)**

www.cdc.gov

The CDC is a U.S. agency responsible for tracking and investigating public health trends. The CDC also is a useful resource for information health and wellness programs.

- **Employee Benefit Research Institute (EBRI)**

www.ebri.org

The mission of EBRI is to contribute to and to enhance the development of sound employee benefit programs and public policy through objective research and education.

- **Healthfinder**

www.healthfinder.gov

Healthfinder is an award-winning federal website for consumers, developed by the U.S. Department of Health and Human Services together with other federal agencies. It is a resource for finding government and nonprofit health and human services information on the Internet, and links to information and websites from more than 1,500 health-related organizations.

- **National Association of Insurance Commissioners (NAIC)**

www.naic.org

NAIC promotes uniformity in the regulation of insurance among the 50 states and the District of Columbia. The NAIC website provides information on how to identify a fraudulent agent or insurer.

- **National Federation of Independent Business (NFIB)**

www.nfib.com

NFIB is a advocate for health care reform and provides useful member benefits and research tools to help you shop for health care.

- **National Association for the Self-Employed (NASE)**

<http://health.nase.org/Health101/Basics.asp>

NASE provides informative and detailed information on finding the best health care options for your small business.

- **U.S. Department of Labor**

www.dol.gov

Provides consumer information on health plans and benefits.

Managed Care Plans

- **The American Heart Association (AHA)**

www.americanheart.org/presenter.jhtml?identifier=4663

AHA provides detailed information on the differences between Health Maintenance Organizations (HMOs), Preferred-Provider Organizations (PPOs) and Point-of-Service (POS) plans.

Consumer-Driven Health Care (CDHC)

- **The Council for Affordable Health Insurance (CAHI)**

http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf

CAHI provides detailed information on consumer-directed health care (CDHC) plans, including health savings accounts (HSAs), health reimbursement arrangements (HRAs) and flexible spending accounts (FSAs).

- **HSAInsider**

www.HSAInsider.com.

HSAInsider is an online source for CDHC. The site has leveraged the Internet to enable small business owners and others to find and purchase high-deductible health plans and HSAs. HSAInsider also provides guidance on laws and best practices concerning HSAs.

Choosing a Health Care Provider

- **AllOptions.com: Small Business Health Insurance**

<http://insurance.alloptions.com/small-business-health-insurance.asp>

A website that provides numerous quotes from various vendors based on an individual's information.

- **Entrepreneur.com: Insurance Center**

www.entrepreneur.com/insurance

This site provides articles on health insurance issues affecting small businesses.

- **HealthDecisions.org: Agents & Brokers**

www.healthdecisions.org/Broker/LearningCenter

This site provides in-depth tools for consumers to help with health care coverage decisions.

- **HealthInsuranceIndepth**

www.healthinsuranceindepth.com/health-insurance-course.html

Site provides an online educational health insurance course at no cost. The five-lesson course is designed to educate consumers on how to maximize the benefits of health insurance policy, while saving money at the same time. The site also helps consumers uncover and design the type of policy that will fit their budget.

- **MedlinePlus: Health Insurance**

www.nlm.nih.gov/medlineplus/healthinsurance.html

A federal government site that provides education information on health insurance.

- **Website 101: Small Business Health Insurance & Healthcare Article Library**

http://website101.com/Health_Insurance

Website 101 has a range of articles targeting small business health insurance issues.

Health Plan Internet Resources

- **Aetna**

www.aetna.com/employer

A health insurance industry giant's site regarding small business.

- **Bank of America: Small Business Health Insurance**

www.bankofamerica.com/insurance

This site allows you to choose a state, and the browser will return small business insurance packages based on location.

- **Blue Cross/Blue Shield: Employer Health Care Coverage Information**

www.bluecross.com/bluefinder

Blue Cross/Blue Shield companies are collectively the largest health insurance provider. This site has their business information and products.

- **BuyerZone: Group Health Insurance Price Quotes**

www.buyerzone.com/benefits/health_insurance

This site asks five basic insurance questions, and the engine returns five different small business insurance quotes.

- **eHealthInsurance**

www.ehealthinsurance.com

A licensed health insurance agency and one of the leading online sources for small businesses to find, compare and purchase health insurance.

- **HealthInsurance.com: Business Owners**

www.healthinsurance.com/hi/web/basics/Business_Owners

An online insurance site that is a collaboration by two of the industry's largest insurance firms.

- **Insurance.com: Small Business Health Insurance Quotes**

<http://www.insurance.com/Health.aspx>

This online broker allows a user to search for small business health insurance by zip code.

- **MedHealthInsurance: Small Business Health Insurance**

www.medhealthinsurance.com/smallbusiness.htm

Another broker that collects information from the potential customer, and then finds the best value out of its portfolio of vendors.

- **MostChoice: Group Health Insurance**

www.mostchoice.com/group-health-insurance.cfm

This broker says it will find the best insurance deal based on your needs.

- **Wells Fargo: Small Business Group Health Insurance Overview**

www.wellsfargo.com/biz/products/insurance/health/overview

The small business health insurance site of American banking giant Wells Fargo.

Source: www.work.com/health-insurance-shopping-web-sites-839.

Cutting Health Care Costs

- **Professional Employer Organizations (PEOs)**

For more information on PEOs, visit the National Association of Professional Employment Organizations (NAPEO) at www.napeo.org. Information on PEO providers and PEO licensing by state can be found at www.staffmarket.com.

- **Mini-Medical Plans**

California Broker has an in-depth article on mini-medical plans at www.calbrokermag.com/Magazine/story/sept2005/alternativehealth.htm.

You can learn more about mini-medical plans by visiting NFIB at www.nfib.com/agla or by visiting broker and provider websites, including www.ehealthinsurance.com and www.healthbenefitsdirect.com/minimedical.aspx.

- **Wellness Programs**

North Carolina-based Wellness Proposals is an agency that has partnered with the country's leading wellness companies. It provides wellness program information and a free-of-charge service that can receive up to 30 different wellness proposals. For more information, visit www.wellnessproposals.com.

For more information on the Guardian wellness program survey, *Benefits and Behavior: The Voice of American Business Owners and Benefit Decision Makers Today*, visit www.guardianlife.com/company_info/press_releases/june_05_2007.html.

The Community Guide provides recommendations for programs and policies to promote health at www.thecommunityguide.org

The CDC Healthier Worksite Initiative website addresses workforce health promotion and provides useful resources for creating programs that reduce costs to employers and improve employee health and morale. Although the site was designed as a resource for wellness program planners in state and federal government, it is also helpful for non-government workplaces. Visit the site at www.cdc.gov/nccdphp/dnpa/hwi/index.htm

Small Business Health Care Reform

- **Small Business Health Plans (SBHPs)**

For more information on SBHPs, visit www.nfib.com/page/SBHPs.html and www.sbhpsnow.com.

- **Medical Liability Reform**

For more information on medical liability reform, visit www.nfib.com/page/medicalLiabilityReform.html.

- **Health Care Tax Deductions**

For more information health care tax deductions, visit www.nfib.com/page/selfEmployedTaxDeduct.html, www.setaxequity.org or *The Wall Street Journal* at http://online.wsj.com/article/SB118895480030317627.html?mod=googlenews_wsj.

- **Health Care Insurance Mandates**

For more information on health care insurance mandates, visit www.nfib.com/page/mentalHealthParity.html and the Council for Affordable Health Insurance (CAHI) at www.cahi.org/cahi_contents/resources/pdf/TrendsEndsMay2006.pdf.

State Health Care Laws

- **Council for Affordable Health Insurance (CAHI)**

Health Insurance Mandates in the States 2008 (includes a comprehensive table of mandates in each state) http://www.cahi.org/cahi_contents/issues/article.asp?id=491

- **General Accounting Office (GAO)**

Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Business www.gao.gov/cgi-bin/getrpt?GAO-03-1133

- **Kaiser Family Foundation (KFF)**

State Health Facts (up-to-date data on managed care enrollment, state consumer protection laws, and state benefit requirements) www.statehealthfacts.kff.org

- **Health Insurance In-Depth**

State Health Insurance Laws and State Health Insurance Regulations www.healthinsuranceindepth.com/individual-state-guides.html



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