Chapter Five: Health Insurance

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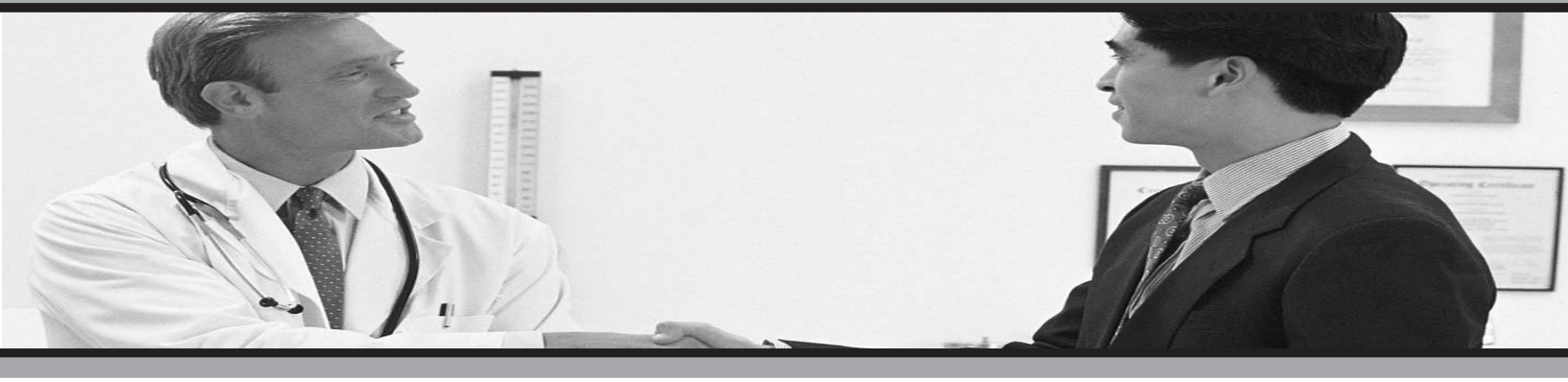
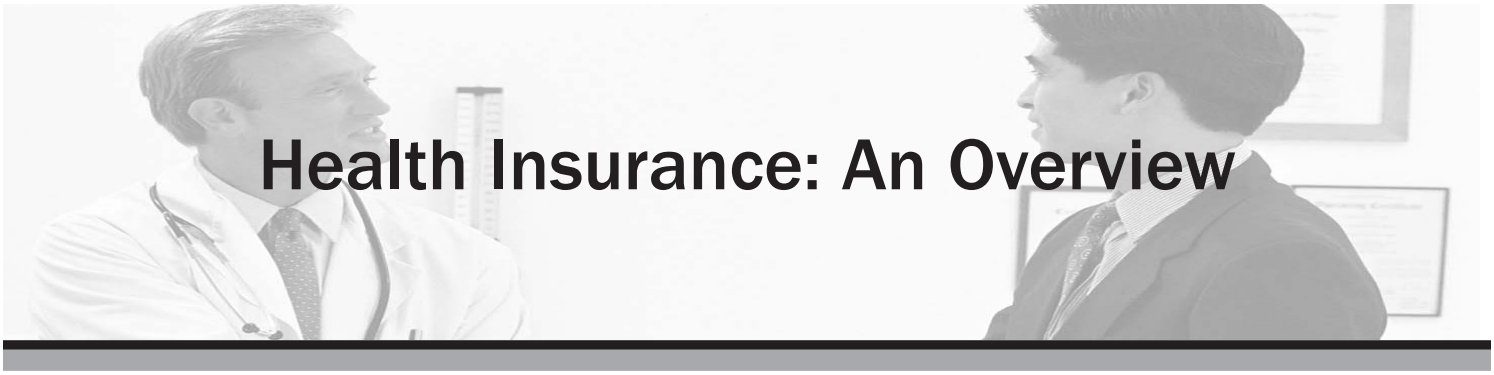




Health Insurance: An Overview

Health insurance is one of the components of a sound financial plan. It provides financial security for your family by providing financial resources for health expenses in times of life's uncertainties. Today, there are two primary forms of health insurance plans, indemnity and managed health care.

INDEMNITY PLAN

With an indemnity plan you can use any medical provider. The provider then sends the bill to the insurance company, which pays part of the costs. Usually you have a deductible, which is the amount of the covered expenses you must pay each year. Once you meet the deductible, most indemnity plans pay a percentage of what they consider the usual and customary charge for covered services. The insurer generally pays 80 percent of the usual and customary costs and you pay the other 20 percent, which is known as coinsurance.

Indemnity plans can be purely indemnity or they can be coupled with Preferred Provider Organizations (PPO). PPOs simply trade a network for volume. That is, you agree to limit yourself to a set universe of providers in exchange for lower premiums (usually 15-20% lower). If you go outside the set network for elective care, you are penalized. However, unlike an HMO (where there would be no coverage), PPO penalties are quite limited.

MANAGED CARE

Managed care plans generally provide comprehensive health services to their members and offer financial incentives for patients to use the providers who belong to the plan. HMOs are the oldest form of managed care plan. In an HMO, instead of paying for each service that you receive separately, your coverage is paid in advance. For a set monthly fee, HMOs offer members a range of health benefits, including preventive care. HMOs will give you a list from which to choose a primary care physician.

Typically, the plan may charge a copayment for certain services. For example, $10 for an office visit, or $5 for every prescription. So, if you join this HMO, you may find that you have few out-of-pocket expenses for medical care—as long as you use doctors or hospitals that participate in or are part of the HMO. Your share may be only the small copayments; generally, you will not have deductibles or coinsurance.

HMO penetration is very minimal in Indiana, at only 13 percent. By comparison, HMOs make up about 32 percent in Kentucky and 17 percent in Ohio. The nationwide average is about 29 percent.

WHAT IS NOT COVERED?

While HMO benefits are generally more comprehensive than those of traditional fee-for-service plans, no health plan will cover every medical expense.

Very few plans cover eyeglasses and hearing aids because these are considered budgetable expenses. Very few cover elective cosmetic surgery, except to correct damage caused by a covered accidental injury. Some fee-for-service plans do not cover checkups. Procedures that are considered experimental may not be covered either. And some child birth plans cover complications arising from pregnancy, but do not cover normal pregnancy or childbirth.

Health insurance policies frequently exclude coverage for preexisting conditions, but federal law now limits exclusions based on such conditions.

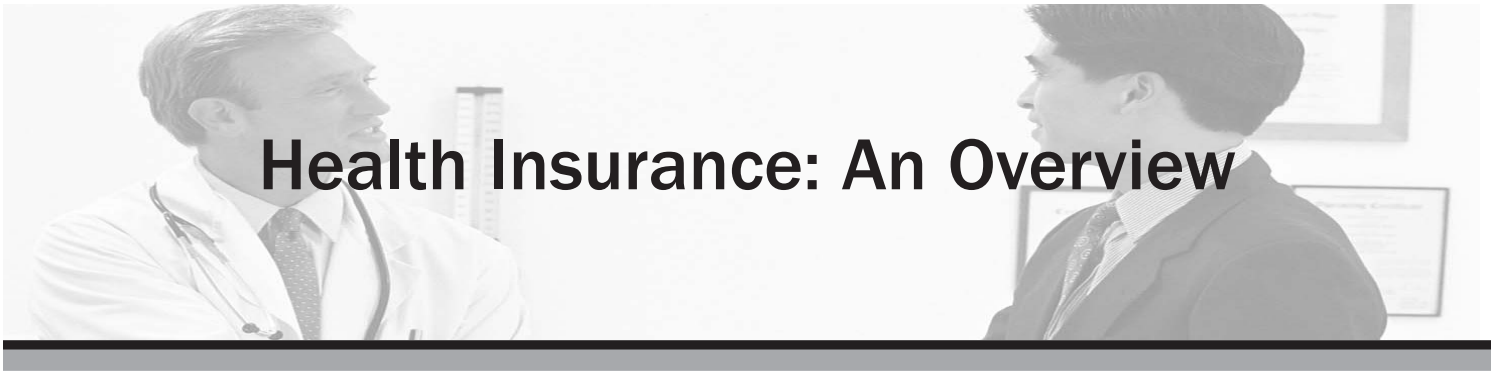
HOW DO I COMPARE HEALTH PLANS?

After you review what benefits are available and decide what is important to you, you can compare plans. Many things should be considered. These include services offered, choices of providers, location and cost. The quality of care is also a factor to think about.

SERVICES: Look at the services offered by each plan. What services are limited or not covered? Is there a good match between what is provided and what you think you will need? For example, if you have a chronic disease, is there a special program for that illness? Will the plan provide the medicines and equipment you may need? Find out what types of care or services the plan won't pay for. Few indemnity and managed care plans cover treatments that are experimental. Ask how the plan decides what is or is not experimental. Find out what you can do if you disagree with a plan's decision on medical care or coverage.

CHOICE: What doctors, hospitals and other medical providers are part of the plan? Are there enough of the kinds of doctors you want to see? If you want to see a specialist, can you refer yourself or must your primary care doctor refer you? Do you need approval from the plan before going into the hospital or getting specialty care?

Location: Where will you go for care? Are these places near where you work or live?



Health Insurance: An Overview

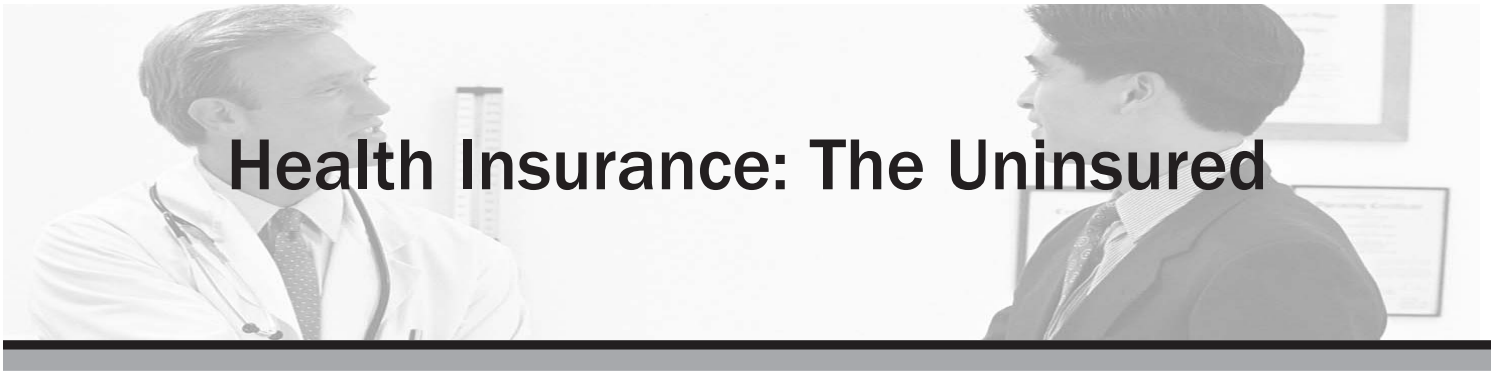
Costs

No health insurance plan will cover every expense. To get a true idea of what your costs will be under each plan, you need to look at how much you will pay for your premium and other costs.

- Are there deductibles you must pay before the insurance begins to help cover your cost?
- After you have met your deductible, what part of your costs are paid by the plan? Does this amount vary by the type of service, doctor, or health facility used?
- Are there any limits to how much you must pay in case of major illness?
- Are there copayments you must pay for certain services, such as doctor visits? If you use doctors outside a plan's network, how much more will you pay to get care?
- If a plan does not cover certain services or care that you think you will need, how much will you have to pay?
- Is there a limit on how much the plan will pay for your care in a year or over a lifetime? A single hospital stay for a serious condition could cost hundreds of thousands of dollars.

Ten Ways to Reduce Health Care Costs

1. Take good care of yourself. Eight out of ten health problems are treated at home.
2. Practice self-examination and get appropriate health screening.
3. Become aware of the health risks of difference lifestyle choices.
4. Know what your medical benefits cover.
5. Take an active role in health care decision making.
6. Ask your doctor about every prescribed medication and medical test.
7. Avoid hospitalization whenever possible. Hospitalization accounts for half of all health care costs.
8. Save the emergency room for emergencies.
9. Check your hospital and doctor bills carefully.
10. Avoid defensive medicine. Defensive medicine refers to tests and services performed to protect physicians from malpractice suits. Ask if they are really necessary and what your options are.



Health Insurance: The Uninsured

U.S. Census Bureau Facts About Health Insurance

- Both the percentage and the number of people without health insurance increased in 2006. The percentage without health insurance increased from 15.3 percent in 2005 to 15.8 percent in 2006 and the number of uninsured increased from 44.8 million to 47.0 million.

- The number of people with health insurance increased to 249.8 million in 2006 (up from 249.0 million in 2005). In 2006, the number of people covered by private health insurance (201.7 million) and the number of people covered by government health insurance (80.3 million) were not statistically different from 2005.

- The percentage of people covered by employment-based health insurance decreased to 59.7 percent in 2006, from 60.2 percent in 2005.

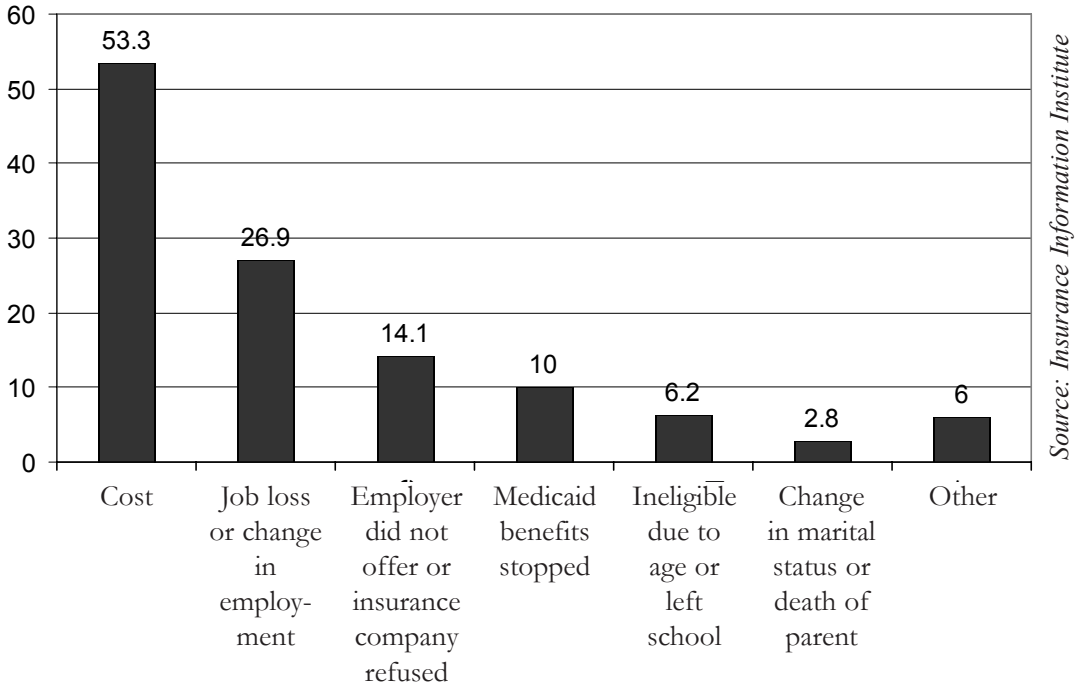
- The percentage of people covered by government health programs decreased to 27.0 percent in 2006 from 27.3 percent in 2005. The percentage and the number of people covered by Medicaid were statistically unchanged at 12.9 percent and 38.3 million, respectively, in 2006.

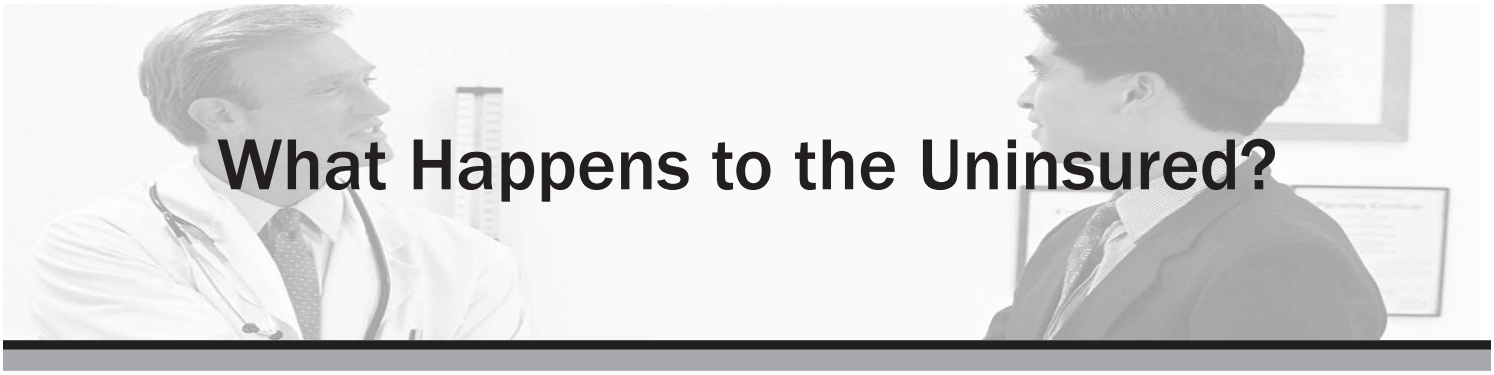
- The percentage and the number of children under 18 years old without health insurance increased to 11.7 percent and 8.7 million in 2006 (from 10.9 percent and 8.0 million, respectively, in 2005). With an uninsured rate in 2006 at 19.3 percent, children in poverty were more likely to be uninsured than all children. 3

- The uninsured rate and the number of uninsured in 2006 were not statistically different from 2005 for non-Hispanic Whites (at 10.8 percent and 21.2 million). The percentage and the number of uninsured Blacks increased (from 19.0 percent and 7.0 million in 2005) to 20.5 percent and 7.6 million in 2006.

- The percentage and the number of uninsured Hispanics increased to 34.1 percent and 15.3 million in 2006.

Reasons Americans Under 65 Are Uninsured, 2004





What Happens to the Uninsured?

MEDICARE

Medicare provides hospital and medical insurance to persons age 65 and older, disabled persons under 65 who receive payments under Social Security or the Railroad Retirement program, and people of all ages with chronic kidney disease.

MEDICAID

Medicaid is financed from state and federal funds and provides medical assistance to persons who are eligible for federal cash assistance. Medicaid also may be available to persons who have enough income for basic living expenses but cannot afford to pay for medical care. Even though state participation is optional, all 50 states participate. However, because states establish their own eligibility criteria, there are large state-to-state variations in coverage and eligibility.

COBRA

Under federal law, group health plans sponsored by employers with 50 or more employees are required to offer continued coverage for you and your dependents for 18 month after you leave your job. This requirement is a part of the

Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. Under the same law, following an employee's death or divorce, or child no longer being an eligible dependent, coverage may be continued for up to 36 months. If you wish to continue your group coverage under this option, you must notify your employer within 60 days of loss of coverage. You must also pay the entire premium, plus a two percent administration charge.

HEALTHY INDIANA PLAN (HIP)

In 2007, Governor Mitch Daniels proposed raising the state's cigarette tax to help fund health insurance for the uninsured. The General Assembly subsequently passed the Healthy Indiana Plan (HIP).

About 562,235 Hoosiers are eligible for this plan. That includes uninsured, non-disabled parents of Medicaid/CHIP children from 22%-200% federal poverty level (FPL); pregnant women up to 200% FPL ; and approximately 41,000 childless adults under 200% FPL (Roughly 11% of childless adults)

Participants must be: Uninsured for 6 months, and not eligible for employer-sponsored health insurance.

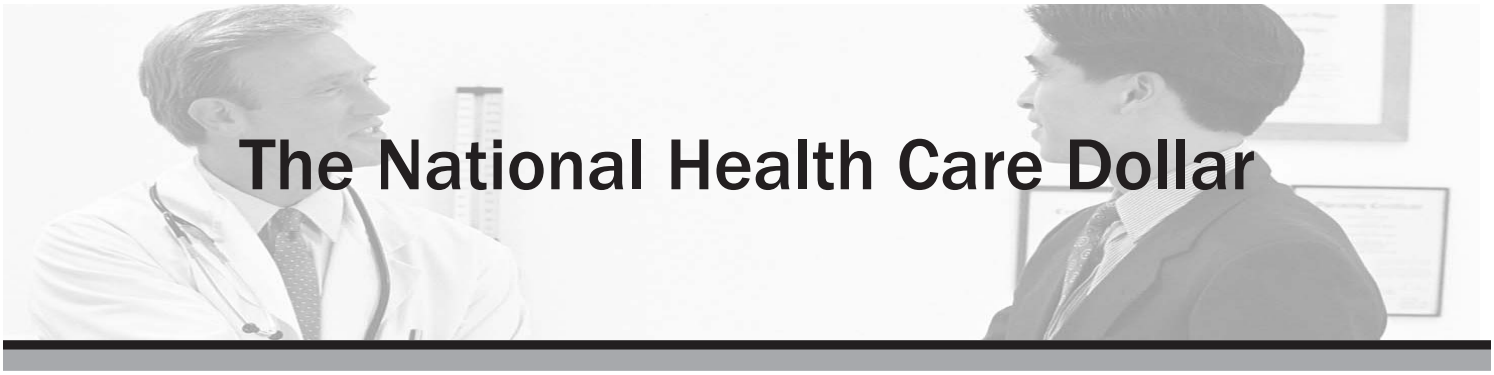
The plan structure provides a POWER Account valued at $1,100 per adult to pay for medical costs. Contributions to the account are made by the State and each participant (based on ability to pay). No participant will pay more than 5% of his/her gross family income on the plan.

A basic commercial benefits package once annual medical costs exceed $1,100 is also provided. Finally, coverage for preventive services up to $500 a year at no cost to participants is included in the plan.

Services covered by HIP include: physician services, prescriptions, diagnostic exams, home health services, outpatient hospital, inpatient hospital, hospice, preventive services, family planning, and case and disease management

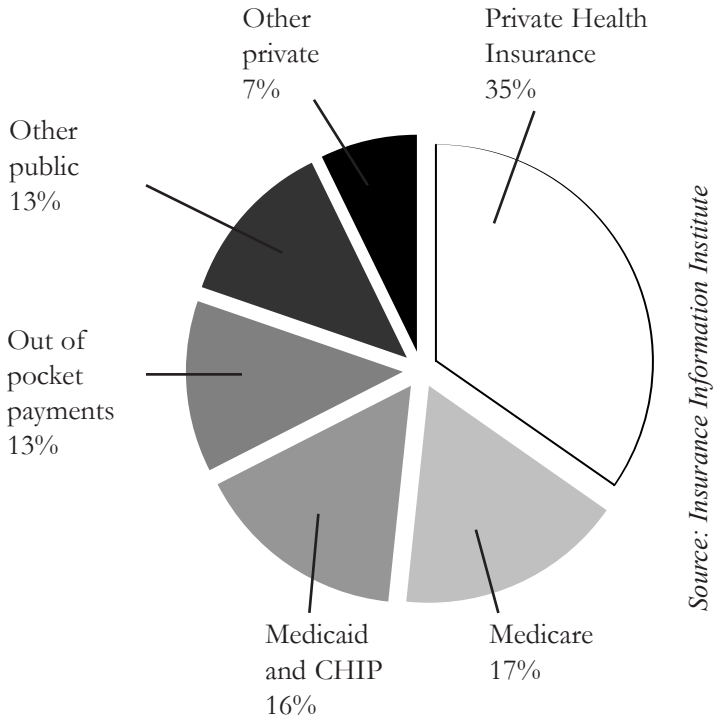
Mental health coverage is similar to coverage for physical health, and includes substance abuse treatment, inpatient, outpatient, and drugs .

Vision and/or dental coverage can be purchased as a rider. Individuals will pay 50% of the premium cost (on top of their POWER Account contribution) for these services.



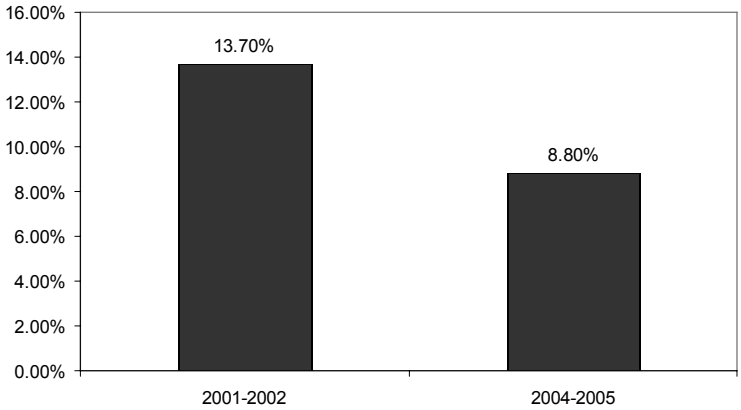
The National Health Care Dollar

The Nation's Health Dollar in 2005

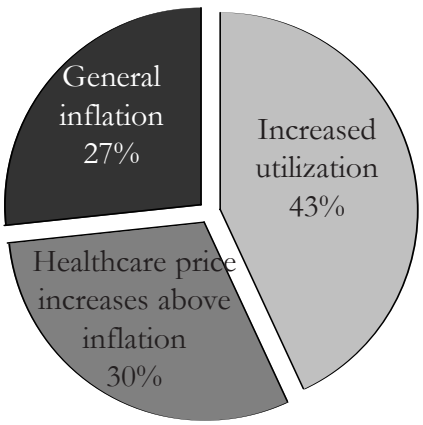


Source: Insurance Information Institute

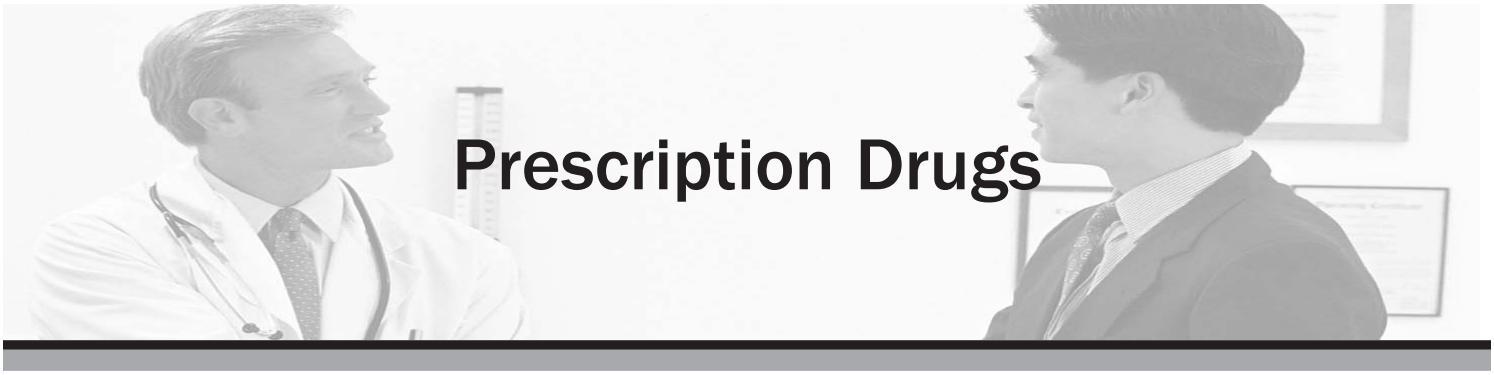
Increase in Insurance Health Premiums



Factors Contributing to 8.8% Increase in Premiums



Source: Pricewaterhouse Coopers



Prescription Drugs

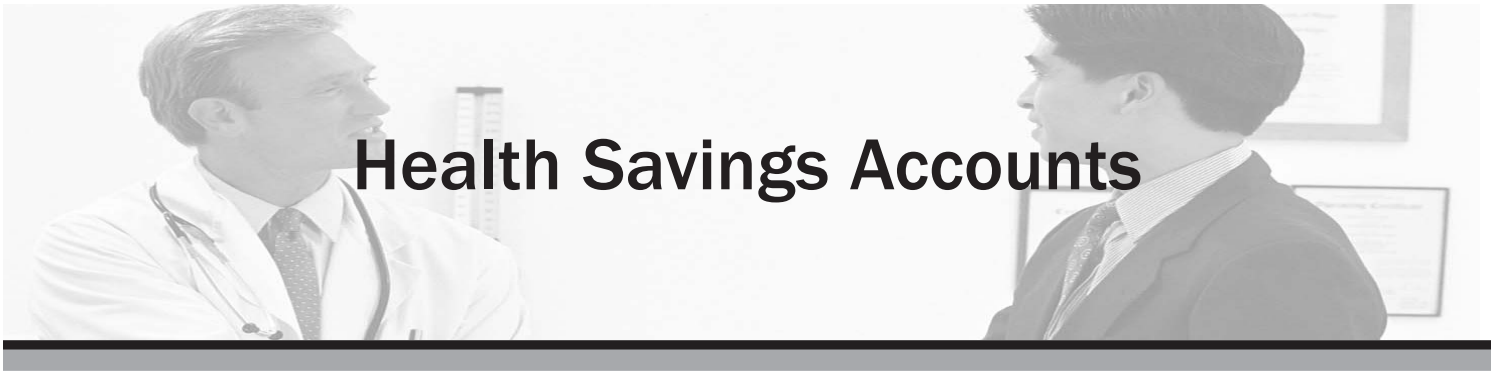
The Rising Cost of Prescription Drugs

Most major categories of health spending have increased moderately over the past few years. However, prescription drug spending has outpaced all other categories. While hospital and physician costs have increased between three and five percent, expenses for drugs have averaged between 10 and 14 percent per year. In 2005, however, the cost of prescription drugs slowed, to 8.6 percent. Drugs now account for a higher percentage of the benefit dollar than they did 15 years ago, but that percentage is stabilizing.

The recent slower growth in prescription drugs is due to a number of converging factors: the introduction of fewer blockbuster drugs, some blockbusters going off patent, the transition of some drugs to over-the-counter status and a lower rate of price growth. One of the most striking reasons is that many health plans are shifting to two, three-, and most recently four-tiered formularies that make beneficiaries more cost conscious when they choose preferred prescription drugs. The number of employers with at least three tiers of copayments has increased from 27 percent in 2000 to 68 percent in 2004.

What Causes Drug Prices to Increase?

- Direct-to-consumer advertising
- Accelerated FDA approval process
- Growth in drug therapy and disease management programs
- Life-enhancing, life-lengthening lifestyle and cosmetic drugs are widely used
- Increase in elderly population to treat chronic and acute health conditions.



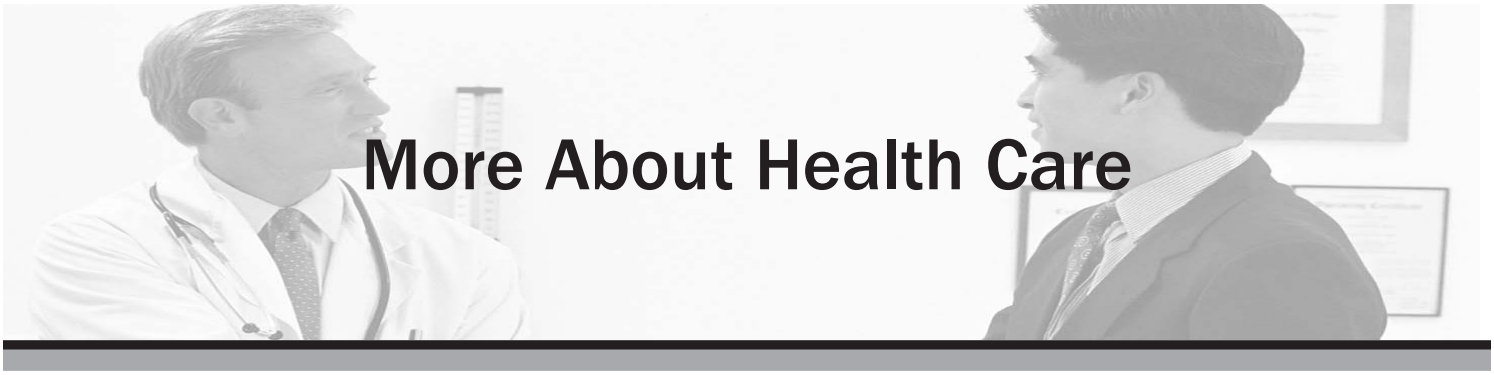
Health Savings Accounts

Health Savings Accounts (HSAs) were included in the Medicare bill passed by Congress in 2004. These plans couple a tax-free savings account with a high deductible major medical policy. Individuals can use the savings account to pay for smaller, more routine expenses while the high deductible portion will protect them from catastrophic illnesses or injuries. Money contributed to the savings account is tax deductible and accrues interest tax-free. The money remains tax free as long as it is used for qualified medical expenses.

In order for a high-deductible plan to qualify for an HSA, it must not require any first dollar coverage for mandates of impose deductibles below the minimum annual deductible. The minimum annual deductible for an HSA is $1,000 for an individual and $2,000 for a family.

Health Savings Accounts work very much the same way as the Medical Savings Accounts, which have been around for decades. However, there are clear advantages to HSAs.

	MSAs	**HSAs**
Eligibility	Self-employed and employer groups up to 50 employees	Individuals and any size employer group
Permanent	No	Yes
Cap on Enrollment	Yes	No
Minimum Deductibles	$1,700 for individuals, $3,350 for family	$1,000 for individuals, $2,000 for family
Who can contribute?	Employer or employee	Individual, employer, and/or employee
Maximum Contribution	65% of deductible for individual	Lesser of 100% of deductible or $2,600 for individuals
	75% of deductible for family	Lesser of 100% of deductible or $5,150 for family



More About Health Care

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

The 1974 Employee Retirement Income Security Act (ERISA) exempts those employers who "self-insure" their health benefit plans from state regulation, taxation and control. Under these plans the employer pays the health care claims directly, rather than purchasing an insurance policy to pay claims, and thus escapes state regulation of insurance.

Since the passage of ERISA, group health insurance in the U.S. has evolved into two separate and unequal parts - one subject to a burdensome array of state insurance regulations and the other almost regulation free.

State regulations on employer-provided traditional insurance have ballooned. The number of state-mandated benefits laws has grown more to more than 1,000 from only 158 at the time ERISA was enacted. These mandates prescribe the terms of group policies, including requirements that plans cover specific services.

With few exceptions, and despite the claims of their proponents, such laws are not moneysavers. Studies in six states have found that mandated coverage accounts for between 7 and 21 percent of all insurance claims, depending on the state. By forcing an expansion of benefits, state regulations cause firms to incur additional insurance expenditures, which translates into higher national health care spending, lower take-home wages for employees of these firms and individuals who must purchase their own health insurance.
National Center for Policy Analysis

HIGH RISK POOLS

Thirty-one states in the country have high risk pools. These pools generally serve individuals in poor health who are self-employed, employees of small businesses that do not offer health insurance to its employees, young adults coming off of their parents' coverage, and new employees not yet eligible for group insurance. For many people, risk pool participation is not permanent.

By design, a risk pool will lose money. Risk pool participants are either sick or injured people who are unable to obtain coverage elsewhere. Premiums are generally higher than private coverage but are capped at a reasonable level. Premiums typically cover only about half the claims costs. Every pool must then have a way to subsidize the remaining losses.

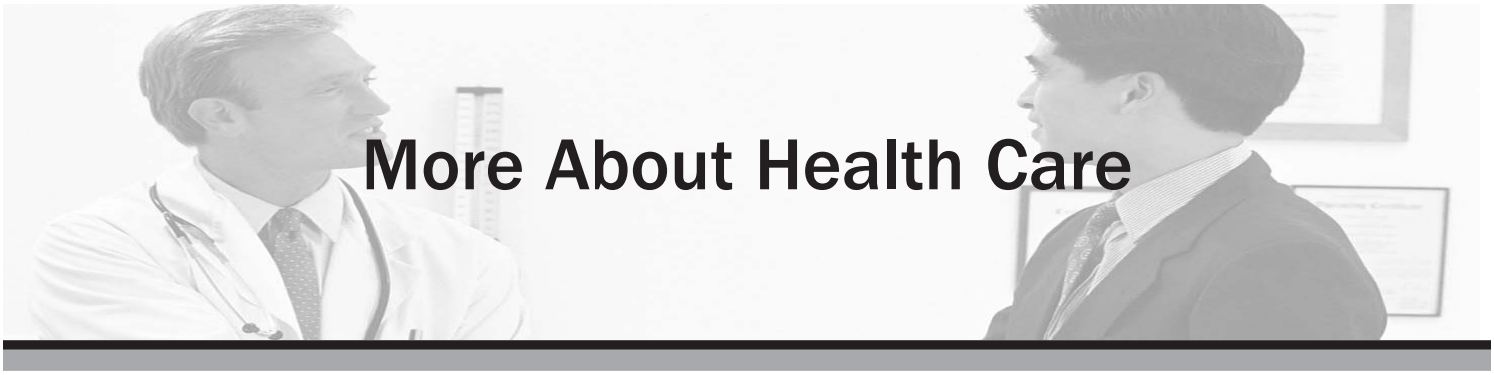
The Indiana Comprehensive Health Insurance Association (ICHIA) was established by the state of Indiana to provide affordable health insurance coverage to individuals who are uninsured, uninsurable, and unable to obtain private health insurance. It became operational in 1982.

ICHIA is funded through a combination of premiums and an assessment on the state, insurers, and HMOs. The assessment methodology was changed in the 2004 session so that seventy-five percent of the net losses of the pool are paid for by the state and the remaining twenty-five percent is split between insurers and HMOs based on each carrier's premium volume.

In the Trade Adjustment Assistance Reform Act that Congress passed in 2002, $100 million was allotted over a two-year period to help fund state high risk pools. $20 million was to be used as seed money to help start up new pools, and $80 million was made available to help offset the costs of existing pools. In 2003, the Department of Health and Human Services disbursed part of the money to the states. Indiana received $2,889,802 towards ICHIA losses.

Suggestions for ICHIA:

- Lifetime Maximum - Nineteen risk pools have benefits capped at $1 million. Six have benefits capped at less than $1 million. Two have benefits capped at $2 million. Virtually no plan in the private market has unlimited benefits.
- Expand the assessment base
- Increase preexisting condition limitations.



More About Health Care

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA), signed into law in August 1996, offers protection for millions of American workers through improved portability and continuity of health insurance coverage.

HIPAA protects workers and their families through the following provisions:

- Limiting exclusions for preexisting medical conditions (known as "preexisting conditions");
- Providing credit against maximum preexisting condition exclusions periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer;
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent;
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors;
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers;
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under federal law;
- Improving disclosure about group health plans.

United States Department of Labor

MEDICAL WAIVERS

Persons applying for individual health insurance have to qualify for coverage through a process known as medical underwriting. Some of these applicants have existing medical conditions that make it impossible to offer coverage to them because of the expected medical costs. In these cases, insurers will often use medical waivers, or riders, to exclude coverage for that specific condition or body part.

The choice of accepting insurance coverage that contains a waiver is entirely up to the individual applying for the coverage. If someone has a minor condition, such as allergies, which involves ongoing maintenance medication or shots, he or she might be willing to accept a medical waiver for their allergies. The person would then be responsible for paying the costs of the allergy medication out of their own pocket, but would have coverage for other health problems that may arise.

On the other hand, someone with a more serious, ongoing medical condition may prefer to reject the medical waiver. If a person rejects the waiver, he or she still has options through another insurer or as a last resort through the high risk pool.

In 2003, the General Assembly passed legislation which allows for the limited use of medical waivers. The legislation established a two-year experimental period during which any carrier offering individual policies can offer coverage with waivers. However, only three carriers offering coverage through association or discretionary groups may utilize waivers. These three carriers are further limited to each issuing no more than 1,500 certificates with waivers.

The waivers can be for no longer than two years in duration, and there can be no more than two waivers per individual. In addition, a notice must be sent to the applicant before issuing coverage containing a waiver. This notice must include a specific description of each condition, complication, service, and treatment for which coverage is being waived.

Health Insurance Mandates

HEALTH INSURANCE MANDATES

A health insurance mandate is a requirement that an insurance company offer specified benefits such as drug and alcohol abuse treatment, contraceptives, and even acupuncture. For almost every health care product or service, there is someone who wants insurance to cover it so they don't have to pay for it themselves.

The problem with mandates is that they increase the cost of health insurance because the insurance is required to pay for care consumers had been funding out of their own pocket. Politically, it is difficult for elected representatives to oppose a proposal that offers "enhanced" care to a large block of potentially motivated voters. The sponsors of mandates, including those who want a government-run health care system, know this fact of political life. The result has been a steady increases of government interference in, and control of, the health care system.

(Council for Affordable Health Insurance, Mandated Health Insurance Benefits CAHI Policy Brief, Volume 5, Number 1, January 2002)

THE COST OF MANDATES

One reason for the proliferation of mandates is that many of them would add very little to the cost of the average health insurance policy. For example, one of the mandates requires insurers to cover costs associated with diabetes. The costs associated with this mandate added no more than one or two percent to the cost of a typical health insurance plan. Politicians can say they are helping those in need and pass the cost of to others in the form of a slight, almost unnoticeable increase, in the cost of a policy.

However, this is but one of many mandates imposed on health insurance coverage. Indiana has adopted mandate after mandate with little reflection on their total cost. It is the accumulation of numerous mandates that begins to weigh heavily on the cost of health insurance and can ultimately lead to people canceling their coverage.

(Council for Affordable Health Insurance, Mandated Health Insurance Benefits CAHI Policy Brief, Volume 5, Number 1, January 2002)

Many Hoosiers receive their health insurance from the government (Medicaid, Medicare, CHIP) or are insured through their employer. Large employers, who self-insure, are not subject to state health insurance regulation due to the federal Employee Retirement Income Security Act (ERISA). Subsequently, health insurance mandate costs fall on those who can least afford it, small employers and individuals. Subsequently, the number of Hoosiers without health insurance has been increasing since 1999.

In Indiana, at least on health mandate passed every year between 1995 and 2003. They are listed below.

2003
HEA 1019 - Mandated cover for treatment of inherited metabolic disease
HEA 1135 - Mandated offer of substance abuse coverage

2002
HEA 1111 - Post-Mastectomy Services Coverage

2001
SEA 311 - Prompt Payment of Claims
HEA 1122 - Autism Insurance Coverage

2000
SEA 212 - Colorectal Cancer Screening
HEA 1293 - Morbid Obesity Offer of Coverage

1999
SEA 126 - Breast and Prostate Cancer Screening
SEA 289 - Health Insurance Claim Recording
HEA 1108 - Mental Health Parity
HEA 1410 - Infant Hearing Loss Testing
HEA 1951 - Dental Anesthesia

1998
SEA 261 - Newborn HIV Testing
SEA 364 - Patient Protection
HEA 1286 – HIPAA Compliance

1997
SEA 184 - Diabetes Coverage
SEA 225 - Coverage of Newly Born Child
HEA 1400 - Mental Health Parity
HEA 1663 - Grievance Procedures
HEA 1684 - Breast Reconstruction Coverage

1996
SEA 117 - Pre-existing Conditions and Coverage
SEA 306 - Domestic Abuse Coverage
Prohibition
SEA 331 - PPP Agreement Terms and Conditions
HEA 1075 – Minimum Maternity Benefits
HEA 1289 - Managed Care Study Committee

1995
SEA 576 - Individual and Small Group Reform
SEA 618 - Nurse Anesthetist Coverage
HEA 1027 - Newborn Coverage