

## **FINAL RECOMMENDATIONS & EXECUTIVE SUMMARY**

**This data was collected as an effort of the State Planning Grant on behalf of the Health Insurance for Indiana Families Committee. The data and reports were received by the committee but the contents of each are not necessarily endorsed or supported by the HIF Committee. The full reports can be viewed online at at:**

**<http://www.in.gov/fssa/dfr/3021.htm>**

# RECOMMENDATIONS

## HEALTH INSURANCE FOR INDIANA FAMILIES (HIIF) FINAL RECOMMENDATIONS NOVEMBER 2004

Funded through the competitive, federally funded State Planning Grant program, the Health Insurance for Indiana Families (HIIF) committee has met monthly since October 2002. The group was charged with developing no- or low-cost options to address the uninsured. The Committee oversaw the development of and reviewed reports on:

- Indiana Market Assessment & Drivers of Health Care Costs
- 10,000 Person Household Survey
- Indiana Statewide Focus Groups, Voices of the Uninsured
- Assessment of State Options for Expanding Health Coverage
- Assessment of Indiana Health Funding
- Indiana Health Care Safety Net
- Actuarial and Economic Analysis of Options to Expand Health Insurance Coverage in Indiana

These reports resulted in a large, comprehensive data analysis of the Indiana health care delivery system as it relates to the uninsured and underinsured. This in depth effort was critical to shaping the recommendations of the HIIF committee. It is anticipated that this data will also provide a foundation for discussion and will be used by policymakers as they consider the Indiana health care delivery system and ways to increase access.

After reviewing the data, the HIIF committee developed guiding principles to create their recommendations.

- 1) **Health care is vital to the well being of all Hoosiers. It provides the foundation for a strong and healthy workforce and increasing access to health insurance is important to Hoosier businesses, and should be considered an integral component of any economic development effort.**
- 2) **Public efforts aimed at addressing unhealthy lifestyles and improving the health status of Hoosiers is an absolutely critical component of any effort to expand access, as it directly contributes to rising health care costs.**
- 3) **Economic recovery may not bring jobs with insurance to Indiana. Indiana's growing health care costs are likely to increase health care premiums, the Medicaid budget, and the number of uninsured.**

- 4) **In light of the State's current budget situation, low-cost or no-cost options should be considered that could make a significant impact in decreasing the number of uninsured.**
- 5) **The issue of the uninsured is a symptom of larger problems in the health care delivery system. Any effort to increase access to health care must simultaneously and comprehensively address systemic reform as it relates to cost and quality.**
- 6) **In the absence of universal health care, there is no single solution to address the uninsured. Strategies to increase access to health insurance must engage a public private collaboration, be comprehensive, multi-faceted and should address the range of factors that contribute to uninsurance.**

**With these guiding principles, the HIIF committee recommends:**

#### **HEALTH STATUS**

**Indiana's low health status and high rates of chronic disease are a significant factor in the State's health care costs. The State must continue its efforts to improve health status across the State through aggressive implementation of mechanisms that reduce poor health status, unhealthy lifestyles, and promote disease management programs, and disease prevention activities. These efforts must also assure that access to care is a high priority, as health status cannot improve without effective health care services.**

**In examining the uninsured in Indiana, both the low-income and employees of small businesses clearly stand out as having high rates of uninsurance, and the HIIF committee recommends that the State focus its effort on these two populations in order to significantly decrease the number of uninsured.**

#### **SMALL BUSINESS:**

HIIF recommends the creation of a voluntary pool for small businesses that employ between 2-50 employees<sup>1</sup>. Consideration should be given to opening the pool to individuals, part-time workers, and others that do not have access to employer sponsored health insurance.

Such a pool may attract high-risk groups, and efforts must be made to assure that the pool's premiums are affordable. Such efforts should consider:

- The impact to the private health insurance market
- Funding the reinsurance for the pool.
- Development of at least 2-3 benefit plans that provide businesses and individuals with pricing options. One of these plans should consider the HIIF sample benefit plan (attached), which excludes some mandated benefits.
- The State should consider assistance to low-income workers.

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<sup>1</sup> Small business as defined by state and federal statute, 2-50 eligible (working more than 30 hours)

## **LOW-INCOME INDIVIDUALS:**

With increasing health care costs and premiums, health insurance can be out of reach for families earning less than 200% of the federal poverty level. Subsidization options should be considered for this population to make coverage more affordable. In 2000, the HIF committee supported and worked toward the passage of the Uninsured Parents Program. While lack of funding for the program prevented implementation, HIF continues to support the concept of such a program. Additionally, HIF agrees that the costs of such a program should involve a shared responsibility including the uninsured person, their employer, providers, as well as community or local government. Additionally,

- 1) The HIF committee is keenly aware of the current efforts to constrain growth in the Medicaid program. However, a Medicaid expansion is recommended, if funding is available, as it provides the only vehicle in which Indiana's investment can be matched with new federal dollars. For every \$38 dollars Indiana puts in the Medicaid program, \$62 dollars is received from the federal government. The HIF committee strongly recommends that the Governor work with the Legislature to find a strategy to increase federal funding to cover low-income Hoosiers by the adjournment of the 2005 Legislative session.
- 2) Voluntary program participation should require the financial contribution of employees, employers, and/or local government entities. HIF recommends that the State investigate the possibility of using these contributions as the required Medicaid State match to leverage federal dollars, as is being tested in other states.

## **SAFETY NET RECOMMENDATIONS**

**While programs to address small businesses and low-income Hoosiers will make a significant impact in increasing access to health insurance there will continue to be uninsured Hoosiers. Therefore, the HIF committee urges the Governor, by the end of 2005 to develop a plan to:**

- Stabilize and strengthen the existing safety net to avoid closings of current safety net venues;
- Define incentives for existing safety net providers to expand both capacity and geographic coverage;
- Facilitate the development of new safety net organizations/providers in high need areas;
- Seek increased funding opportunities for safety net systems.

**HIF recommends this be accomplished by:**

1. Developing a statewide primary care access plan which could involve the expansion of existing safety net organizations or the creation of new independent entities and provide support for implementation of plan including:
  - a. Identifying an organization that is charged with assisting communities in developing FQHCs and providing assistance with the application and budgeting processes, organizational and infrastructure development and assessing community readiness.
  - b. Identifying potential funding sources to support the organization.
2. Targeting available Community Health Center (CHC) funding towards health centers that meet State goals and expectations involving access, disease management, and quality of care.
3. Identifying potential funding to support community based initiatives that encourage local planning and development around building systems for indigent care or more efficiently coordinating disparate systems of indigent care.
4. Encouraging the development of new FQHCs
  - a. Promote designations through CHC funding requirement
  - b. Identify funding to provide technical assistance to CHCs to assist them in obtaining FQHC designation
  - c. Increase political advocacy to reduce current federal inequities in geographical distribution of Section 330 funding.
5. Preserving and enhancing the Indiana Medicaid program as it is a critical support to the safety net structure upon which the uninsured rely and make the following changes:
  - a. Preserve existing Medicaid eligibility by considering returning to the old “lock-in” period of eligibility
  - b. Aggressively target Medicaid DSH funding to hospitals serving the most disproportionate payer mixes
  - c. Explore implementation of Medicare-like demonstration programs that provide incentives and rewards to safety net systems that deliver FQHC-like services in an efficient, high quality fashion.
  - d. Encourage or create rewards for safety net providers that provide cost-effective care with risk-based Medicaid plans. FQHCs should be encouraged to partner with local hospitals or plans which reward providers for cost effective, high quality care.
  - e. Favor RBMC applications from safety net provider based Managed Care Organizations.
6. Develop a plan to mitigate recruiting difficulties of safety net organizations, especially in rural areas, including but not limited to:
  - a. Consider modification of mid-level provider authority
  - b. Expand health professional scholarship and loan repayment programs for students joining eligible safety net organizations.

## **BENEFITS**

The HIIF committee strongly believes that all benefit packages should contain basic health benefits and preventative health services. However, the committee believes it is better to provide some health care to more Hoosiers, rather than full services to a limited number of people. The committee has developed a sample benefit package, which considers the mandated benefits (see attached).

The HIIF committee recommends that all legislative efforts to mandate benefits for the State be reviewed by an external and bi-partisan committee for medical necessity and impact on health care premiums. The committee also recommends further consideration of the impact of allowing essential benefit health plans in the private insurance market.

### **DELIVERY OF HEALTH CARE:**

The State of Indiana, in partnership with the Indiana University School of Medicine, providers, insurers, and other key stakeholders should initiate a review of the State's practice patterns to identify those issues that may impact the cost and quality of the Indiana health care delivery system.

### **DATA**

The State Planning grant has allowed for an unprecedented amount of data to be collected and analyzed. The process, however, has revealed the substantial lack of comprehensive data on the Indiana health care delivery system, and the importance of such information.

HIIF strongly recommends the Governor, by 2005, take action to build upon the foundation of the HIIF reports and identify an on-going process to collect, analyze, and review key health data so the State is positioned to respond to changes and issues in the health care delivery system.

**SAMPLE HIF BENEFITS PACKAGE**  
**Small Group Coverage Options Comparison Chart**

Covered Services	Essential Benefits Coinsurance	Managed Care Benefits w/ Coinsurance	Managed Care Benefits w/ Copayments
Preventive Care *	\$20	\$20	\$20
Physician Services	30%	30%	\$35
DME and Corrective appl.	50% \$1500 annual max	50% \$1,500 annual max	50% \$1,500 annual max
Diabetic Supplies	50%	50%	50%
Therapies	20%	20%	\$30 per visit
SNF	30%	30%	\$500 per admission
Home Health	30%	30%	\$10 per visit
Hospice	30%	30%	Covered in Full
Mandates <ul style="list-style-type: none"> <li>• PDD</li> <li>• Biotech Drugs</li> <li>• Morbid Obesity</li> </ul>	Not covered	<ul style="list-style-type: none"> <li>• 50%</li> <li>• 50%</li> <li>• 50%</li> </ul>	<ul style="list-style-type: none"> <li>• 50%</li> <li>• 50%</li> <li>• Optional rider</li> </ul>
Inpatient	30%	30%	\$500 per admission
Outpatient	20%	20%	\$250/surgical proc. 20% lab/x-ray
ER/UC	50% / 20%	50% / 20%	\$125/ \$50
Maternity	30% per pregnancy	\$500 per pregnancy	\$500 per pregnancy
MH/SA	Not covered	Acute intervention only – 30%	Rider available
Prescription Drugs	\$10 generic 50% brand	\$10 generic \$40 brand 50% non-formulary OR \$10 generic 50% brand	\$10 generic \$40 brand 50% non-formulary  (Not subject to deductible)
Deductible		\$1000/\$2000	\$500/\$1500
Coinsurance Max		\$3000/\$6000	Not applicable
Lifetime Max		\$500,000	\$500,000

1. Insurer required to file for benefit and rate approval
2. Low wage earner premium assistance would be based on the actuarial value of the medical pricing excluding administrative load
3. Available to small business and individual market
4. Educational component to be offered by State to ensure program requirements for eligibility and offerings are standardized
5. Aggregate health status data to be maintained at State level

**Payers required to participate in the State Medicaid Disease Management Program for enrolled members**

# EXECUTIVE SUMMARY

**The summary represents a synopsis of the reports listed below. This data was collected as an effort of the State Planning Grant on behalf of the Health Insurance for Indiana Families Committee.**

**The data and reports were received by the committee but the contents of each are not necessarily endorsed or supported by the HIIF Committee. The full reports can be viewed online at at:**

- Indiana Market Assessment & Drivers of Health Care Costs, by Mathematica Policy Research, Inc.
- 10,000 Person Household Survey, by State Health Access Data Assistance Center, University of Minnesota
- Indiana Statewide Focus Groups, Voices of the Uninsured, by Health Evolutions
- Assessment of State Options for Expanding Health Coverage, Health Management Associates
- Assessment of Indiana Health Funding, Health Evolutions
- Indiana Health Care Safety Net, Health Management Associates, Seema Verma, Health Evolutions
- Actuarial and Economic Analysis of Options to Expand Health Insurance Coverage in Indiana, by The Lewin Group

*John Brown, a 45-year-old Hoosier father of two, was laid off from his job and can't afford the \$800.00 per month cost of family health insurance provided through COBRA. His wife was working full-time but her employer was small and did not offer health insurance. They applied for Medicaid, but their income was too high. Despite history of heart disease in his family, John put off going to the doctor for checkups because he couldn't afford it, or his medication. When he had severe chest pains, his family finally persuaded him to go to the hospital, where he was told he needed immediate open-heart surgery. With no insurance, the family is in crisis.*

*The X Corporation is an Indiana business with 35 employees, owned by John Smith and his wife. The Smiths didn't understand much about health insurance but they knew they needed it and their employees wanted it. Last year their rates increased by 40%. Business had been slow, but even in a good year they couldn't afford the rate increase. They looked at other policies and asked their employees to help pay for the increase. With the premium increase John won't be able to provide raises for employees this year. The new plan has higher premiums and employees are unhappy*

*they are getting less. They have to pay more to see the doctor, and for prescriptions. John is afraid his employees will leave, and if the rates go up any more, he won't be able to offer any coverage leaving both his family and his employees.*

Hoosiers and people around the United States are paying more for health care than ever before. Recent increases in health care premiums have left some Hoosiers without insurance, underinsured, or on the verge of losing coverage. Employers face double digit increases in premiums. While much has been said about the uninsured, there is growing discussion about the impact of both health care costs and the uninsured on business in Indiana and all Hoosiers.

### ***Numbers of Uninsured***

Nationwide there are approximately 45 million uninsured. In Indiana, the percentage of Hoosiers without coverage is lower than the national average. The Family and Social Services Administration (FSSA) telephone survey, which interviewed more than 10,000 people showed an uninsured rate of 9.2%. Numbers increase when subgroups such as adults over 65, children under the age of 19 are excluded. The number rises, when those that were uninsured at some point throughout the year are considered.<sup>2</sup> Most importantly, every survey indicates that consistent with national trends, the number of uninsured has increased in Indiana over the past five years.

2003 Census Bureau Estimate	13.9%
2001 Census Bureau Estimate	11.8%
2003 FSSA Phone Survey Estimate (10,000 Hoosiers)	9.2%
Between Ages 19-64	10.3%
Uninsured At Some Point in Last Year	12.3%

### **FACE OF THE UNINSURED**

*"The cost for my family coverage would be approximately \$500 per month out of my \$16,000 annual salary or \$1300 per month before taxes."  
Region 6 Certified Nurse Assistant working at a Nursing Home*

*"I left my teaching position with good health insurance to care for my children, one of whom has a physical disability. My husband works construction and does not have access to insurance. Although my children are eligible for Hoosier Healthwise my husband and I are left without any coverage."  
Region 4 mother*

<sup>2</sup> 10,000 Person Household Survey, A Report to the Health Insurance for Indiana Families Committee by SHADAC, September 2003: Executive Summary (pg. 2).  
<http://www.in.gov/fssa/files/survey.pdf>

*"I have bills of over \$500,000 for hospital debt. I know I will never be able to pay it off."*

*Region 8 woman*

The picture of the uninsured has changed considerably over the past ten years. The passage of the federal Children's Health Insurance Program helped provide health insurance to almost 500,000 Indiana children. Whereas historically the uninsured were often unemployed or low-income, the faces of the uninsured have changed to include mostly working families and more of the middle class. The uninsured cross many income levels, races, and areas of the State. Notably almost two thirds of the uninsured in Indiana work.

- **Working Families:** More than 64% of the uninsured in Indiana are families that earn low wages – incomes below 200 percent of the federal poverty level (about \$36,200 for a family of four). More surprising, the remaining third of the uninsured earn more than 200% of the federal poverty level and the additional twenty one percent of the uninsured earn over 300% of the federal poverty level, which for a family of four is an annual salary of \$54,300. <sup>3</sup> These are working people who often hold not one, but as many as three jobs to pay their bills, clothe their children, and put food on the table. Most of them earn too much to be eligible for Indiana Medicaid. Despite the financial situation of many of the uninsured, scores of interviews with uninsured Hoosiers conducted across the state indicated a strong willingness to contribute toward premiums...anywhere from \$50 to \$500 a month.
- **Urban & Rural Areas:** Uninsured individuals can be found throughout the state in both rural and urban areas. The highest rates of uninsurance are found in both Gary and Muncie Metropolitan Statistical Areas (MSA), where the rates are 11.5% and 10.5% respectively. <sup>4</sup> Focus groups with the uninsured in these regions indicate that the downsizing and closing of the steel plants have affected the region; this has not only affected the workers but the company retirees and their spouses. While the Indianapolis MSA has a lower rate of uninsured it is where forty percent of the total uninsured in the state reside.

## **THE INDIANA SAFETY NET**

*"I cannot obtain affordable medical coverage, so I regularly visit the free clinic, as do many of the men living in my recovery home. Indiana public health programs help women and children, but it is difficult for men to qualify for public healthcare programs."*

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<sup>3</sup> *10,000 Person Household Survey*, A Report to the Health Insurance for Indiana Families Committee by SHADAC, September 2003: 7-11.

<http://www.in.gov/fssa/files/survey.pdf>

<sup>4</sup> *10,000 Person Household Survey*, A Report to the Health Insurance for Indiana Families Committee by SHADAC, September 2003: 13-15.

<http://www.in.gov/fssa/files/survey.pdf>

A middle aged male diabetic who manages a new life recovery home

*“I cannot get my disabled mother physician care without providing money up front. She is in need of specialty diagnostic and treatment procedures, which require 100% payment in advance before the physician will treat her. In order to get her routine care, she goes to the free clinic and utilizes prescription cards from the major companies to obtain medications.”*

A middle-aged man who cares for his disabled mom

*“I make about \$750 per month from Social Security and cannot afford my prescription drugs. As an alternative I lay down to alleviate abdominal pain. I attempted to get treated at the local hospital emergency room for diagnostic services, but was then referred to a large public teaching hospital in the city for a CT scan. After 36 hours, the hospital informed me that since I was not a resident within the tax district that supports the hospital they were unable to provide treatment. I was sent back home without receiving any treatment.”*

Disabled man in his mid 60s

For uninsured Hoosiers, obtaining health care services presents a multitude of challenges. Uninsured individuals delay care, receive less preventative health services, and do not seek treatment until their condition is more advanced. As a result, uninsured Hoosiers report their health status to be fair or poor at a higher rate than those with health insurance. The vast majority of uninsured Hoosiers are more likely to use free clinics and the hospital emergency room for their regular source of care. Without a free clinic, the uninsured are very reluctant to seek care due to damaging their credit record or the threat of personal bankruptcy.

- **State & Federal Programs:** Both the state and federal government have established programs that attempt to address the needs of the uninsured; these programs are aimed at directly supporting safety net institutions, or in the case of the Medicaid program providing health care coverage to low-income individuals.

Low-income individuals typically seek care at safety net providers and these providers are the main source of care to Medicaid recipients, as well as the uninsured. Current programs include: the hospital Disproportionate Share program, Health Care for the Indigent (HCI), and community health centers. Approximately \$167.1 million amount is spent on these programs.<sup>5</sup> Most of the funding that comes from the federal government requires a state contribution. For every \$38 dollars Indiana invests in the Medicaid program, they receive \$63 in federal funding. This makes investment in the Medicaid program an opportunity to avail more federal resources. Conversely, when state funding is cut, it also reduces the amount of federal funding that Indiana receives.

- **Indiana Medicaid:** Medicaid is instrumental in providing care to the uninsured; the growing numbers of uninsured coupled with the rising costs of health care can place a burden on this program. The Medicaid program in Indiana ranks as one of the lowest in the nation for its eligibility threshold, providing coverage for individuals with incomes at

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<sup>5</sup> *Assessment of IN Health Funding*, A Report to the Health Insurance for Indiana Families Committee by Health Evolutions, February 2004: 3, 16, 17.

26% of the federal poverty level. Additionally, the state receives one of the lowest amounts of funding for federally qualified health centers. This is mainly due to the fact has lacked the infrastructure to create federally qualified health centers.

- **Safety Net Variability:** While the state has made progress over the last five years in expanding the number of health centers and increased funding through use of the tobacco settlement funding, the safety net in Indiana varies according to geography and the vast majority of the state reports a lack of services for the uninsured. This is especially true in rural areas. Safety net providers however, are struggling to keep their doors open. Outdated facilities, rising costs and increased patient loads result in long wait times. Many Indiana safety net providers are rationing care.
- **Lack of Mental Health, Dental and Specialty Services:** A recent study by the Indiana Primary Health Care Association found 66 counties are underserved by primary care services. Additionally, even in areas where services are well organized there are critical gaps. Mental health, dental and specialty services are in scarce supply for the uninsured. Some of the issues relate to an overall shortage of providers, for both insured as well as the uninsured. Another explanation is the lack of a designated funding source for some services, such as specialty care. In the case of mental health services, access is deficient in many areas of the state and services are limited for even those with insurance. Patients routinely wait 3-5 months for specialty care appointments, in those where services are available. Almost three-fourths of responders to a Step Ahead Council Survey conducted by FSSA in January 2004 reported that access to specialty care is poor in their county.<sup>6</sup> These services are loosely organized in most counties and rely on private donations and physician volunteers.
- **Hospitals & Emergency Room Care:** Hospitals are to a large extent, the barometer of the success or failure of any safety net system. A higher proportion of the uninsured are more likely to use an emergency room as their regular source of care than people with private or public coverage. By federal law, emergency departments are required to provide necessary screening and stabilization services to any patient who comes to an emergency room regardless of ability to pay. If there is not sufficient primary care or specialty care services, the emergency room will be filled with patients seeking these services.

#### **Charity Care & Bad Debt**

According to the American Hospital Association, 112 non-specialty acute care hospitals in Indiana reported charity care in 2002 totaling over \$293 million and total “bad debt,” of over \$544 million. The vast majority of reported charity care – 80 percent – was reported by just twenty hospitals located predominantly in urban areas of the state. These hospitals are critical not only to the safety net and the uninsured, but also to the health system as a whole. Without their presence the uninsured would turn to other private hospitals. Over the past five years, these twenty hospitals have benefited financially from the expansion of the Hoosier Healthwise Program, and in

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<sup>6</sup> *The IN Health Care Safety Net Assessment*, A Report to the Health Insurance for Indiana Families Committee by Health Management Associates, Health Evolutions, Seema Verma Consulting, April 2004: 16-18.

some cases supplemental Medicaid payments. However, the ever-growing number of uninsured patients combined with the increasing workforce costs and other health care cost increases is placing greater financial strain on these hospitals. Wishard Memorial Hospital, the largest indigent care provider in the State, ended CY 2003 with a deficit of about \$30 million, equal to 10 percent of its annual budget. The future hospital funding outlook is uncertain. Increasing financial pressure on hospitals from these sources as well as an increasing number of uninsured is likely to reduce the capacity of the hospital safety net to provide hospital care for the uninsured in the future. While an uninsured pregnant woman will almost certainly be able to be admitted to a hospital through its emergency room to have her baby delivered, a chronically ill uninsured adult who needs diabetic education and monitoring may find it difficult or impossible to access that care. Tragically, they may only be able to receive treatment when amputation is required.

## ACCESSING HEALTH CARE IN INDIANA

*"I lost my benefits after the premiums went up 250% in one year. I was covered under my parents' plan until I graduated from college. After that, I carried an individual plan with a \$100 deductible and even some prescription coverage. Although I never filed a claim, the premiums started going up and I gradually increased my deductible to \$1,000 and dropped all coverage except major medical and hospitalization. When the premiums reached \$2,400 per year, I dropped the coverage and now have no insurance. I work two part-time jobs making about \$8.00 per hour*

25-year old single woman without any children

*"I work for McDonald's and I am on their insurance plan. I have to accrue \$300 dollars for prescriptions before being reimbursed and only get a small percentage of medical bills paid by insurance plan."*

A single mother in her early 40s with children

Employer based coverage is the dominant source of health insurance for people under 65, covering nearly seven out of ten Hoosiers. However, employer based coverage in Indiana has slowly eroded consistent with national trends. Over 60% of those that lack health coverage work for businesses that do not offer health benefits and they do not qualify for public programs. Three in ten Hoosiers qualify for employer-sponsored insurance, but do not buy it. In these cases the benefits that are offered are often too expensive for employees with modest incomes. In some instances the employee may not qualify because they do not work enough hours, are seasonal workers or they have a lengthy waiting period before becoming eligible.

- **Small Employers:** Smaller firms (<50 employees) have an offer rate of 44% versus 98% of large firms (>50 employees). Over 58% of the uninsured work for employers with less than 50 employees.<sup>7</sup>

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<sup>7</sup> [10,000 Person Household Survey, A Report to the Health Insurance for Indiana Families Committee by SHADAC, September 2003: 25-26](http://www.in.gov/fssa/files/survey.pdf)  
<http://www.in.gov/fssa/files/survey.pdf>

- **Part-time Employees:** Workers in establishments that employ a high number of part-time workers or have large numbers of low-wage workers are less likely to have employer-based coverage. In 2002, Indiana establishments with mostly part-time workers covered just 17 percent of their workforce, a rate that has fallen from 26% in 2000.
- **Low-Wage Workers:** Low-wage employers paid 31 percent of premiums compared to 18 percent of higher wage establishments. In Indiana many low-wage workers that work for large or mid-sized employers cannot afford the insurance offered them. Once offered coverage, workers in small establishments are about as likely as workers statewide to be eligible for coverage and to take it up. However, when eligible for coverage only about half of low-wage workers take it up.
- **Individual Market:** When employers do not offer health insurance, individuals have no choice but to obtain health insurance in the individual market. Premiums are generally much higher. Additionally, insurers are not required to offer health insurance to everyone and many will not offer health insurance to individuals that appear to have health problems. If they do offer health insurance, or if an individual seeks coverage through the Indiana Comprehensive Health Insurance Association (ICHIA), premiums can be difficult to afford.

### **Costs of Health Care Coverage for Hoosiers**

- **Premiums Are Increasing:** Health insurance premiums have been rising in Indiana. Indiana's health premiums have been higher than the national average and higher than neighboring states. However the amount of increase is not considered to be statistically significant. The average premium for single coverage in Indiana as a percentage of the average wage has risen steadily—from 7 percent in 1997, to 9 percent in 2001. The average family premium relative to wages reached 25 percent of the average wage in 2001. Group premiums rose nearly 15% from 1997-2001. Even if group premiums in Indiana rose at the national average growth rate from 2001 to 2003, they will have grown 45 percent in three years, exceeding \$4 billion in 2004.
- **Effect on Business:** Increases in rates have affected both small and large employers and their employees. Premiums for small employers have been much higher than premiums for larger groups. Small businesses have responded by scaling back benefits and shifting costs to employees. Most large Indiana employers have not scaled back benefits but employees may be paying more out of pocket expenses.
- **More Health Care Expenses for Hoosiers:** Consistent with national trends, higher premiums have resulted in a majority of Hoosiers contributing more of their paychecks to health insurance. Additionally, the higher cost of coverage in low-wage establishments is striking. Additionally, more insured individuals are required to pay increasing out-of-pocket costs for deductibles and co-pays and they may be reluctant to access services. This may impact the health status of Hoosiers as they may delay or avoid care.

### **DRIVERS OF HEALTH CARE COSTS IN INDIANA**

The national health care spending per capita has risen twice as fast as the gross domestic product. Overall, this growth has been driven by increases in both the utilization and price of health care services. Indiana has averaged lower annual growth (3.8 percent) in health care spending per capita from 1994 to 1998 than the U.S. as a whole (4.0 percent); however, growth at the end of that period exceeded the national average. As 1998 is the most recent data available, it is unknown whether higher growth has continued, but it may be responsible for Indiana's rising premiums, lower employer offer rates, growing Medicaid costs and ultimately increasing numbers of uninsured and underinsured patients. Analyses of a range of health care services indicate that key cost drivers in Indiana appear to be related to population health status and the cost of care.

### **Population Characteristics & Health Status**

- **Aging Population:** Indiana is undergoing demographic and economic changes that are likely to affect the affordability and structure of private health insurance. The state has a high birth rate while, paradoxically, the average age of the population is rising. As a result, the ratio of children to workers in Indiana is rising, as are health care costs for adults as the baby boomers enter their 50s and 60s.
- **Unhealthy Population:** Adults aged 45 to 64 are the fastest-growing segment of Indiana's population, and they have shown the greatest increases in some very costly diseases—including heart disease, diabetes, hypertension, and cerebrovascular disease. Smoking and obesity are more prevalent in Indiana than in the nation as a whole, increasing the severity of chronic conditions and contributing to Indiana's high rates of lung cancer and pulmonary conditions—both extremely costly. Greater incidence of these diseases has been linked to growing expenditures for hospital care in Indiana, and greater use of prescription drugs nationally.

### **Hospital Care In Indiana**

Similar to national expenditure patterns, expenditures for hospital care in Indiana dominate other categories of health care spending. However, compared to the national average, Hoosiers spent a greater share of their health care dollars on hospital care than on noninstitutional care (physician services and home health care). In 1998, spending for hospital care accounted for 40 percent of total health care spending in Indiana, compared to 37 percent of total spending nationally. However, spending for physician care—including both preventive and chronic care—was relatively low just 26 percent of total spending, compared to 29 percent nationally—as was spending in smaller categories of care including dental care, durable medical supplies, and other costs not specified (8 percent in Indiana and 10 percent nationally). Relative spending for prescription drugs in Indiana (13 percent) was equal to the national average.

At least since 1998, per capita spending for hospital care in Indiana has exceeded the national average. In 2002, hospitals spent 4 percent more per capita than the national average (\$1,506

versus \$1,445). Growth in hospital spending per capita in 2002 substantially exceeded the national average (7.3 percent) and that of most neighboring states. The cost of hospital care in Indiana appears to be related to the likely cumulative impacts of bed supply, staffing per bed, cost per worker and longer lengths of stay. Duplication of high cost technology may also contribute to growing hospital costs.

In localized areas, hospitals have engaged in a burst of building and renovation which is likely to have driven up health care costs in some areas of the state.

### **Hospital Utilization**

- **Longer Length of Stay:** From 1998 to 2002, the number of hospital admissions in Indiana fell from 116 to 114 admissions per thousand residents (-2 percent), compared to growth of 2 percent in hospital admissions per resident nationwide. While Indiana has historically had typical average length of stays, in 2002, this number increased more than 9 percent, to 609 inpatient days per thousand residents. However, during the same time period, the national number of inpatient days increased less than 1 percent, to 603.9 per thousand residents in 2002.
- **More Procedures:** Consistent with Indiana's orientation towards high technological capacity and its high rates of chronic disease, a number of specialized hospital procedures are performed more frequently in Indiana among Medicare beneficiaries than the national average—including coronary artery bypass grafting, carotid endarterectomy, and percutaneous coronary interventions. However, the availability of technology in Indiana hospitals is high, even relative to available measures of procedures performed. This suggests that Indiana hospitals may amortize the fixed cost of investment in technological capacity over fewer procedures, potentially contributing to the higher average cost for care in Indiana hospitals.
- **Low penetration of HMO's:** This has meant that cost control has relied more on cost sharing by beneficiaries, and less on either systematic price negotiation or a culture of preventive care and health care management. This may be contributing to Indiana's growing health care costs.

### **Supply**

- **Hospital Beds:** Indiana has a high supply of hospital beds per capita compared to the national average and all neighboring states except Kentucky. In 2002, Indiana hospitals reported 3.1 beds per thousand population, which is approximately 11 percent more than the national average. Indiana's lower average use of hospital beds suggests higher vacancy rates in Indiana compared to the national average or the average in neighboring states.
- **High Cost Technology:** A greater percent of Indiana hospitals had CT scanners, diagnostic radioisotope facilities, magnetic resonance imaging, positron emission tomography, and single photon emission computed tomography. Adjusted for population size, the supply of hospital technology ranged from 14 percent above the

national average (for CT scanners) to 65 percent above the national average (for positron emission tomography).

- **Practice Style:** Indiana also has a very high supply of surgeons, suggesting a relatively aggressive style of care delivery that is consistent with Indiana's higher cost of hospital care. Indiana's supply of surgeons also is about twice the national average. Indiana also appears to have fewer primary care physicians as a share of health practitioners than the national average. Additionally, allied health professionals—including therapists and technicians—represent a larger proportion of health practitioners in Indiana. However, registered nurses and physician assistants represent a smaller proportion than either the national average or the average in any neighboring state, and their numbers are not growing appreciably. This distribution of medical professionals may reflect a style of medical practice that is different in Indiana and that drives faster cost increases.

## **THE IMPORTANCE OF HEALTH INSURANCE TO THE ECONOMY**

Increasing numbers of uninsured impact the insured and the state's economy by contributing to premium increases. Providers shift costs of the uninsured to their insured patients. As care to the uninsured can be more expensive and complicated, the impact of this cost shifting is significant.

**Impact on Employers:** The growing cost of health care could deter employers from locating to Indiana. To the extent employers are unable to pass the cost of coverage on to workers, rising health care costs may depress employment overall, or reduce hours worked. In addition, by crowding out other employee benefits (such as pension contributions) as well as household saving, rising premiums also may reduce household wealth. Finally, rising premiums probably depress rates of employee coverage by discouraging take-up. As Indiana continues to focus on expanding employment, minimizing the tax burden, and meet the demands on public resources for education and other priorities, rising health care costs is a source of real concern.

**Role of Health Care to Indiana's Economy:** The production of health care services is an important component of Indiana's economy. Hospitals, physician offices and clinics and other health care providers employ many people across the state, and may be the major employer in some communities. Claims paid by insurers support economic activity in Indiana's health services sector. While the potential for uncompensated care may also rise with rising premiums, net income may be maintained if (as is widely assumed) providers pass uncompensated costs forward into the prices they charge to insured patients. Expenditures for health insurance also support economic activity in the state's financial services sector.

**Effect of Reducing Health Care Costs by 25%:** Tough constraints on health care costs in Indiana could reverse the effect of rising premiums on the state's economy. It might ease downward pressure on wages and stimulate employer demand for labor. These effects could encourage greater consumption of other goods and services and support greater household saving. In turn, rising general employment and wages would lift

personal earnings, while lower health care costs could reduce the cost of health benefits for public employees and public-program beneficiaries.

If Indiana could constrain premium growth to achieve a 25 percent decrease in real premiums, studies project that this would equate to 52,000 net new jobs and a \$7.6 billion net increase in output and household income. Such cost reduction might occur if annual premium growth declined from an average of 10 percent per year to 7 percent over ten years. Lower cost growth that ultimately would achieve expenditure levels that are 25 percent less than projected would result some in net loss of employment in health care services, but a net job gain of about 2 percent in all sectors combined.<sup>8</sup>

- **Reduce Burden To Safety Net:** Finally, any increase in health care coverage in Indiana is likely to reduce the burden of uncompensated care on health care providers. The distribution of and charity care in Indiana is concentrated among relatively few hospitals. A 25 percent reduction in self-pay admissions could potentially reduce levels of charity care by 15 percent in Indiana hospitals that provided significant charity care in 2002. Because nearly two thirds of hospital uncompensated care in Indiana is bad debt and not charity care, the estimated reduction in these hospitals' uncompensated care was much lower—about 9 percent.<sup>9</sup> These reductions however translate into millions of dollars for providers, especially safety net providers. These savings could be important for assuring a system of care for the remaining uninsured.

## **NATIONAL EFFORTS TO ADDRESS THE UNINSURED**

### **Medicaid Expansions**

At this time there is no federal policy initiative to broadly address the uninsured. Some states are expanding Medicaid programs under waiver guidelines that allow flexibility in benefit design and encourage private partnerships, States are developing employee/employer buy-in programs, scaling back benefits to cover more people, and revising eligibility guidelines to make them less restrictive. Funding for these programs have come from general funds, local governments, as well as provider and HMO taxes.

### **Market Reform**

Insurance market reforms are unlikely to lead to substantial reductions in the number of uninsured. State efforts have included funding of stop loss coverage or reinsurance. Other efforts have entailed allowing the development of bare bones or mandate free policies. These plans have not historically had high take up rates, and several studies indicate eliminating mandated benefits does not significantly decrease price. Purchasing pools have also been formed, but participation has not been high. Other pools have been vulnerable to attracting high-risk individuals or groups. Tax credits have not been widely used, as they have not been sufficient to make an impact in reducing the cost of coverage.

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<sup>8</sup> *Indiana's Health Care Sector and Economy*, A Report to the Health Insurance for Indiana Families Committee by Mathematica Policy Research, September 2004: 18-22.

<sup>9</sup> *Indiana's Health Care Sector and Economy*, A Report to the Health Insurance for Indiana Families Committee by Mathematica Policy Research, September 2004: 24-25.

## **Community Based Programs**

Many coverage initiatives have also taken place on the local level. Coverage models have enrolled eligible individuals into limited ambulatory coverage programs or have attempted to subsidize employer-sponsored programs in a three-share model (employer, employee, and government entity). Finally, the federal government has unveiled a plan to increase the number of health centers, and has funded the Healthy Communities Access Program (HCAP) aimed at encouraging local providers to develop systems of care for their uninsured.