The State of Health Insurance Coverage in Indiana 2009

© 2010 Center for Health Policy (10-H06)
Department of Public Health, IU School of Medicine
Indiana University–Purdue University Indianapolis (IUPUI)
410 W. 10th Street, Suite 3100
Indianapolis, Indiana 46202

INDIANA UNIVERSITY
CENTER FOR HEALTH POLICY
Department of Public Health

The Center for Health Policy

The mission of the Center for Health Policy is to collaborate with state and local government and public and private healthcare organizations in policy and program development, program evaluation, and applied research on critical health policy-related issues. Faculty and staff aspire to serve as a bridge between academic health researchers and government, healthcare organizations, and community leaders. The Center for Health Policy has established working partnerships through a variety of projects with government and foundation support.

This proposal was prepared as a public service for the State of Indiana to promote discussion on various options regarding the future of state-level health reform in Indiana. The views expressed are those of the authors and do not necessarily reflect the positions of Indiana University and the Center's partner organizations or funders.

The authors would like to thank Mike Foddrill, Emily Duckworth, Bhargavi Vemuri, and Lyndy Kouns. This report would not have been possible without their contributions.

Please direct all correspondence and questions to Eric R. Wright, PhD, Director, Center for Health Policy, Department of Public Health, Indiana University School of Medicine, 410 W 10th Street, HS3119, Indianapolis, IN 46202; Email: ewright@iupui.edu; Phone: (317)274-3161.

Table of Contents

Introduction	4
Overall Insurance Coverage	5
Private Insurance Coverage - Employment Based	6
Private Insurance Coverage - Individual Market	13
Medicare	16
Indiana Medicaid: Overview	18
Indiana Medicaid: Hoosier Healthwise	20
Indiana Medicaid: Care Select	21
Indiana Medicaid: Hoosier Rx	22
Healthy Indiana Plan (HIP)	23
Indiana Comprehensive Health Insurance Association (ICHIA)	24
Uninsured	25
Map 1	26
Health Care Spending	28
Drivers of Health Care Spending	31
Thoughts for Policymakers	34
References	35
Appendix 1	39
Appendix 2	40
Appendix 3	41
Appendix 4	42
Appendix 5	43

Authors

Eric R. Wright, PhD, Director, Center for Health Policy; Professor and Division Director for Health Policy and Management, Department of Public Health, IU School of Medicine; Co-Director, Consortium for Health Policy, Law and Bioethics, Indiana University - Purdue University Indianapolic (IUPUI)

Michael Cook

INTRODUCTION

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act, better known as health care reform legislation. Among the numerous changes that will be made in the coming years to the U.S. health insurance system is the mandating of new health insurance exchanges, which are marketplaces designed to give Americans better access to affordable health insurance. State policymakers have the option to create their own insurance exchange or allow the federal government to create one for them.

As decisions are being made regarding the implementation of the new health care reform law, one of the central concerns for policymakers to understand is the current health insurance landscape available to consumers. The state of Indiana provides several insurance options for individuals based upon age and medical needs. In this policy paper, we will provide an overview of health insurance coverage in the state of Indiana while detailing each government option available to consumers.

OVERALL INSURANCE COVERAGE*

In 2009, the State of Indiana had an 83.7% insured rate for all individuals under the age of 65, which included coverage by both private insurance and government insurance. The remaining 16.3%, or roughly 898,000 Hoosiers, were uninsured. Nearly 3,618,000 Hoosiers under the age of 65, or 65.6% of the state population, were enrolled in a private health insurance plan. Approximately 94% of the total private insurance coverage for individuals under the age of 65, or nearly 3.4 million Hoosiers, was obtained through employers. Another 335,000 Hoosiers purchased health insurance through the individual market.[1] See Table 1 for details.

Another 22.1% of Hoosiers under the age of 65 are covered through various public insurance programs. The most prominent of these programs, Medicaid, is a series of programs designed for lower income families, pregnant women, and children. These programs include Hoosier Healthwise, the Children's Health Insurance Program, and Care Select. Insurance is also available for adults who do not qualify for a Medicaid plan through the Healthy Indiana Program and the Indiana Comprehensive Health Insurance Association (ICHIA). Finally, elderly and disabled Hoosiers have access to the federally-funded and administered Medicare program. Each of these government options will be further explored.

Table 1: Indiana Insurance Coverage, All Ages Under 65, 2009

	Number of Hoosiers Under 65	% of Hoosiers Under 65
PRIVATE	3,618,000	65.6%
Employer Coverage	3,410,000	61.8%
Individual Purchase	335,000	6.1%
PUBLIC	1,221,000	22.1%
Medicaid	997,000	18.1%
Medicare	140,000	2.5%
UNINSURED	898,000	16.3%

There is a margin of error of about 4% due to overlap between some public and private programs.

Source: U.S. Census Bureau, 2008

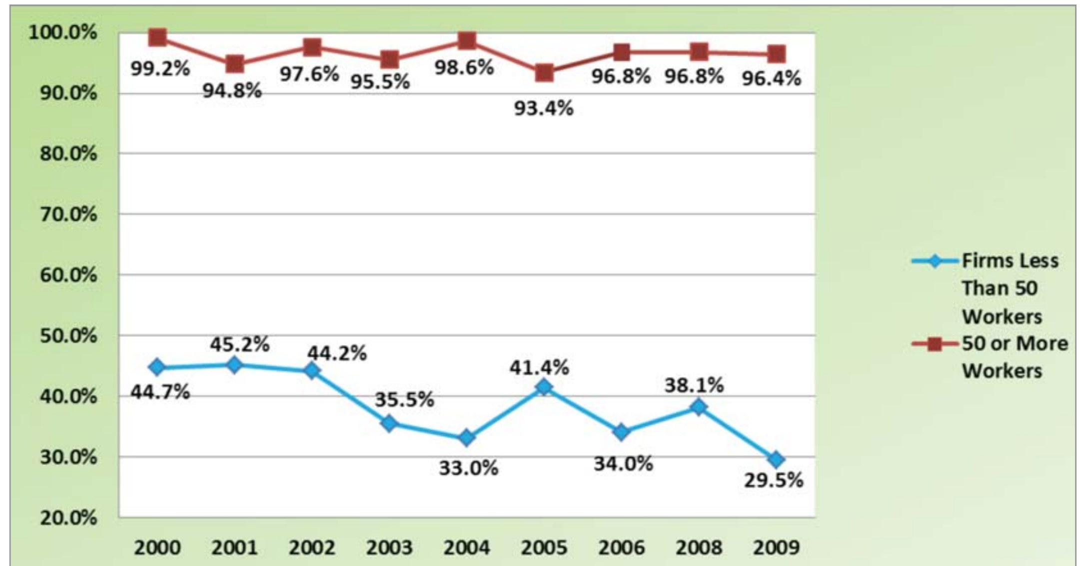
*We attempted to find the most up-to-date statistics for both the state and federal level; however, some data is known to lag behind in updates, so statistics will range from 2006 to 2010.

PRIVATE INSURANCE COVERAGE - EMPLOYMENT BASED

Health insurance coverage through an employer differs depending upon the size of the firm. In 2009, 29.5% of businesses in Indiana consisting of less than 50 employees offered health insurance, while 96.4% of larger businesses with 50 employees or more offered coverage.[2] While the coverage trend for larger firms has been relatively stable over the past 10 years, smaller firms have seen a significant drop in coverage. Coverage has fallen from a high of 45.2% in 2001 to only 29.5% in 2009, as shown in Figure 1.[3] A comparison between the size of a firm and health insurance coverage for both the United States and Indiana is shown in Figure 2. Finally, health insurance coverage is broken down by industry in Figure 3.

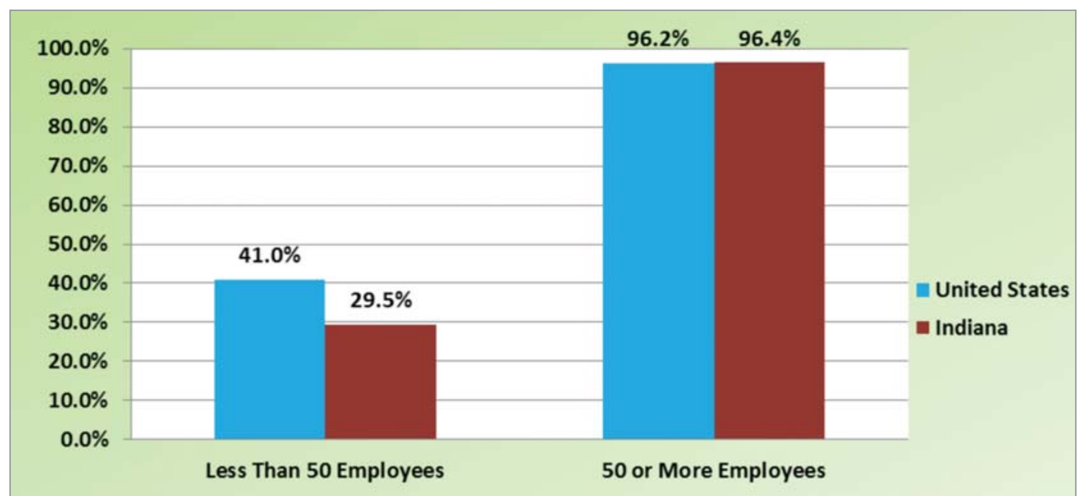
For the nearly 3.6 million Hoosiers under 65 with private insurance,[1] coverage comes with expensive premiums. On average in 2009, Hoosier employees seeking an individual insurance policy through his or her employer contributed $1,070 annually toward the premium, with the employer

Figure 1: Private Insurance Coverage by Firm Size, Indiana



Source: Medical Expenditure Panel Survey at the Agency for Healthcare Research, 2009

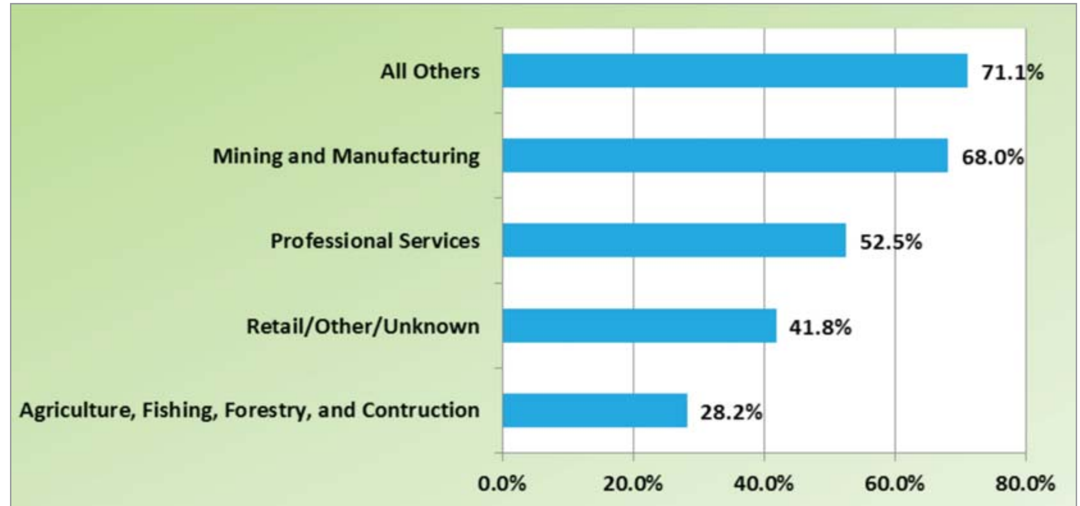
Figure 2: Private-Sector Establishments Offering Health Insurance, 2009



Source: Medical Expenditure Panel Survey at the Agency for Healthcare Research and Quality, 2009

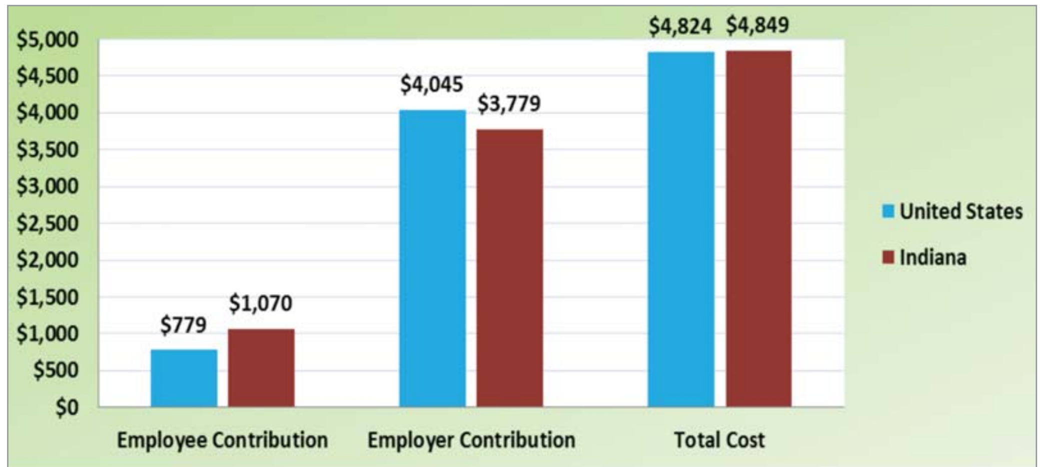
picking up nearly $3,880, as shown in Figure 4. An employee seeking a family insurance plan was paying even more: $3,257 toward the annual premium, with the employer picking up the remaining $9,615, as shown in Figure 5.[4]

Figure 3: Percent of Hoosier Companies That Offer Health Insurance by Industry, 2009



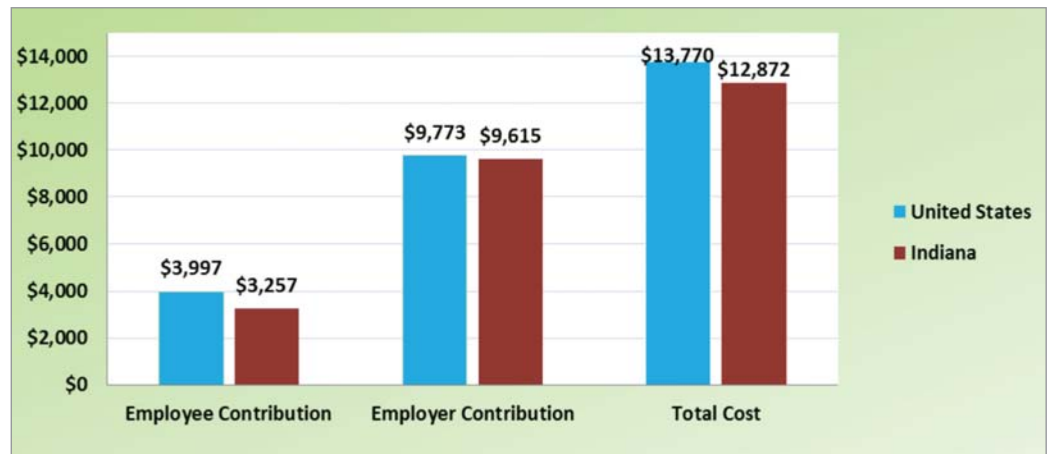
Source: Medical Expenditure Panel Survey at the Agency for Healthcare Research and Quality, 2009

Figure 4: Indiana Average Single Coverage Premium, 2009



Source: Kaiser Family Foundation State Health Facts, 2009

Figure 5: Indiana Average Family Coverage Premium, 2009



Source: Kaiser Family Foundation State Health Facts, 2009

In the United States, both single and family coverage insurance policies have seen dramatic premium increases over the past decade. In 1999, the annual premium for a single coverage insurance policy offered through an employer averaged $2,196, while the annual premium for family coverage was $5,791. Those figures have risen steadily over time and the current annual premiums for single and family coverage average $5,049 and $13,770, respectively.[5]

In Indiana, the single and family coverage premiums have followed the national trend. The increases have been equally problematic for smaller businesses as for larger employers. The average single coverage premium has risen from $2,783 in 2000 to $4,586 in 2009 for a firm with less than 50 workers, while firms with 50 or more workers have seen a similar increase. Family premiums have become even more costly: the average premium for firms with less than 50 workers has risen from $6,409 in 2000 to $11,682 in 2009.[3] See Figures 6 and 7 for details.

Figure 6: Indiana's Average Single Coverage Annual Premium, 2000-2009

Source: Medical Expenditure Panel Survey at the Agency for Healthcare Research, 2009

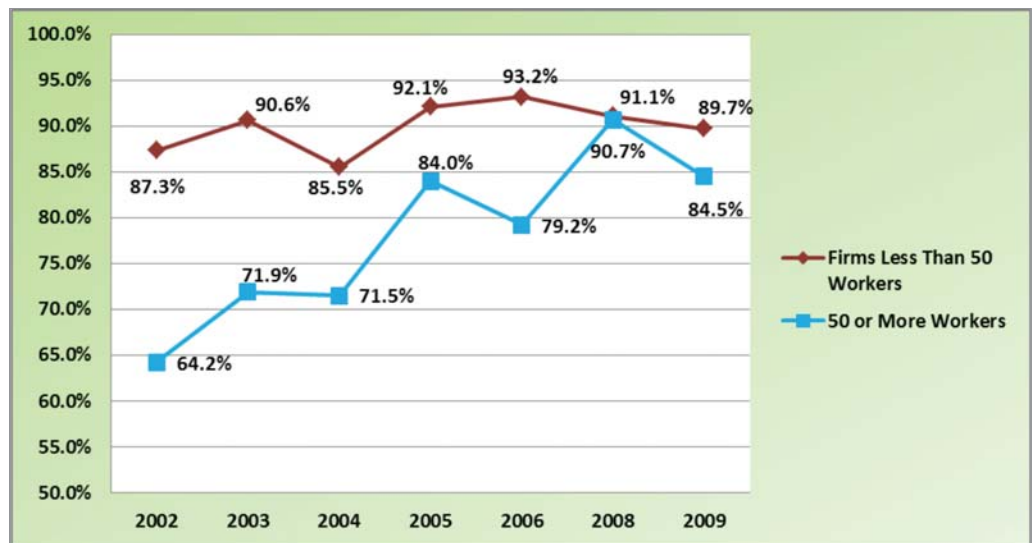
Figure 7: Indiana's Average Family Coverage Annual Premium, 2000-2009

Source: Medical Expenditure Panel Survey at the Agency for Healthcare Research, 2009

While average annual premiums for employees have been rising over the past 10 years, the emphasis on cost-sharing has also been on the rise, especially in U.S. firms of less than 200 workers. Specifically, the percentage of all small firms enrolled in a health insurance plan with an annual deductible of $1,000 or more for a single coverage policy has increased from only 16% in 2006 to 46% in 2010. Larger firms of more than 200 workers have also seen an increase in high deductible coverage, from 10% in 2006 to 27% in 2010.[5]

In Indiana, the gap between large and small employers that offer health plans with annual deductibles has been narrowing over the past several years, as shown in Figure 8. While Hoosier firms with less than 50 employees have typically offered health insurance with a deductible at a higher rate than larger firms, larger firms are now equally as likely to offer coverage with an annual deductible. In 2009, almost 90% of firms with less than 50 workers offered coverage with a deductible, while almost 85% of larger firms offered coverage with a deductible.[3]

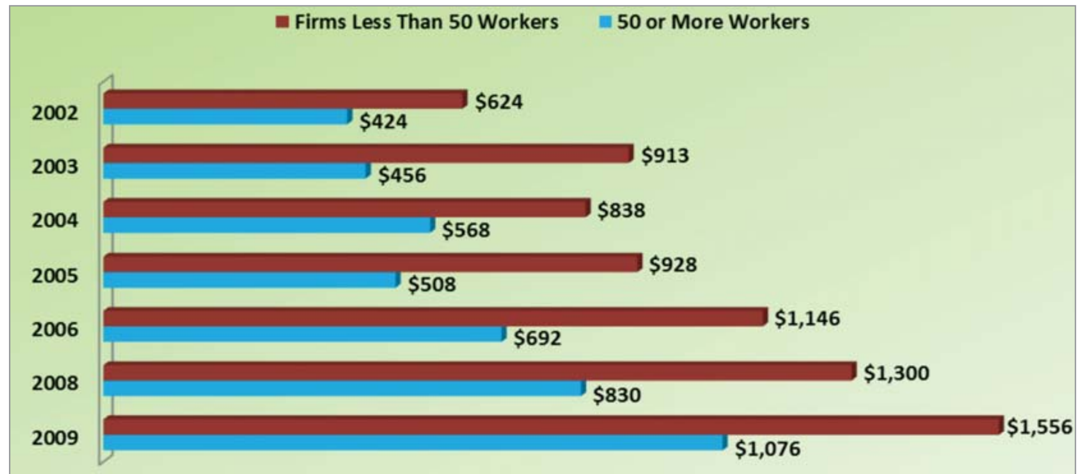
Figure 8: Percentage of Hoosier Firms Offering Health Insurance with Annual Deductibles by size, 2002-2009



Source: Medical Expenditure Panel Survey at the Agency for Healthcare Research, 2009

In addition to having a higher percentage of health insurance offered with a deductible, Indiana small business plans are also more likely to contain a higher deductible, as shown in Figures 9 and 10. An average single coverage deductible for a firm with less than 50 workers in 2009 was $1,556, while a deductible for a family coverage for a firm this size was $3,207. Larger firms averaged a significantly smaller deductible for single and family coverage in 2009: $1,076 and $1,838, respectively.[3]

Figure 9: Average Single Coverage Annual Deductible by Firm Size in Indiana, 2002-2009



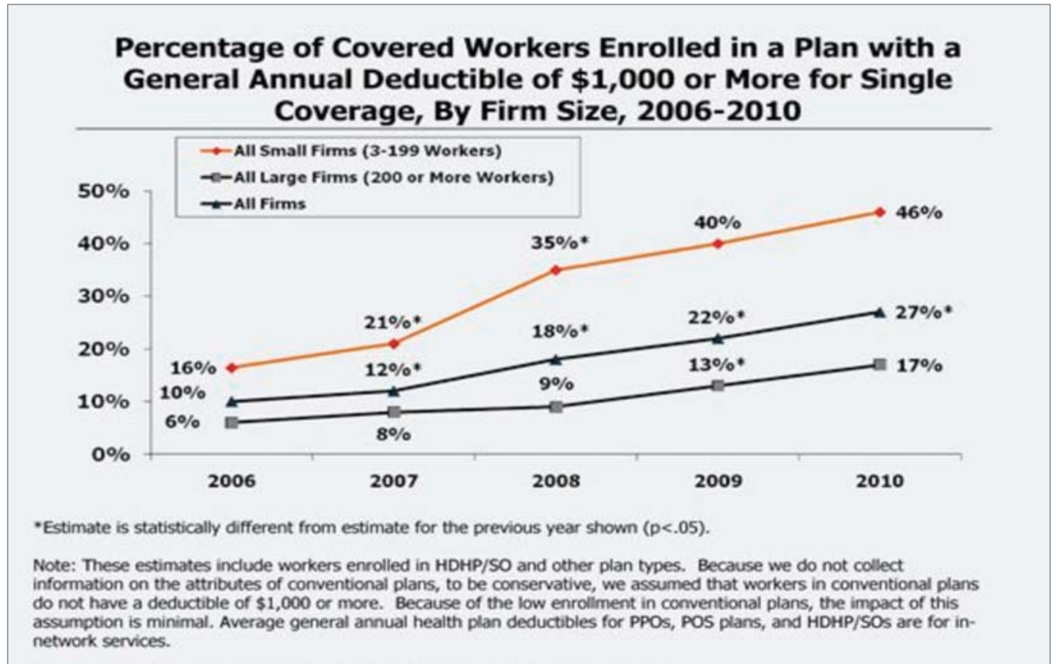
Source: Medical Expenditure Panel Survey at the Agency for Healthcare Research, 2009

Figure 10: Average Family Coverage Annual Deductible by Firm Size in Indiana, 2002-2009

Source: Medical Expenditure Panel Survey at the Agency for Healthcare Research, 2009

The trend for higher cost sharing is occurring for all firm sizes throughout the United States. The percentage of firms with less than 199 workers offering single health insurance policies has risen from 16% in 2006 to nearly 50% in 2010, as seen in Figure 11. A similar trend is occurring for firms with more than 200 workers.[5]

Figure 11: Percentage of Covered Workers with Annual Deductible of $1,000 or More for Single Coverage by Firm Size in the United States, 2006-2010



This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

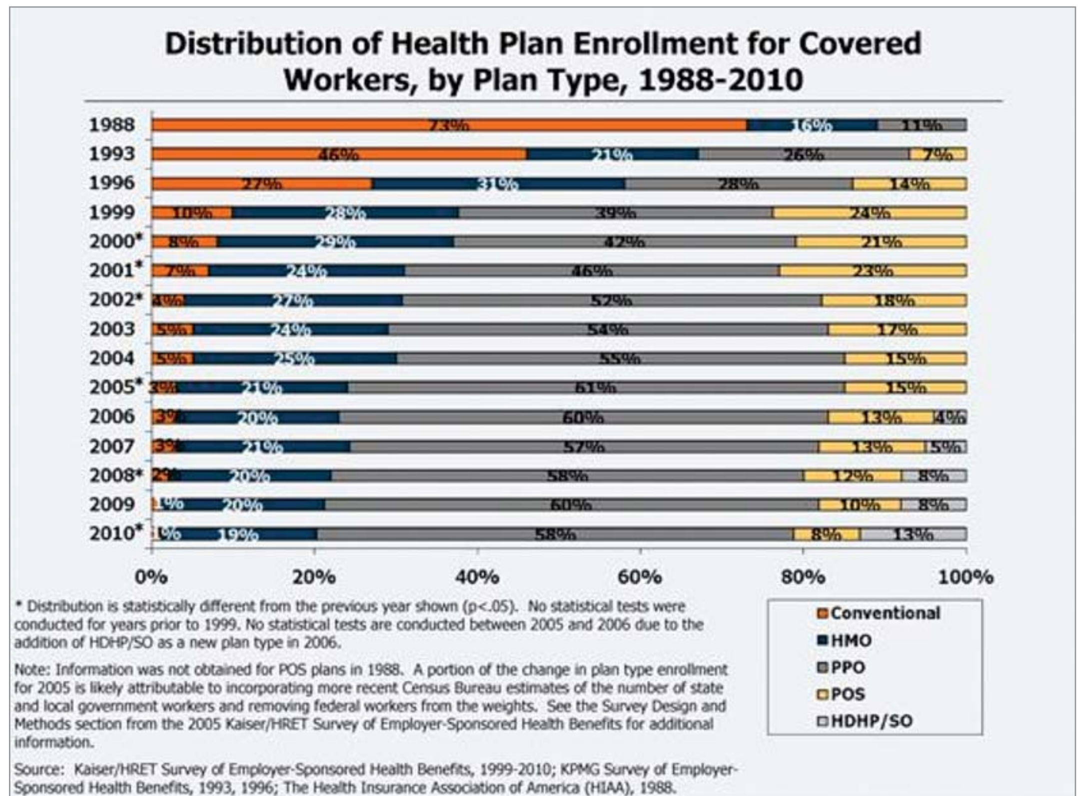
*Please note that Figure 11 uses a source that defines "small firm" as firms with less than 199 workers, while an earlier source defined "small firm" as less than 50 workers.

Employers in the United States are also dramatically changing the plan type they offer to their employees. In 1988, 73% of insurance coverage was through conventional, or indemnity, insurance; in 2010, that rate has dropped to only 1%. As conventional plans have decreased, preferred provider organization (PPO) plans have risen as the dominant employer plan; in 2010, 58% of plans were PPOs. Another noticeable trend is the rise of high deductible health plans (HDHP), or consumer-driven insurance options; in 2010, 13% of employers offered an HDHP, which is an increase from 4% in 2006.[5] See Figure 12 for more information.

Another option available to employers is to pursue a self-funded insurance plan. Self-funded plans are "insurance arrangements in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims."[5] The percentage of U.S. firms in a partially or completely self-funded insurance plan has increased from 44% in 1999 to 59% in 2010.[5]

Under the federal health care reform law, self-insured plans are not subject to a number of important insurance regulations, including the minimum loss-ratio requirements, the essential benefits requirements, or the guaranteed issue of coverage requirement.[6] This has been the cause of some concern for the state health insurance Exchanges, particularly for small businesses that use self-insured plans; if relatively healthy self-insured pools remain outside of an exchange until their pool becomes sicker and more costly, they could potentially inflate premiums within the Exchange.[7]

Figure 12: Distribution of Health Plan Enrollment for Covered Workers in the United States, 1988-2010



This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

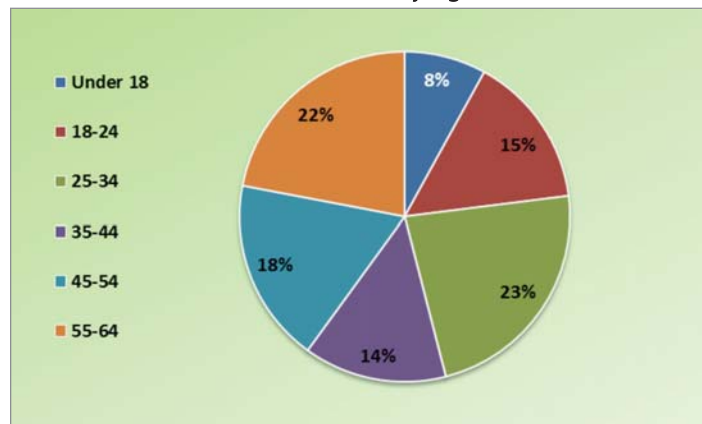
PRIVATE INSURANCE COVERAGE - INDIVIDUAL MARKET

Individuals who are self-employed or are otherwise seeking health insurance without an employer are also paying a high premium for coverage. A recent survey of individual policy owners conducted by the Kaiser Family Foundation found that, nationwide, the average annual premium for individuals buying their own health insurance was $3,606, while people seeking family coverage were paying an average of $7,102.[8] One study found Indiana on the less expensive side of individual insurance: in 2009, the average annual premium for an individual policy was $2,930, while the annual premium for family coverage was $6,236.[9]

Even more startling than the high premiums is the high average of out-of-pocket spending, including co-pays and deductibles, for individuals seeking insurance without their employer. Excluding insurance premiums, these individuals paid an average of $1,690 out-of-pocket for healthcare costs.[8]

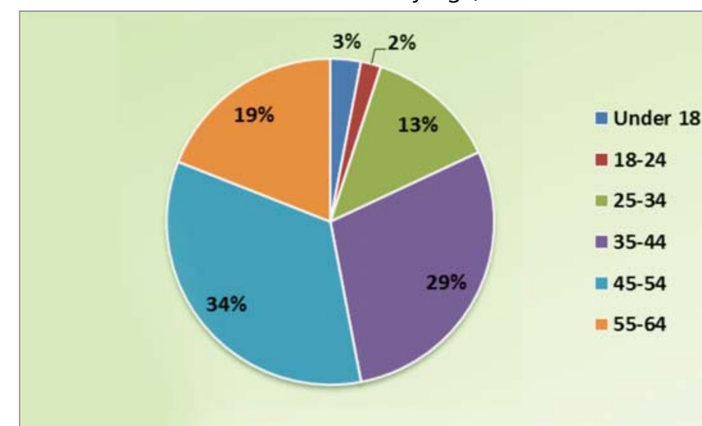
The customers in the individual insurance market include a wide range of ages. A study of insurance companies found a relatively even distribution of single policies for all ages, while family policies are skewed towards those ages 35 to 64 (see Figures 13 and 14). Not surprisingly, premiums rose with both age and family size; the average annual premiums ranged from $1,350 for individuals under 18 to $9,952 for a family plan of those ages 60 to 64.[9]

Figure 13: Percentage of Single Coverage Policy Owners in the Individual Health Insurance Market by Age, 2009



Source: America's Health Insurance Plans, 2009

Figure 14: Percentage of Family Coverage Policy Owners in the Individual Health Insurance Market by Age, 2009



Source: America's Health Insurance Plans, 2009

A separate survey conducted by the Kaiser Foundation of people in the non-employer insurance market found that 37% of respondents were self-employed, compared to 29% who worked full- or part-time for an employer that did not provide health insurance. 66% of respondents reported having an income of more than $50,000 a year, while 34% reported making less than $50,000. Finally, 62% of respondents believed themselves to be in excellent or very good health.[8]

Those in the individual insurance market who are successful in acquiring a policy tend to have coverage from preferred provider organizations (PPO). In 2009, as shown in Table 2, one study found that almost 83% of survey respondents with individual insurance coverage in the United States were covered under a PPO, while over 11% had a health savings account. Coverage for a family in the individual market was slightly different; almost 73% reported having coverage from a PPO, while almost 25% reported using a health savings account.[9]

Those seeking insurance in the private market have a variety of insurance companies from which to choose; however, several companies have significant market share. In fact, five insurance companies – Anthem, WellPoint, UnitedHealthcare, Cigna HealthCare, and Aetna - control 85.5% of the private insurance market in Indianapolis, as shown in Figure 15.[10] Since its merger in 2004, Anthem Blue Cross Blue Shield has been a subsidiary of WellPoint. A 2004 report from *Health Affairs* found that four companies controlled 60% of the total health insurance market in Indiana; Anthem Blue Cross Blue Shield controlled the largest share at 46%.[11] In 2009, WellPoint Inc.'s market share in Indiana had grown to 60%, with M*Plan from UnitedHealthCare group taking an additional 15% for a combined 75% market share of the private insurance industry.[12]

In 2007, the American Medical Association (AMA) released data regarding the state of health insurance competition throughout all 50 states. With health maintenance organizations (HMOs) and preferred provider organizations (PPOs) combined, the AMA found that WellPoint had over half of the private insurance market in a number of major Indiana cities, including Anderson (72%), Columbus (54%), Elkhart-Goshen (68%), Fort Wayne (52%), and Indianapolis (68%). Combined with the second most

Table 2: Individual Health Insurance Coverage, United States, 2009

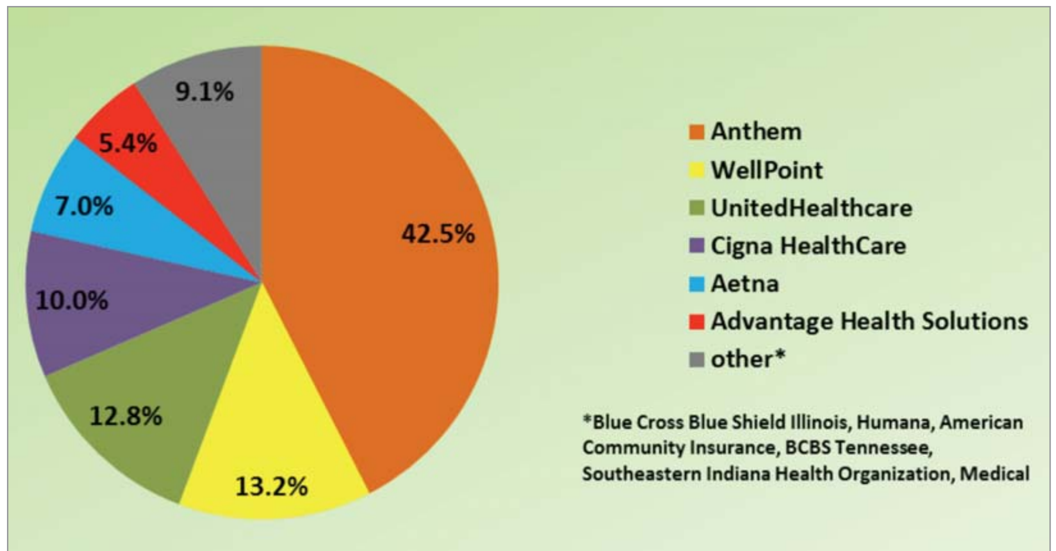
	Single Coverage		Family Coverage	
Preferred Provider Organization	1,527,795	82.8%	565,382	72.9%
Health Savings Account	207,901	11.3%	182,687	23.5%
Health Maintenance Organization	38,053	2.1%	12,537	1.6%
Indemnity	71,229	3.9%	15,211	2.0%
TOTAL	1,844,978	100.0%	775,817	100.0%

Source: America's Health Insurance Plans, 2009

prominent insurer in each city, two insurance companies on average controlled 81.4% of the private insurance market.[13]

While all of these numbers suggest fewer options for Hoosiers in the private market, some research suggests that less competition may not necessarily be a problem. One study focused on 341 HMOs and found that "less, not more, competition was associated with better health plan performance in several – though not all – factors."[14] Less competition may also result in improved customer service and stronger "operating efficiency" depending upon how a state's private insurance market is set up.[15] Further research into the health outcomes, the price of premiums, and the overall competitiveness of a state's insurance market would be necessary to make any firm conclusions about the positive or negative aspect of insurance competition.

Figure 15: Share of Private Insurance Market in Indianapolis by Insurance Company, 2009



Source: Wall, J.K., 2009

MEDICARE

Hoosiers over the age of 65 and those with Social Security Disability Insurance are entitled to receive health insurance through Medicare. Medicare consists of three separate parts: hospital coverage (Part A), medical insurance (Part B), and prescription drug coverage (Part D). Medicare Advantage, otherwise known as Part C, consists of supplemental Medicare coverage from private companies that add additional protection for medical needs. All working individuals are automatically enrolled in the premium-free Medicare Part A on the day they turn 65 years old. In 2010, 996,966 Hoosiers are enrolled in either Part A and/or Part B. Almost 84% of those enrolled are aged, while 16.3% are disabled.[16] Of the total number of Medicare enrollees, 160,217, or 16.1% of beneficiaries, are currently enrolled in a Medicare Advantage plan.[17] Medicare Advantage consists of many private plans that combine and supplement medical and drug insurance with varying monthly premiums.

Individuals who enroll in Medicare Part B have a monthly premium. Depending upon income and marital status, the premium can range from $110.50 to $353.60.[18] Meanwhile, depending upon an individual's income, Part D's monthly premium can range from $23.10 to $100.70 in the state of Indiana.[19]

In 2010, Medicare was financed through three primary means: a Medicare payroll tax (40%), general revenues from income taxes (39%), and beneficiary premiums (12%). The federal government has been spending more each year to finance Medicare; in 2010, the program cost $522 billion, or 13% of federal spending.[20] By comparison, in 2000, the total program cost was only $221.8 billion.[21] Medicare has seen substantial growth over the past 50 years (see Figure 16).

Figure 16: Total Medicare Outlays (in Billions), 1967-2010

Source: Center for Medicare and Medicaid Services, 2010.

While Medicare itself does not directly impact the state of Indiana's budget, the phenomenon of dual eligibles does have some influence. Dual eligibles are very poor and sick individuals who simultaneously qualify for both Medicaid and Medicare. Prime examples of dual eligibles are elderly individuals with multiple chronic conditions as well as mental illness. They rely on Medicaid to pay for any Medicare premiums as well as to provide insurance on features that Medicare does not, such as long-term care.[22] In 2005, there were 140,335 dual eligibles in the state of Indiana, accounting for $2.5 million of the Medicaid budget.[23] By using the2005 Medicaid data from the Medicaid Statistical Information System (MSIS), we can calculate the expensive nature of the dual eligibles: only 14% of the Medicaid population is using a little over half of the non-administrative Medicaid budget.[23]

The scope of Hoosier Medicaid includes

- *Hoosier Healthwise*, a blended insurance program that covers low income families, pregnant women, and children through the *Children's Health Insurance program.*
- *Care Select*, which is a long-term care program designed for the aged and disabled.
- The *Hoosier Rx Benefit*, which helps pay the annual premium for Medicare Part D.

Traditional Medicaid, or Fee-For Service Medicaid, is also available as the source of coverage for dual-eligibles and mentally or physically disabled individuals.[24] The Medicaid system is administered by Office of Medicaid Policy and Planning (OMPP) within the Indiana Family and Social Services Administration (FSSA).[25]

During state fiscal year (SFY) 2009, the Indiana General Assembly allocated $1.116 billion in General Funds to be spent on the Medicaid system, with the federal government paying $3.989 billion. SFY 2009 and SFY 2010 were also notable for federal stimulus spending that amounted to additional income for the state of nearly $550 million in 2009 and $289 million in 2010. Including administrative expenses, the Office of Medicaid Policy and Planning was allocated over $6.223 billion during SFY 2009 and $6.738 billion during SFY 2010.[26] The share of state and federal spending on Medicaid has seen a steady increase over the past five years.

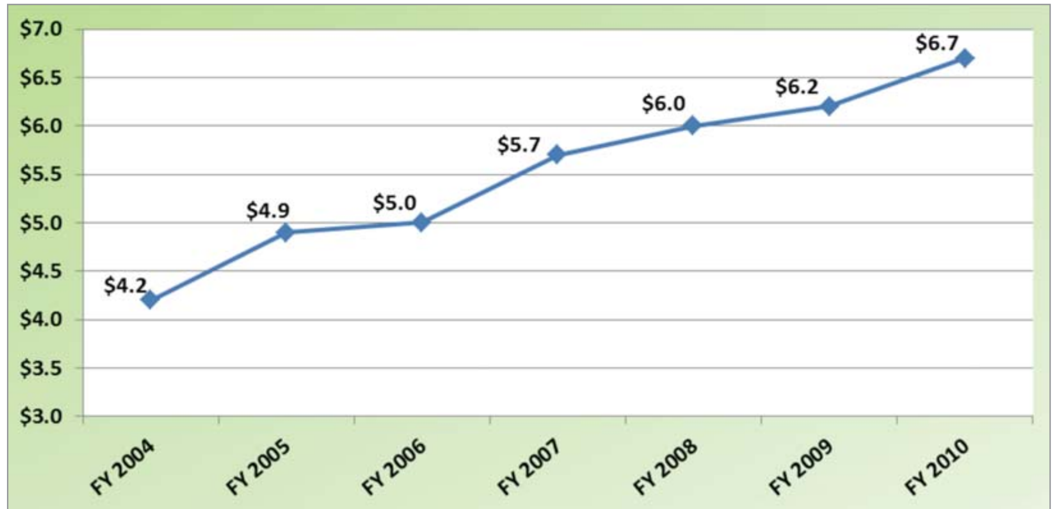
A recent report from the Kaiser Family Foundation discussed the impact of the recent economic recession on Medicaid programs across the country. During FY 2010, total Medicaid spending growth averaged 8.8% across all states, which is higher than the projected 6.3% annual growth. This growth in spending has been linked to an 8.5% increase in enrollment across all states, which, again, is higher than the 6.6% annual enrollment growth projected at the beginning of the fiscal year. As a result of the tighter budgets, 48 state governments attempted to control cost, including benefit restrictions and provider rate cuts.[27]

Federal Poverty Level

State aid programs like Medicaid determine eligibility using the Federal Poverty Level. Forty-eight states, including Indiana, follow the same uniform guidelines for determining the degree to which a person or family is in poverty. In 2009 and 2010, a single individual making $10,830 a year would be considered at 100% of the Federal Poverty Level (FPL), while a family of four making only $22,050 a year would qualify for 100% FPL.

Source: CMS 2010 Poverty Guidelines, 2010

Figure 17: Total Medicaid Planning and Policy Budget for Indiana (in Billions), 2004-2010



Source: Indiana State Budget Agency, 2010

Determining the exact number of enrollees in the Indiana Medicaid system can be difficult, as multiple sources suggest different numbers. In 2007, according to the Office of Medicaid Policy and Planning's county reporting system, 849,479 Indiana residents were receiving Medicaid benefits.[28] However the Centers for Medicare and Medicaid Services reported through their Medicaid Statistical Information System (MSIS) that there were 986,229 unique beneficiaries of Medicaid in the state for 2007.[29] Finally, the 2009 Annual Social and Economic Supplement of the Current Population Survey (CPS) completed through the Census Bureau estimated that 732,000 Hoosiers were receiving Medicaid benefits.[30] The difficulty of knowing the actual number of recipients is heightened by the inclusion of Medicare dual eligibles as well as the overlap from the various programs in Indiana that constitute Medicaid.

INDIANA MEDICAID: HOOSIER HEALTHWISE

Of the various Indiana Medicaid programs, the largest is Hoosier Healthwise. The program is designed to provide free or low-cost health insurance to:

- children up to age 19
- pregnant women, and
- low-income working families.

Table 3: Monthly Income Requirements for Hoosier Healthwise (as of March 1, 2009)

	Pregnant Women			Children	
Family Size	Low-Income Families (Package A) – TANF	Pregnancy-Related Coverage (Package B) – 200% FPL	Full Coverage (Package A) - TANF	Premium-free (Package A) – 150% FPL	Low-Cost Premium (Package C) – 250% FPL
1	$139.50	N/A	N/A	$1,354	$2,257
2	$229.50	$2,429	$229.50	$1,822	$3,036
3	$288.00	$3,052	$288.00	$2,289	$3,815
4	$346.50	$3,675	$346.50	$2,757	$4,594
5	$405.00	$4,299	$405.00	$3,224	$5,373
For Each Additional Member Add:	$58.50	$624	$58.50	$468	$780
Asset Limit:	$1,000	N/A	$1,000	N/A	N/A

Source: FSSA, 2010

The program has three packages of coverage depending on the type of recipient. Low-income working families can be eligible for a premium-free package A, while children have access to the Children's Health Insurance program through Package C which includes a premium of between $22 and $50 depending upon family size and income. Meanwhile, depending on income and asset ownership, pregnant women may qualify for pregnancy-related coverage under Package B or full health insurance coverage under Package A.[31]

Individuals seeking coverage through Hoosier Healthwise must meet both income and asset requirements:

- Income (see Table 3 for details):
  - o Children only – 150% FPL ($27,465 for a single parent with two children) for no premium, Package A; OR 250% FPL ($45,775 for single parent with two children) for low premium, Package C (otherwise known as CHIP)
  - o Pregnant Women – 200% FPL ($21,660) for a pregnancy-related Package B; Temporary Assistance to Needy Families (TANF) guidelines for full Package A coverage
  - o Low Income Families – TANF guidelines (around 15% FPL) for Package A
- Asset limit: $1000 for low-income families and pregnant women seeking Package A coverage.

In the past several years, Hoosier Healthwise has changed so that recipients now have a choice of insurance providers through Anthem Blue Cross Blue Shield, MDwise, or MHS – Managed Health Services. Through their provider recipients either choose, or have assigned to them, a primary care physician (PCP) who is responsible for providing all primary care as well as referrals. Once enrolled, recipients' covered services include hospital care, prescription drugs, mental healthcare, home health, nursing care, dental, vision, and more.[7]

INDIANA MEDICAID: CARE SELECT

Care Select was created in 2007 by the FSSA "to improve the quality of care and health outcomes while controlling the growth of healthcare costs for members."[32] It is a long-term care management program designed for the aged, blind, physically and mentally disabled, and other specific individuals. Currently, there are around 73,000 individuals enrolled in the program who are also enrolled in Indiana's traditional Medicaid program.[32] Individuals and couples seeking traditional Medicaid and the Care Select program must make under 100% FPL.[33] Individuals who are dually eligible for Medicaid and Medicare are not allowed to enter the Care Select program.

Effective October 1, 2010 the program will shift focus toward disease management rather than long-term care. Members with chronic conditions, including asthma, diabetes, coronary heart disease, and hypertension, will be able to participate in programs that the original Care Select organizations provide. Some 32,000 members of traditional Indiana Medicaid will now be eligible for the program; however, those no longer eligible for Care Select can still be enrolled in traditional Medicaid.[32]

INDIANA MEDICAID: HOOSIER Rx

Originally created in 2000 as a way of paying for prescription drugs for low-income older individuals, Hoosier Rx has since been changed into a program that pays the premium for Medicare Part D, prescription drug coverage. Depending upon whether or not an individual has assistance from Medicare directly in paying for monthly Part D premiums, Hoosier Rx can provide up to $1,200 per year to cover the difference between out-of-pocket costs and Medicare coverage.[34] The program is financed with money from the Tobacco Settlement Fund; in FY 2009, the state of Indiana allocated $1.12 million for Hoosier Rx,[26] while the state received an estimated $161 million in revenue from tobacco settlements.[35] Much of the remaining balance goes into tobacco prevention efforts.

To qualify for Hoosier Rx, an individual must:

- be a 65-year-old resident of the state;
- have Medicare Part A and/or Part B;
- have a yearly individual or married income of less than 150% of the federal poverty level ($16,245 for an individual in 2010); and
- be enrolled in a Medicare Part D plan.

In 2007, the program had 2,300 enrollees.[34]

HEALTHY INDIANA PLAN (HIP)

Another option available for individuals seeking health insurance coverage is through the Healthy Indiana Plan (HIP). The program was created in 2008 and is administered by either Anthem Blue Cross and Blue Shield or MDwise as a consumer-driven health insurance program. HIP is a Medicaid waiver program funded by an increase in the cigarette tax to $0.95 per pack as well as a portion of the state's Disproportionate Share Hospital (DSH) funding.‡

In 2008, the state reported that over 45,000 Hoosiers were receiving health insurance through the program.[36] By September 2009 the number of enrollees had grown to nearly 47,000, while over 123,000 applicants were denied entry into the program. Reasons for denial included failure to verify income, having insurance coverage within the past six months, and having access to insurance through an employer.[37]

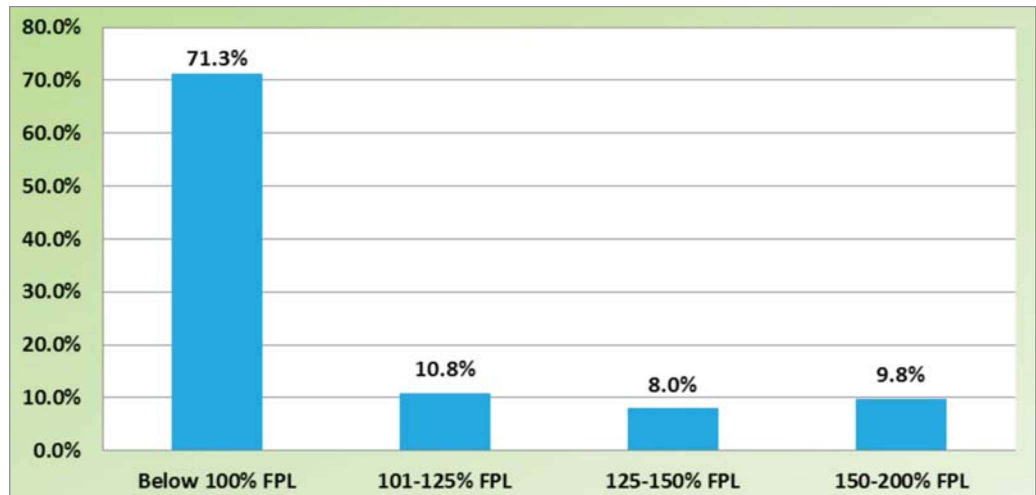
Healthy Indiana Plan is targeted at low-income individuals who neither qualify for Medicaid nor receive employer-based coverage. Qualifying individuals must

- have gone six months without access to employer coverage, Medicaid, or Medicare; and
- make less than 200% FPL ($21,660, individual, in 2010).[38]

While individuals within the program must make less than 200% FPL, a large majority of enrollees are below 100% FPL. In November 2009, over 71% of enrollees were below 100% FPL, with an additional 11% under 125% FPL, as shown in Figure 18.[37]

Once an individual is covered, the plan contains three distinct features: a Personal Wellness Responsibility (POWER) account, total coverage for preventive care, and a high deductible. An enrollee is expected to cover the $1,100 deductible with money from his or her POWER account, which is a monthly contribution on a graduated scale made by either the enrollee or the state. The theory behind the account is that by giving enrollees direct control over how their health insurance dollars are spent, they will be more conscious of price and use rates of healthcare services. To make enrollees aware of prevention, the Healthy Indiana Plan provides comprehensive coverage for preventive care without forcing an enrollee to withdraw from his or her POWER account. Once the $1,100 deductible has been reached, the provider is expected to pay for full coverage up to an annual limit of $300,000 or a lifetime limit of $1,000,000 in benefits.[38]

Figure 18: Percent of Total HIP Membership by FPL, November 2009



Indiana Check Up Plan Task Force, 2009

Printed with permission from the Family and Social Services Administration.

‡DSH funding refers to the federal government allocating a higher reimbursement rate for Medicaid providers that care for a disproportionately higher number of Medicaid patients. The theory behind using DSH funding is simply that these hospitals should be seeing less Medicaid patients and should be receiving higher reimbursement rates.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ICHIA)

One last option for individuals seeking health insurance is the Indiana Comprehensive Health Insurance Association (ICHIA). Originally started in 1982, the ICHIA is a high-risk insurance pool for individuals with health conditions, such as cancer, that inhibit their ability to purchase affordable insurance. In 2008, the ICHIA provided health insurance to 6,561 Hoosiers.[39]

Funding for the ICHIA comes from premiums collected by the insurance companies operating in the state of Indiana as well as from a partial tax credit against the premium taxes paid by the insurance companies. During SFY 2009 and SFY 2010, the state of Indiana allocated $38.5 million per year towards ICHIA.[26] ICHIA plans are provided through Anthem Blue Cross and Blue Shield. Five plans with increasing deductibles are available, covering a wide range of healthcare services.

The monthly policy premium can be significantly higher than what an individual would pay either through an employer-based plan or government plan. There are significant variations in the cost of the premium depending upon an individual's sex, age, and plan of choice. An individual choosing a lower-deductible plan could pay between $255 and $1,300 a month depending upon their age and sex. The highest-deductible plan, which is $5,000, has a premium range from $135 to $890 a month.[40]

To qualify for coverage with the ICHIA, an individual must also follow guidelines created by the Health Insurance Portability and Accountability Act, or HIPAA. These qualifications include:

- having had at least 18 months of continuous credible coverage, the last day of which falls under a group health plan
- having used available COBRA coverage
- not eligible for Medicaid, Medicare, or a group health plan
- not having insurance
- applying for ICHIA coverage within 63 days of losing prior coverage[41]

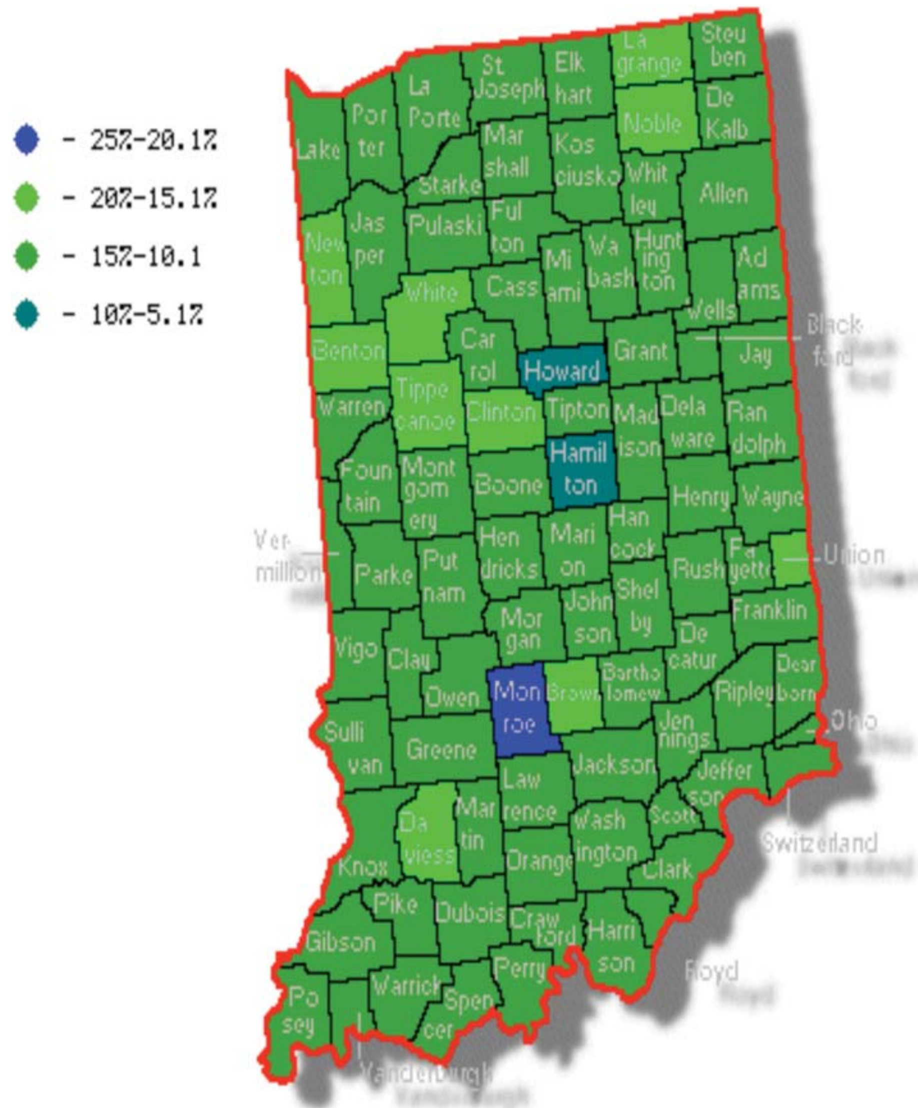
The percentage of Hoosiers under the age of 65 who are uninsured has risen over the past decade, and the recent recession has caused the rate to increase from 14% in 2008 to over 16% in 2009, as shown in Figure 19.[1] In 2007, the counties with the highest percentage of uninsured include Monroe County (21.2%), Tippecanoe (19.8%), Brown (17.7%), Union (17.5%), and Benton (16.8%).[42] See Table 4 for a full listing.

Table 4: Uninsured Percentage in Indiana by County, 2007

21.2	Monroe County	13.9	Sullivan County	12.7	Clay County	11.7	Perry County
19.8	Tippecanoe County	13.8	Allen County	12.7	Lawrence County	11.7	Wells County
17.7	Brown County	13.6	St Joseph County	12.7	Putnam County	11.6	Henry County
17.5	Union County	13.5	Grant County	12.7	Starke County	11.6	Miami County
16.8	Benton County	13.5	Jasper County	12.6	Decatur County	11.6	Shelby County
16.7	Daviess County	13.5	Randolph County	12.6	Franklin County	11.4	Posey County
16.4	LaGrange County	13.4	Jackson County	12.6	Jay County	11.3	Gibson County
16	Newton County	13.4	Lake County	12.5	Huntington County	11.3	Pike County
15.7	Noble County	13.4	Steuben County	12.5	LaPorte County	11.2	Clark County
15.3	White County	13.3	Fulton County	12.4	Hancock County	11.2	Vanderburgh County
15.2	Clinton County	13.2	Delaware County	12.3	Boone County	11.1	Dearborn County
15	Elkhart County	13.2	Dubois County	12.3	Morgan County	11.1	DeKalb County
14.9	Owen County	13.2	Knox County	12.2	Martin County	11	Scott County
14.7	Marshall County	13.2	Parke County	12.2	Montgomery County	10.9	Blackford County
14.5	Carroll County	13.2	Porter County	12.2	Whitley County	10.8	Wabash County
14.5	Cass County	13.2	Rush County	12.1	Madison County	10.7	Floyd County
14.4	Kosciusko County	13.1	Bartholomew County	12.1	Vermillion County	10.7	Wayne County
14.3	Ohio County	13.1	Marion County	12	Harrison County	10.6	Fayette County
14.3	Spencer County	13.1	Washington County	11.9	Adams County	10.4	Hendricks County
14.3	Switzerland County	12.9	Greene County	11.9	Fountain County	10.3	Warrick County
14.3	Warren County	12.9	Vigo County	11.9	Jennings County	10.2	Johnson County
14.1	Pulaski County	12.8	Jefferson County	11.9	Tipton County	10	Howard County
13.9	Crawford County	12.8	Ripley County	11.7	Orange County	9.4	Hamilton County

Source: U.S. Census Bureau, 2007

Map 1: Uninsured Percentage in Indiana by County, 2007



Source: Texas A&M University Color-Coded Maps program

Males and females hold a very similar rate of uninsurance in Indiana; however the differences between races are much more pronounced, as shown in Table 5. While around 12% of nonelderly whites are uninsured, over 17% of nonelderly African Americans lack insurance, and over one in 4 Hispanic-Americans lack insurance.[43]

Table 5: Indiana's Uninsured Population by Various Characteristics, 2008

RACE	
White, non-Hispanic	12.3%
Black, non-Hispanic	17.6%
Hispanic	26.2%
GENDER	
Males	14.2%
Females	12.6%
BY POVERTY LEVEL	
Under 100%	28.7%
100-133%	23.6%
134-300%	16.4%
301-400%	7.1%
Over 400%	3.7%
WORK STATUS	
Full Time Worker	10.8%
Part Time Worker	24.4%
Non Worker	24.0%

Source: State Health Facts, 2008

Some individuals in Indiana who lack health insurance are also working. Nearly 25% of nonelderly part-time workers lack health insurance, while over 10% of nonelderly full time workers are without coverage.[43]

Finally, working individuals above the poverty line may also be without health insurance. While almost 30% of individuals who are federally considered "in poverty" are without insurance, almost 25% of individuals up to 133% FPL, or over $22,000 for a family of four in 2010, are without coverage.

Figure 19: Indiana Uninsured Rate, All Persons Under 65, 1999-2009

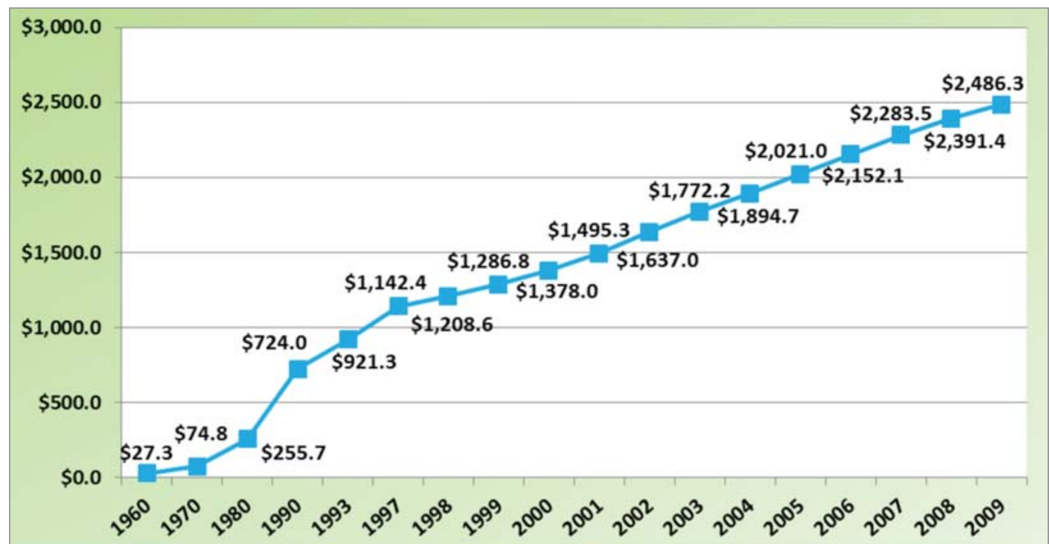
Source: U.S. Census Bureau, 2010

HEALTH CARE SPENDING

The cause of high health insurance premiums in Indiana and the United States is not easy to understand. In 2009, the United States spent nearly $2.5 trillion on health care expenditures, which amounts to 17.6% of GDP; this is up from 16.6% of GDP in 2008.[44] As indicated in Figure 20, there has been an alarming increase in the United States' health care expenditures from 1960-2009.

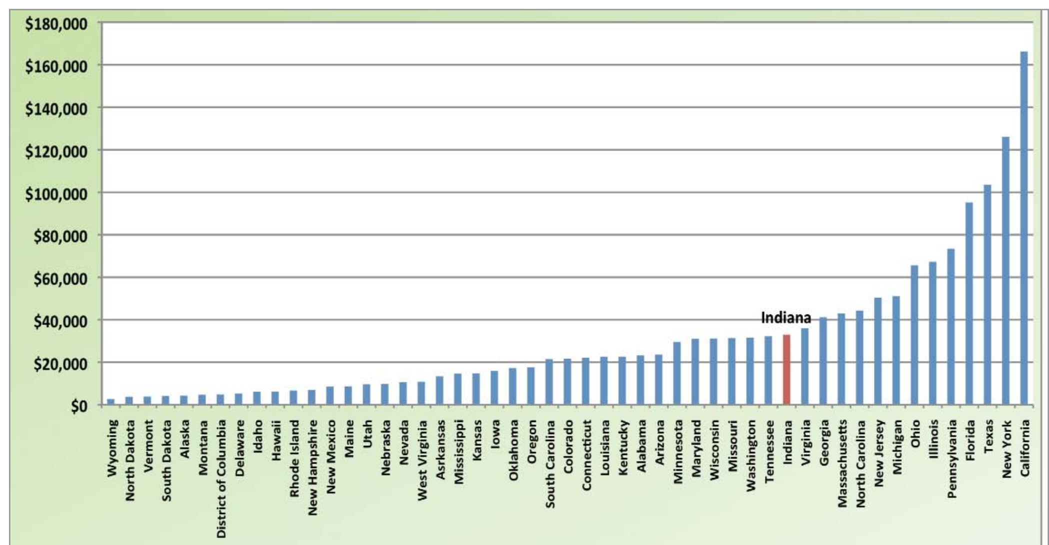
The most recent state health care expenditures data reveals Indiana to be ranked 38th out of 51 states plus the District of Columbia. In 2004, Indiana spent $32,951,000 on health care. Figure 21 compares Indiana's health care spending with the rest of the country. When broken down by service, hospital care accounted for 38.7% of Indiana's total health care expenditures.[46] Table 6 and Figure 22 detail where Indiana spends its health care dollars.

Figure 20: National Health Care Expenditures (in billions), 1960-2009



Source: CMS, 2010

Figure 21: Total Health Care Expenditures by State (in millions), 2004



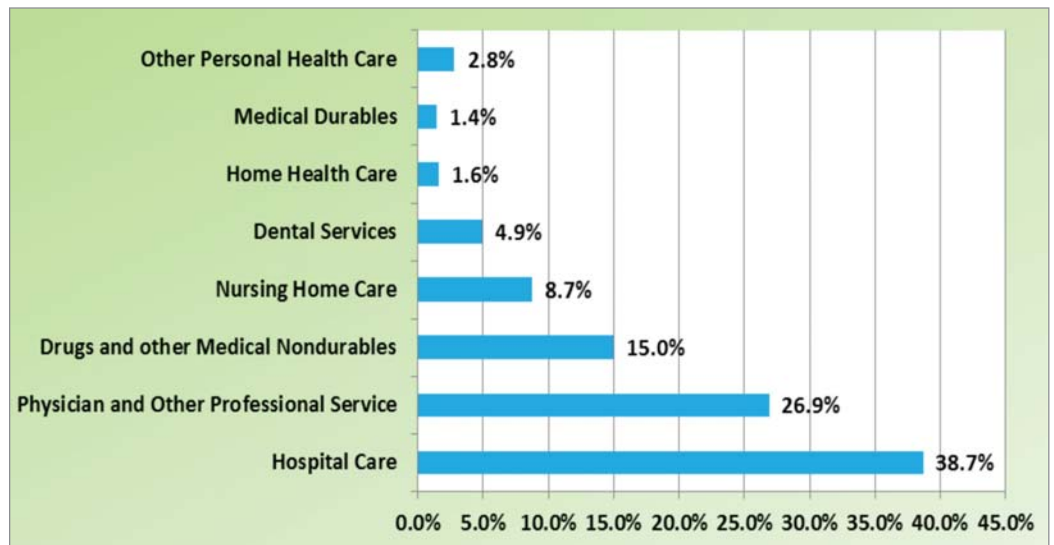
Source: CMS, 2007

Table 6: Health Care Expenditures for Indiana (in millions), 2004

Expenditure	2004
Hospital Care	$12,761,000
Physician and Clinical Services	$7,869,000
Drugs and Other Medical Nondurables	$4,951,000
Nursing Home Care	$2,871,000
Dental Services	$1,606,000
Other Professional Services	$1,002,000
Other Personal Health Care	$911,000
Home Health	$509,000
Durable Medical Products	$470,000
Total Personal Health Care	$32,951,000

Source: CMS, 2007

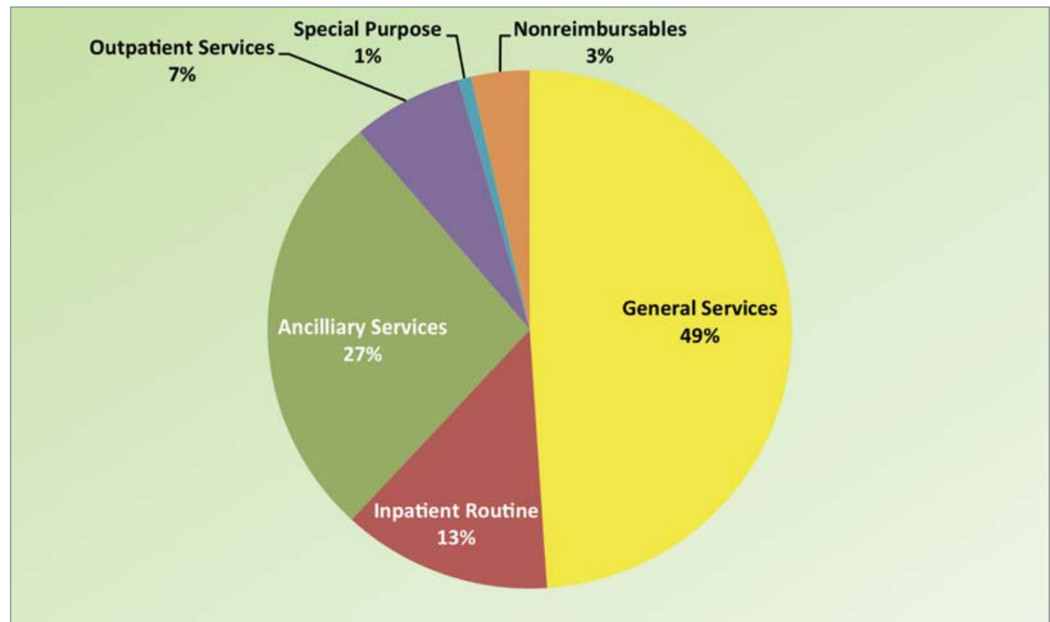
Figure 22: Percentage of Health Care Expenditures by Service, Indiana, 2004



Source: CMS, 2007

The Centers for Medicare and Medicaid Services requires acute care hospitals to submit annual cost reports for reimbursement purposes. Currently, 22 Indiana hospitals have submitted reports for 2010. Appendices 1 through 5 breaks down Indiana hospital expenses by the categories of general service, inpatient routine, ancillary, outpatient service, and nonreimbursables. Other reimbursable and special purpose expense categories were not included due to lack of sufficient data from reporting hospitals. Figure 23 averages the available hospitals' expense categories.

Figure 23: Percentage of Health Care Expenditures by Service, Indiana, 2004



Source: Indiana State Department of Health, 2010

DRIVERS OF HEALTH CARE SPENDING

There is no easy answer as to why the United States and Indiana spend so much money on health care. A variety of factors drive up health care spending, including: a fragmented delivery of care; an increase in physician specialization; new technology and procedures; defensive medicine; and unhealthy Hoosier lifestyles.

Fragmented and Inefficient Delivery of Care

Indiana's health care delivery system is designed for more procedures and testing rather than less. For example, when a patient seeks care in Indiana for a chronic disease they often receive services with little or no coordination between providers.[46] Specialty and primary care providers often administer parallel patient care where there is minimal effort or ability to share information or a treatment plan. This lack of coordination leads to unnecessary expenditures, administrative waste, repeat of needless procedures, the loss of critical patient information, treatment delays, jeopardizing of patient safety, and complications of ongoing treatment plans. For administration alone, Indiana spends an estimated $5.5 billion annually.[47]

Specialty Technology and Procedures

One major driver of health care spending is the discovery and usage of new technology and procedures. Empirical studies estimate total health care spending due to new technology range anywhere from 38% to over 65%.[48] In some cases new technology becomes a substitution for less effective procedures while in many other cases technology allows treatments to become more attractive to patients due to reduced pain.[48] What is unclear, however, is whether the increased spending due to technology has resulted in better overall outcomes and more appropriate care.

In the late 1980s, Robert Brook and his colleagues at RAND Corporation began questioning the appropriateness of medical procedures that had been performed and found that "as much as one-fifth to one-quarter of acute care services were felt to be used for equivocal or inappropriate reasons."49 In one study, a RAND team investigated the appropriateness of specific procedures and found that coronary angiography, carotid endarterectomy, and endoscopy of the upper gastrointestinal tracts was inappropriate in 17%, 32%, and 17% of the cases, respectively.[50]

Over the years researchers have continued to question the need for many procedures that are performed, and a recent study found that in regions where cardiac catheterization labs were more numerous the number of patients receiving this procedure was also greater.[51]

As of 2002, Indiana had a great availability of some types of specialized technology in its hospitals, including computed tomography (CT) scanners, magnetic resonance imaging (MRI), and positron emission tomography (PET) scanners.[51] According to Mathematica, the supply of hospital technology ranged from 14% higher than the national average for CT scanners to 65% higher for PET scanners. They commented that, "the availability of technology in Indiana hospitals is high, even relative to available measure of procedures performed," suggesting "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."[55]

Defensive Medicine

Defensive medicine, defined as "a deviation from sound medical practice that is induced primarily by a threat of liability"[52] or "actions taken to minimize the chance of being wrong when the medical and legal consequences of being wrong are severe"[53], also tends to increase costs to the system. Studies have estimated that defensive medicine costs make up 5-9% of the health care budget in the United States.[54] It has also been shown that physicians in areas of high risk, such as obstetrics and gynecology, are particularly prone to use defensive medicine.[52]

Defensive medicine also drives up costs by inducing medical providers to order minimally indicated tests primarily to make the patient happy or to show that they have done everything possible. Many tests are expensive, such as MRIs and CT scans, and may not prove helpful however they have the effect of allowing the patient to feel the provider is engaged in diligent care.[52] Some practitioners in particularly vulnerable areas have restricted their practices to avoid some of the more frequently litigated services.[52]

Unnecessary referral of patients to a specialist is another issue.[56] Often these patients could be seen just as easily by their primary care provider as a specialist. In some cases, specialists respond to the glut of referrals from primary care providers to maintain their provider base.[57] Defensive medicine could also be one of the reasons behind this increase in specialist referrals.

Unhealthy Lifestyles

Increasing health care costs go well beyond hospitals. A significant factor outside of the health care system leading to higher health care spending is Indiana's overall poor health statuses. A report comparing the 50 states and the District of Columbia found that Indiana had the 16th worst infant mortality rate and the 20th worst preventable mortality rate.[58] These high rates of disease and mortality can be directly linked to smoking, poor diet, inactivity, and alcohol abuse. Table 7 shows the leading causes of death and associated morbidity, while Table 8 shows the actual causes of death which represent the behaviors and disease vectors that cause the diseases constituting the leading causes of death.

Table 7: Leading Causes of Death in Indiana and the United States, 2006

Cause of Death	Indiana Rank	Number of Deaths in Indiana	Percent of Deaths in Indiana	National Rank	Number of Deaths in the United States	Percent of Deaths in the United States
Heart Disease	1	14,375	25.8%	1	631,636	26.0%
Malignant Neoplasms	2	12,903	23.2%	2	559,888	23.1%
Chronic Lower Respiratory Disease	3	3,291	5.9%	4	124,583	5.1%
Cerebrovascular	4	3,238	5.8%	3	137,119	5.7%
Unintentional Injury	5	2,480	4.5%	5	121,599	5.0%
Alzheimer's Disease	6	1,696	3.0%	7	72,432	3.0%
Diabetes Mellitus	7	1,682	3.0%	6	72,449	3.0%
Nephritis	8	1,372	2.5%	9	45,344	1.9%
Influenza	9	1,129	2.0%	8	56,326	2.3%
Septicemia	10	832	1.5%	10	34,234	1.4%

Source: Centers for Disease Control WISQARS, 2009

Table 8: Actual Causes of Death in the United States, 1990 and 2000

Actual Cause	Number in 1990	Percent in 1990	Number in 2000	Percent in 2000
Tobacco	400,000	19%	435,000	18.1%
Poor Diet and Physical Inactivity	300,000	14%	400,000	16.6%
Alcohol Consumption	100,000	5%	85,000	3.5%
Microbial Agents	90,000	4%	75,000	3.1%
Toxic Agents	60,000	3%	55,000	2.3%
Motor Vehicle	25,000	1%	43,000	1.8%
Firearms	35,000	2%	29,000	1.2%
Sexual Behavior	30,000	1%	20,000	0.8%
Illicit Drug Use	20,000	< 1%	17,000	0.7%
Total	1,060,000	50%	1,159,000	48.2%

Source: McGinnis and Foege, 2004. Percentages are for all deaths.

Tobacco use is still the leading cause of preventable death, accounting for an estimated 435,000 deaths in the United States in 2000.[59] Unfortunately, high numbers of Indiana residents continue to smoke and suffer the consequences. In 2010, Indiana's adult smoking rate was 26.0%; the highest rate in the United States.[60] In 2009, the Centers for Disease Control and Prevention estimated that Indiana spends $521 million on Medicaid expenditures due to smoking.[64]

Second only to tobacco use as actual causes of death, poor diet and physical inactivity have dramatically increased preventable morbidity and mortality in all age cohorts in recent decades. In 2000, an estimated 15% of all deaths in the United States were attributed to poor diet and physical inactivity.[60] In 2010, Indiana was ranked as the 17th most obese state with an adult obesity rate at 28.1%.[61] One study estimated that from 1998 to 2000, Indiana spent $1.637 billion on total health care expenditures due to obesity; the same study also attributed $379 million in Medicare expenditures and $522 in Medicaid in the state of Indiana due to obesity.[62] Among the most troubling consequences are increasing rates of type 2 diabetes, heart disease, stroke, hypertension, arthritis-related disabilities, and some cancers.

THOUGHTS FOR POLICYMAKERS

Policymakers need to be aware of the potential long-term impact the healthcare reform law will have on specific state insurance initiatives. The future of the Health Indiana Plan has been questioned by Governor Mitch Daniels as the health reform law has expanded to cover all individuals up to 133% of the federal poverty level. Daniels believes that many of the current Healthy Indiana Plan enrollees will be pushed into Medicaid in 2014 as the main changes to the health insurance system take place. In addition, the federal Medicaid waiver being used to fund HIP expires at the end of 2012 and the Secretary of Health and Human Services, Kathleen Sebelius, has yet to determine whether the waiver will be renewed.[36]

Policymakers should also note that from 2014 to 2016 the federal government will finance 100% of the cost of expanding Medicaid, and from 2016 and beyond the federal share of financing will fall to around 90%.63 Depending upon the federally mandated "essential health benefits", this expansion of Medicaid may continue to put financial pressure on the state.

With regard to private insurance, policymakers must keep in mind the current structure of the market as they design the state's health insurance exchange system, discussed in the IU Center for Health Policy Proposal for a "Hoosier Health Insurance Exchange". The effectiveness of the exchange may be both heightened and lessened due to the monopolistic market power of the top insurance companies. With options from only a few major insurance companies, consumers and small businesses may find it easier to make educated decisions on the coverage level they need, but the exchange may be skewed towards higher premiums.

The passage of healthcare reform presents many opportunities for Hoosier policymakers to become trendsetters for others around the country. Policymakers should view the information presented as a way of identifying both strengths and weaknesses of our insurance system. Indiana should seize this opportunity to move ahead of others and become a leading voice in the healthcare community.

REFERENCES

1. U.S. Census Bureau (2008). Health insurance coverage status and type of coverage by state for all persons under 65: 1999 to 2008. Accessed August 30, 2010 from the Current Population Survey's Annual Social and Economic Supplement Web site at http://www.census.gov/hhes/www/hlthins/data/historical/index.html
2. Agency for Healthcare Research and Quality (2009). Percent of private-sector establishments that offer health insurance by firm size and state: united states, 2009. Retrieved on September 14, 2010 from http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/ic09_iia_f.pdf
3. Agency for Healthcare Research and Quality (2009). Private-sector data by firm size and state. Retrieved on October 6, 2010 from http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=2&year=-1&tableSeries=2&tableSubSeries=&searchText=&searchMethod=3&startAt=1
4. State Health Facts (2008). Indiana: employer-based health premiums. Retrieved on September 8, 2010 from the Kaiser Family Foundation at http://www.statehealthfacts.org/profileind.jsp?cat=5&sub=67&rgn=16
5. Kaiser Family Foundation (2010). Employee health benefits: 2010 survey. Retrieved on September 23, 2010 from http://ehbs.kff.org/pdf/2010/8085.pdf
6. Temchine, D. (2010). Health care reform law on self-insured erisa health and welfare benefit plans: a guide for employers. Retrieved on October 29, 2010 from http://www.ebglaw.com/files/40540_Temchine-PPACA-WHITE-PAPER-EMPLOYERS.pdf
7. Jost, T. (2010). Health insurance exchanges and the affordable care act: eight difficult issues. Retrieved on October 29, 2010 from the Commonwealth Fund at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf
8. Kaiser Family Foundation (2010). Survey of people who purchase their own insurance. Retrieved on September 8, 2010 from http://www.kff.org/kaiserpolls/upload/8077-R.pdf
9. America's Health Insurance Plans (2009). Individual health insurance 2009: a comprehensive survey of premiums, availability, and benefits. Retrieved on September 24, 2010 from the AHIP Center for Research and Policy at http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf
10. Wall, J.K. (2009). Health insurer Anthem's market share swells. Retrieved on September 8, 2010 from Indianapolis Business Journal at http://www.ibj.com/article/print?articleId=10846
11. Robinson, J. (2004). Consolidation and the transformation of competition in health insurance. Health Affairs, 23(6), 11-24.
12. Furnas, B. & Buckwalter-Poza, R. (2009). Health care competition. Retrieved September 9, 2010 from The Center for American Progress at http://www.americanprogress.org/issues/2009/06/pdf/health_competitiveness.pdf
13. American Medical Association (2007). Competition in health insurance: a comprehensive study of U.S. markets (2007 ed.). Washington, D.C.
14. Scanlon, D., Swaminathan, S., Lee, W., and Chernew, M. (2008). Does competition improve health care quality? HSR: Health Services Research, 43(6), 1931-1951.
15. Dolbeck, A. (2003). Consolidation in the health insurance industry. Retrieved on October 14, 2010 from http://findarticles.com/p/articles/mi_qa3755/is_200311/ai_n9326419/
16. State Health Facts (2010). Indiana: Total number of Medicare beneficiaries, 2010. Retrieved on September 14, 2010 from the Kaiser Family Foundation at http://www.statehealthfacts.org/profileind.jsp?ind=290&cat=6&rgn=16&cmprgn=1
17. Centers for Medicare & Medicaid Services (2010). Monthly ma enrollment by state/county/contract. Retrieved on September 14, 2010 from http://www4.cms.gov/MCRAdvPartDEnrolData/MECPSC/list.asp#TopOfPage

18. Social Security Online (2010). Medicare part b premiums: rules for beneficiaries with higher income. Retrieved on September 20, 2010 from http://www.ssa.gov/pubs/10161.html

19. State Health Facts (2010). Indiana: Medicare prescription drug plan premiums, 2010. Retrieved on September 20, 2010 from

20. State Health Facts (2010). Medicare Spending and Financing. Retrieved on September 14, 2010 from the Kaiser Family Foundation at http://www.kff.org/medicare/upload/7305-04-2.pdf

21. Center for Medicare and Medicaid Services (2010). 2010 annual report of the board of trustees of the federal hospital insurance and federal supplementary medical insurance trust fund. Retrieved on November 29, 2010 from https://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf

22. Coughlin, T., Waidmann, T, & O'Malley Watts, M. (2009). Where does the burden lie? Medicaid and Medicare spending for dual eligible beneficiaries. Retrieved September 7, 2010 from the Kaiser Family Foundation at http://www.kff.org/medicaid/upload/7895-2.pdf

23. Medicaid Statistical Information System (2005). FY 2005 quarterly cube. Retrieved August 30, 2010 from the Centers for Medicare and Medicaid Services Web site at http://msis.cms.hhs.gov/

24. Indiana Medicaid (2010). Am I eligible? Retrieved on September 30, 2010 from http://member.indiana medicaid.com/am-i-eligible.aspx

25. Kinney, E. (2002). Medicaid and state budgets: a case study of Indiana. Retrieved August 31, 2010, from the Kaiser Family Foundation Web site at http://www.kff.org/medicaid/upload/Medicaid-and-State-Budgets-A-Case-Study-of-Indiana.pdf

26. Indiana State Budget Agency (2009). 2009 – 2011 as-passed state budget. Retrieved August 31, 2010, from http://www.in.gov/sba/files/ap_2009_c_6_5_hhs_data.pdf

27. Kaiser Commission on Medicaid and the Uninsured (2010). Hoping for economic recovery, preparing for health reform: a look at Medicaid spending, coverage and policy trends. Retrieved on October 5, 2010 from http://www.kff.org/medicaid/upload/8105.pdf

28. Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (2007). Compiled list of OMPP county reports for December 2007. Retrieved September 2, 2010 from the Indiana FSSA Web site at http://www.in.gov/fssa/ompp/2659.htm

29. Medicaid Statistical Information System (2007). FY 2007 quarterly cube. Retrieved August 30, 2010 from the Centers for Medicare and Medicaid Services Web site at http://msis.cms.hhs.gov/

30. U.S. Census (2008): Health insurance coverage status and type of coverage by state and age for all people: 2008. Retrieved August 30,2010 from the Current Population Survey's Annual Social and Economic Supplement Web site at http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm

31. Indiana Family and Social Services Administration (2010). Hoosier Healthwise. Retrieved September 2, 2010 from the Indiana FSSA Web site at http://www.in.gov/fssa/ompp/2544.htm

32. (2010). FSSA announces changes to Medicaid. Retrieved on September 3, 2010 from Kokomo Perspective at http://www.kokomoperspective.com/news/state_news/article_ef64bbb4-aeba-11df-8c3f-001cc4c002e0.html

33. State Health Facts (2010). Indiana: Medicaid/chip eligibility. Retrieved on October 5, 2010 from http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=54&rgn=16

34. National Conference of State Legislatures (2010). State pharmaceutical assistance programs. Retrieved on September 15, 2010 from http://www.ncsl.org/default.aspx?tabid=14334#Subsidy

35. Campaign for Tobacco-Free Kids (2010). Actual tobacco settlement payments received by the states, 2002-2010. Retrieved on September 15, 2010 from http://tobaccofreekids.org/research/factsheets/pdf/0365.pdf

36. Trapp, D. (2010, June). Health reform law may trump Indiana health plan for poor. Retrieved on September 7, 2010 from American Medical News at http://www.ama-assn.org/amednews/2010/06/21/gvsb0621.htm

37. Indiana Check Up Plan (2009). Task force report on healthy Indiana plan. Retrieved on October 6, 2010 from http://www.in.gov/legislative/igareports/agency/reports/FSSA88.pdf

38. Kaiser Family Foundation (2008). Summary of healthy Indiana plan: key facts and issues. Retrieved September 1, 2010 from http://www.kff.org/medicaid/upload/7786.pdf

39. State Health Facts (2008). Indiana: state high risk pool programs and enrollment, December 2008. Retrieved on September 7, 2010 from the Kaiser Family Foundation at http://www.statehealth facts.org/profileind.jsp?ind=602&cat=7&rgn=16

40. Indiana Comprehensive Health Insurance Association (2010). Medicare rates without pharmacy benefits. Retrieved on September 20, 2010 from https://www.onlinehealthplan.com/content/html/acs/12/Rate_Tables_eff_070110.pdf

41. (2009). Consumer guide to getting and keeping health insurance. Retrieved on September 1, 2010 from http://healthinsuranceinfo.net/getinsured/indiana/individual-health-plans/indiana-comprehensive-health-insurance-association-ichia/

42. U.S. Census Bureau (2007). 2007 Health insurance coverage by counties: Indiana. Retrieved on September 27, 2010 from http://www.census.gov/did/www/sahie/data/2007/tables.html

43. State Health Facts (2008). Indiana: nonelderly uninsured. Retrieved on September 24, 2010 from http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=40&rgn=16

44. Martin, A., Lassman, D., Whittle, L., & Catlin, A. (2011). Recession contributes to slowest annual rate of increase in health spending in five decades. Health Affairs 30,1, 11-22.

45. Centers for Medicare and Medicaid Services (2007). Health expenditures by state of residence. Retrieved on January 19, 2011 from http://www.cms.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccountsResidence.asp#TopOfPage

46. Schoen, C., Davis, K., How, S. K. H., & Schoenbaum, S. C. (2006). US health system performance: a national scorecard. Health Affairs, 25(6), 457-475.

47. Himmelstein, D. U., Woolhandler, S., & Wolfe, S. M. (2004). Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States, and the District of Columbia, with State-Specific Estimates of Potential Savings. International Journal of Health Services, 34(1), 79-86.

48. Ginsburg, P.B. (2008). High and rising health care costs: demystifying u.s. health care spending. Retrieved on January 21, 2011 from Robert Wood Johnson Foundation at http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf

49. Brook, R. H., Kamberg, C. J., Mayer-Oakes, A., Beers, M. H., Raube, K., & Steiner, A. (1989). Appropriateness of Acute Medical Care for the Elderly [Electronic Version], 210. Retrieved 2008, from http://rand.org/pubs/reports/2007/R3717.pdf.

50. Chassin, M., Losecoff, J., Park, R., Winslow, K., Kahn, K., & Merrick, N. (1987). Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? Journal of the American Medical Association, 258(18), 2533-2537.

51. Terry, K. (2007). Rx for Health Care Reform. Nashville: Vanderbilt University Press.

52. Studdert, D. M., et. al. (2005). Defensive medicine widespread, with serious consequences. Retrieved on April 7, 2011 from http://commongood.org/healthcare-newscommentary-inthenews-239.html.

53. U.S. Congress, Office of Technology Assessment (1994). Defensive Medicine and Medical Malpractice, OTA-H—602. Washington, D.C.: U.S. Government Printing Office.

54. Anderson, R. E. (1998). The high costs of defensive medicine. Retrieved on April 7, 2011 from http://www.thedoctors.com/TDC/PressRoom/IntheMedia/CON_ID_000697.

55. Chollett, D., Nyman, R., & Smieliauskas, F. (2004). Factors that Drive Health Care Costs in Indiana. Washington, DC: Mathematica Policy Research, Inc.o. Document Number).

56. Forrest, C. B. (2003). Primary care in the United States: Primary care gatekeeping and referrals: effective filter or failed experiment? BMJ: British Medical Journal, 326(7391), 692.

57. Bodenheimer, T., Lo, B., & Casalino, L. (1999). Primary Care Physicians Should Be Coordinators, Not Gatekeepers. JAMA: The Journal of the American Medical Association, 281(21), 2045.

58. Cantor, J. C., Schoen, C., Belloff, D., How, S. K. H., & McCarthy, D. (2007). Aiming Higher: Results from a State Scorecard on Health System Performance: New York: The Commonwealth Fund, June.

59. Mokdad, A., Marks, J., Stroup, D., & Gerberding, J. (2005). Correction: Actual Causes of Death in the United States, 2000. JAMA, 293(3), 293-294.

60. Center for Disease Control (2010). Tobacco control state highlights 2010. Retrieved on January 20, 2011 from http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/pdfs/highlights2010.pdf.

61. Trust for America's Health (2010). New report: Indiana ranks 17th most obese state in nation. Retrieved on January 17, 2010 from http://healthyamericans.org/reports/obesity2010/release.php?stateid=IN.

62. Zollinger, T., Saywell, R., & Barclay, J. (2006). Obesity-Related Data in Indiana: A Resource Guide (Prepared for the Indiana State Department of Health o. Document Number).

63. Kaiser Family Foundation (2010). Explaining health reform: benefits and cost-sharing for adult Medicaid beneficiaries. Retrieved on September 15, 2010 from http://www.kff.org/healthreform/upload/8092.pdf

64. Armour, B., Finkelstein, E., & Fiebelkorn, I. (2009). State-level Medicaid expenditures attributable to smoking. Retrieved on January 25, 2011 from the Centers for Disease Control and Prevention at http://www.cdc.gov/pcd/issues/2009/jul/pdf/08_0153.pdf

Appendix 1: Percentage of General Service Expenses from Select Indiana Hospitals, 2010

	Total	Percentage	TOTAL EXPENSES
Integra Specialty Hospital	$2,729,232	33.4%	$8,167,293
St. Vincent Carmel Hospital	$49,057,379	36.1%	$135,769,403
Memorial Hospital and Health Care Center	$56,624,788	42.5%	$133,153,248
Dunn Memorial Hospital	$8,257,967	43.4%	$19,010,488
St. John's Health System	$79,802,398	44.0%	$181,427,690
St. Vincent Heart Center	$47,533,802	45.6%	$104,325,464
St. Vincent Hospital and Health Care Center	$391,143,588	45.8%	$853,684,531
St. Mary's Warrick Hospital	$6,790,481	46.5%	$14,617,521
St. Vincent Randolph Hospital	$11,702,022	47.9%	$24,445,970
St. Vincent Williamsport Hospital	$9,043,957	48.2%	$18,771,194
St. Vincent Seton Specialty Hospital - Lafayette	$5,930,318	48.3%	$12,266,406
St. Joseph Regional South Bend	$126,574,222	49.3%	$256,768,358
St. Joseph Hospital and Health Care Center	$46,369,193	49.5%	$93,583,322
St. Vincent Salem	$3,308,508	50.4%	$6,570,320
St. Vincent Seton Specialty Hospital - Indianapolis	$20,675,692	51.3%	$40,281,030
St. Vincent Jennings Hospital	$9,510,552	52.9%	$17,979,752
St. Joseph Regional Plymouth	$24,604,516	53.1%	$46,323,298
St. Vincent Clay Hospital	$9,742,013	54.2%	$17,977,408
Marion General Hospital	$64,087,916	54.5%	$117,537,604
St. Vincent Frankfort Hospital	$12,905,018	57.7%	$22,365,888
St. Vincent Mercy Hospital	$13,777,468	58.7%	$23,464,604
St. Catherine Hospital	$100,786,417	60.6%	$166,378,755

Source: Indiana State Department of Health

General Expenses include: employee benefits, administration, laundry, housekeeping, dietary costs, maintenance of personnel, nursing administration, pharmacy, medical records and library, maintenance and repairs, and other general categories.

Appendix 2: Percentage of Inpatient Routine Expenses from Select Indiana Hospitals, 2010

	Total	Percentage	TOTAL EXPENSES
St. Vincent Salem	$370,050	5.6%	$6,570,320
St. Vincent Clay Hospital	$1,074,410	6.0%	$17,977,408
St. Vincent Jennings Hospital	$1,201,079	6.7%	$17,979,752
St. Vincent Mercy Hospital	$1,661,734	7.1%	$23,464,604
St. Vincent Williamsport Hospital	$1,353,790	7.2%	$18,771,194
St. Vincent Frankfort Hospital	$1,960,303	8.8%	$22,365,888
Memorial Hospital and Health Care Center	$11,981,622	9.0%	$133,153,248
St. Joseph Regional Plymouth	$4,531,313	9.8%	$46,323,298
Marion General Hospital	$12,383,249	10.5%	$117,537,604
St. Vincent Randolph Hospital	$2,613,136	10.7%	$24,445,970
St. Joseph Hospital and Health Care Center	$10,226,317	10.9%	$93,583,322
Dunn Memorial Hospital	$2,103,959	11.1%	$19,010,488
St. Catherine Hospital	$19,856,430	11.9%	$166,378,755
St. Vincent Hospital and Health Care Center	$103,019,878	12.1%	$853,684,531
St. Vincent Heart Center	$13,257,977	12.7%	$104,325,464
St. John's Health System	$23,537,072	13.0%	$181,427,690
St. Joseph Regional South Bend	$34,040,124	13.3%	$256,768,358
St. Vincent Carmel Hospital	$18,447,453	13.6%	$135,769,403
St. Mary's Warrick Hospital	$2,170,248	14.8%	$14,617,521
St. Vincent Seton Specialty Hospital - Lafayette	$3,578,766	29.2%	$12,266,406
St. Vincent Seton Specialty Hospital - Indianapolis	$11,936,124	29.6%	$40,281,030
Integra Specialty Hospital	$2,482,879	30.4%	$8,167,293

Source: Indiana State Department of Health, 2010

Inpatient Routine Expenses include: adult and pediatrics, intensive care units, coronary care units, burn intensive care units, surgical intensive care units, sub providers, nursery, skilled nursing facility, ICF/MR, and other long term care.

Appendix 3: Percentage of Ancillary Service Expenses from Select Indiana Hospitals, 2010

	Total	Percentage	TOTAL EXPENSES
St. Vincent Seton Specialty Hospital - Indianapolis	$7,088,935	17.6%	$40,281,030
St. Vincent Williamsport Hospital	$3,303,535	17.6%	$18,771,194
St. Catherine Hospital	$31,484,710	18.9%	$166,378,755
St. Vincent Seton Specialty Hospital - Lafayette	$2,565,478	20.9%	$12,266,406
Marion General Hospital	$26,329,613	22.4%	$117,537,604
St. Vincent Mercy Hospital	$5,586,337	23.8%	$23,464,604
St. Vincent Frankfort Hospital	$5,555,435	24.8%	$22,365,888
Memorial Hospital and Health Care Center	$33,304,332	25.0%	$133,153,248
St. Mary's Warrick Hospital	$3,782,044	25.9%	$14,617,521
St. Joseph Regional Plymouth	$12,111,227	26.1%	$46,323,298
St. Vincent Hospital and Health Care Center	$230,377,073	27.0%	$853,684,531
St. Vincent Jennings Hospital	$4,890,815	27.2%	$17,979,752
St. John's Health System	$49,353,425	27.2%	$181,427,690
St. Vincent Carmel Hospital	$37,662,184	27.7%	$135,769,403
Dunn Memorial Hospital	$5,401,862	28.4%	$19,010,488
St. Joseph Regional South Bend	$73,770,947	28.7%	$256,768,358
St. Vincent Clay Hospital	$5,403,780	30.1%	$17,977,408
St. Vincent Randolph Hospital	$7,428,502	30.4%	$24,445,970
St. Vincent Salem	$2,109,620	32.1%	$6,570,320
Integra Specialty Hospital	$2,821,776	34.5%	$8,167,293
St. Joseph Hospital and Health Care Center	$32,529,317	34.8%	$93,583,322
St. Vincent Heart Center	$40,657,640	39.0%	$104,325,464

Source: Indiana State Department of Health

Ancillary Service Expenses include: operating rooms, recovery rooms, delivery rooms, anesthesiology, radiology, laboratory, clinical lab services, intravenous therapy, respiratory therapy, physical therapy, occupational therapy, and other hospital-specific departments.

Appendix 4: Percentage of Outpatient Expenses from Select Indiana Hospitals, 2010

	Total	Percentage	TOTAL EXPENSES
St. Vincent Seton Specialty Hospital - Indianapolis	N/A	0.0%	$40,281,030
St. Vincent Seton Specialty Hospital - Lafayette	N/A	0.0%	$12,266,406
Integra Specialty Hospital	$133,406	1.6%	$8,167,293
St. Vincent Carmel Hospital	$2,674,866	2.0%	$135,769,403
St. Vincent Heart Center	$2,173,686	2.1%	$104,325,464
St. Joseph Hospital and Health Care Center	$2,745,329	2.9%	$93,583,322
St. Catherine Hospital	$6,465,892	3.9%	$166,378,755
St. Vincent Hospital and Health Care Center	$35,400,898	4.1%	$853,684,531
Marion General Hospital	$5,188,415	4.4%	$117,537,604
Dunn Memorial Hospital	$886,118	4.7%	$19,010,488
St. Joseph Regional South Bend	$15,236,127	5.9%	$256,768,358
St. John's Health System	$11,849,961	6.5%	$181,427,690
St. Vincent Frankfort Hospital	$1,591,484	7.1%	$22,365,888
St. Vincent Clay Hospital	$1,387,022	7.7%	$17,977,408
Memorial Hospital and Health Care Center	$13,246,731	9.9%	$133,153,248
St. Vincent Randolph Hospital	$2,454,905	10.0%	$24,445,970
St. Vincent Mercy Hospital	$2,394,633	10.2%	$23,464,604
St. Joseph Regional Plymouth	$4,968,583	10.7%	$46,323,298
St. Vincent Salem	$718,436	10.9%	$6,570,320
St. Mary's Warrick Hospital	$1,738,557	11.9%	$14,617,521
St. Vincent Jennings Hospital	$2,226,127	12.4%	$17,979,752
St. Vincent Williamsport Hospital	$3,924,379	20.9%	$18,771,194

Source: Indiana State Department of Health, 2010

Outpatient Expenses include: clinics, emergency rooms, observation beds, and rural health clinics

Appendix 5: Percentage of Nonreimbursables from Select Indiana Hospitals, 2010

	Total	Percentage	TOTAL EXPENSES
Integra Specialty Hospital	N/A	0.0%	$8,167,293
St. Vincent Seton Specialty Hospital - Indianapolis	N/A	0.0%	$40,281,030
St. Vincent Seton Specialty Hospital - Lafayette	N/A	0.0%	$12,266,406
St. Vincent Mercy Hospital	$44,331	0.2%	$23,464,604
St. Joseph Regional Plymouth	$108,343	0.2%	$46,323,298
St. Joseph Hospital and Health Care Center	$309,785	0.3%	$93,583,322
St. Vincent Heart Center	$702,359	0.7%	$104,325,464
St. Vincent Jennings Hospital	$151,179	0.8%	$17,979,752
St. Mary's Warrick Hospital	$136,191	0.9%	$14,617,521
St. Vincent Salem	$63,706	1.0%	$6,570,320
St. Vincent Randolph Hospital	$247,408	1.0%	$24,445,970
St. Vincent Frankfort Hospital	$353,648	1.6%	$22,365,888
St. Vincent Clay Hospital	$370,183	2.1%	$17,977,408
St. Joseph Regional South Bend	$7,146,838	2.8%	$256,768,358
St. Catherine Hospital	$5,924,945	3.6%	$166,378,755
St. Vincent Williamsport Hospital	$711,598	3.8%	$18,771,194
St. John's Health System	$10,950,717	6.0%	$181,427,690
St. Vincent Hospital and Health Care Center	$58,658,375	6.9%	$853,684,531
Marion General Hospital	$8,613,673	7.3%	$117,537,604
Dunn Memorial Hospital	$1,565,489	8.2%	$19,010,488
Memorial Hospital and Health Care Center	$15,439,823	11.6%	$133,153,248
St. Vincent Carmel Hospital	$27,259,241	20.1%	$135,769,403

Source: Indiana State Department of Health, 2010

Other nonreimbursables include: gift shops, research, physicians' private offices, nonpaid workers, marketing, public relations, foundations, and other nonreimbursable categories.