~~Insurance industry FAQs, needed definitions heading into Medicare reform. Deficit reduction and related health reform.~~

#1~~.~~ Question: How will insurance companies be ~~impacted~~ affected by cuts to the Medicare budget as a result of deficit reduction?

Answer: ~~Because i~~Insurers that contract with Medicare take government premium dollars and provide health benefits for their customers under Medicare Advantage, the program that insurance companies ~~contract with~~offer to provide health benefits ~~to~~ for seniors. Therefore, deficit reduction could lead ~~to~~ insurance companies to make such choices as cutting benefits ~~to~~ for seniors, ~~and making related different choices such as~~ raising~~higher~~ deductibles or~~,~~ co-payments, or decreasing their ~~less~~ coverage of certain services. Insurance companies that do~~n~~ not~~'t~~ alter benefits to make up these cuts could in turn squeeze ~~medical~~health ~~-~~care providers. As a result, insurance companies may ~~thus~~ change~~ing~~ how they pay doctors and hospitals, possibly cutting their payments or offering ~~them~~ contracts that squeeze their reimbursements.

Myth: Enrollment will fall just because there are cuts. A September report from The U.S. Department of Health and Human Services said enrollment went up in 2010 and premiums fell, in part because of more competition. ~~(Can I get a link to that HHS report? Here is the link).~~ http://www.hhs.gov/news/press/2011pres/09/20110915a.html

Statistic: The Affordable Care Act includes $145 billion in lower payments to Medicare Advantage providers ~~over~~ during the next 10 years. Critics ~~said~~ say that lower payments ~~would~~ will force insurance companies to increase premiums~~,~~ and that fewer people ~~would~~ will enroll. ~~Statistic source: The U.S. Department of Health and Human Services. (Can I get a link to that HHS report where this stat resides?) Here is that link:~~ http://www.hhs.gov/asl/testify/2011/03/t20110330e.html

#2~~.~~ Question: How will the move toward electronic medical records ~~impact~~ affect insurance companies?

Answer: Insurance companies will be able to track ~~in~~ real-time transactions ~~between insurance companies~~with doctors' offices and hospitals, which will be able to submit ~~as well as get their~~ claims ~~submitted~~ electronically and get paid faster~~from doctors and hospitals so they are more quickly paid~~. Studies show that many health~~medical~~ care providers submit claims on ~~via~~ paper, which analysts say can cause several problems: slow payments~~;~~, frustrated consumers ~~wanting~~ who want to know if their procedures are covered; and ~~create~~ medical errors created when hand-written orders are misread and not carried out properly or information is typed incorrectly into the system ~~wrong by manual order entry~~.

#3~~.~~ Question: What is a self-insured health plan?

Answer: A self-insured health plan ~~—~~-also ~~also~~ referred to as a self-funded plan because the employer funds the premiums~~—is—i-- is~~ one in which the employer assumes the financial risk for providing health care benefits to its workers. Self-insured employers pay for each out-of-pocket claim as ~~they are~~it is incurred, instead of paying a fixed premium to an insurance carrier as they would~~,~~ under a fully~~-~~ insured plan. Usually, a self-insured employer will set up a special trust fund to earmark money (company and employee contributions) to pay incurred claims. Employee contributions ~~s~~ generally comprise

Comment [SR1]: Use health care providers for all references (instead of medical care provider).

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ntribute between 20 to 40 percent to of the fund, depending on the company. Self-insured health plans are regulated by federal rules, as opposed to fully insured health plans, which are regulated by states.

Myth: Insurance companies make all the decisions on about what is covered and how much is paid to doctors, hospitals and other health care providers of medical care. (STATEMENT ON WHY THIS IS A MYTH) There is is a myth because there are often consumer groups and health plan enrollees in general who think the decisions about on what is covered are is the insurance company's call alone. Rather — and , and particularly with self-funded plans — the , the call on what is covered is made by the employer or company offering the employees benefits.

Statistics: According to a 2000 report by the Employee Benefit Research Institute (EBRI), approximately 50 million workers and their dependents receive benefits through self-insured group health plans sponsored by their employers. This represents 33 percent% of the 150 million total participants in private employment-based plans nationwide.

#4. Question: What is are an insured health plans?

Answer: These are state-regulated health plans that generally sell offer coverage to individuals (, such as self-employed people), or that marketto small -groups coverage (, which is generally to less fewer than 50 employees, such as small businesses with fewer than 50 employees). With insured plans, the risk is taken on by the insurance company, which who pools premiums paid by their customers and uses the money to pay claims, provide benefits, invest in their business, and turn a profit for shareholders.

Statistic: 9.8 percent of Americans, purchase medical health care coverage directly from insurance companies. Statistic source: www.census.gov

#5 . Question: What is ERISA?

Answer: The Employee Retirement Income Security Act (ERISA) is a . This federal law that was, adopted in 1974 as a way to curb fraud and mismanagement of employee pension funds and related health benefit plans. It , pre-empts state regulations for insurance. Employers who provide health benefits say their relationships with doctors and hospitals are not subject to state insurance department regulations because ERISA is pre-empted by state rules.

Statistics: 55 percent of health insurance coverage is employment-based Statistic source: www.census.gov

Experts: Employee Benefit Research Institute www.ebri.org

Myth: For people with who have private insurance, insurance companies decide what is covered. WE WILL NEED TO STATE WHY THIS IS A MYTH This is a myth because a lot ofmany consumers think insurance companies provide only set co-payments or deductibles. They , and don't not realize these decisions are made in consultation with employers and human resources departments. They and can vary from health plan to health plan and employer to employer, depending on what the company wants to pay for. In addition, C coverage decisions can also include input from unions, which increasingly barter bargain for over what is covered, and how much workers have and will be willing

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~~to pay for in their contracts.~~

#6~~.~~ Question: What do insurance companies do with the profits they make?

Answer: Profits are spent in a variety of ways, d~~D~~epending on who owns the insurance companies~~, profits are spent in a variety of ways~~. Some insurance companies are owned by shareholders, some are owned by policy-holders, and others are considered to be nonprofit and are owned by tax-exempt foundations. ~~Though ownership of health plans varies from non-profit and for-profits owned by investors and shareholders to mutual insurance companies owned by policyholders,~~ All insurance companies, however, use their profits ~~are used~~ to invest in their businesses, improve their information systems, and ~~to~~ continue to grow or provide competitive benefit packages. ~~To be sure,~~ F~~f~~or-profit insurance companies do have a duty to provide dividends and earnings per share to shareholders, ~~in providing dividends and earnings per share~~ but nonprofits and mutual insurance companies also make money. If a tax-exempt ~~For a~~ non-profit insurance company ~~that is exempt from taxes~~is , ~~a~~ profitable ~~company~~, it is rewarded with a higher credit rating or debt rating from an agency like Moody's Investors Service. Such a rating allows non-profits to borrow more money and use debt to expand ~~its~~ their businesses. Profits allow all insurance companies to expand reserves, which are required at certain levels by state regulators in order to pay claims and avoid insolvency. Mutual insurance companies that are owned by policyholders also use their profits to grow reserves, which are used to expand their businesses as well.

Myth: Non-profit health plans do not turn a profit. ~~WE WILL NEED TO STATE WHY THIS IS A MYTH.~~ This is a myth because many people think nonprofit means these entities make no money. In fact, they make money just like for-profits do—b~~b~~ut they are nonprofit and get a property tax exemption, in part because they have a charitable mission or might be owned by a charitable nonprofit foundation.

~~Experts: John Colombo, University of Illinois at Champaign Law School JCOLOMBO@law.illinois.edu~~

#7~~.~~ Question: What is HIPAA?

Answer: HIPAA is the Health Insurance Portability and Accountability Act of 1996.~~:~~ Signed by President Bill Clinton in 1996, this~~e~~ law is primarily designed to provide health plan enrollees with continuing coverage by limiting a health plan's or employer's ability to drop someone with a pre-existing medical condition. Therefore, it prohibits discrimination against individuals based on what is called their "health status." Employees or ~~customers of~~ health plan participants are eligible to keep their insurance if the employees~~y~~ leave their jobs.

~~Experts: National Committee for Vital and Health Statistics. Text of the law is here: www.access.gpo.gov/ (Public Law 104-191)~~

Myth: HIPA~~P~~A only deals with privacy of medical records. HIPA~~P~~A also requires that all claims submitted to Medicare be done so electronically, except for certain circumstances. It also created several programs to control fraud and abuse within the health care system. ~~And~~ In addition, it ~~it~~ regulates the use and disclosure of certain medical information held by health care clearinghouses, employer-sponsored health plans,

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Comment [SR10]: AP style, no hyphen for nonprofit.

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Comment [SR11]: Experts: John Colombo, University of Illinois at Champaign Law School JCOLOMBO@law.illinois.edu

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Comment [SR12]: Experts: National Committee for Vital and Health Statistics. Text of the law is here: www.access.gpo.gov/ (Public Law 104-191)

health insurers, and medical servicehealth care providers.

#8. Question: What is a Medigap?

Answer: Medicare Supplement Insurance (Medigap) This is supplemental insurance that seniors can purchase from private companies to add to traditional Medicare coverage. There are 10 Medigap plans known as "optional riders," lettered A through J. There are also certain states that have their own standardized Medigap plans.

Statistic: Fewer than 5 percent of Americans have just Medicare coverage alone.
Statistic source: www.census.gov

Experts: Aon Hewitt Associates has a couple of Medicare expert consultants. Frank McArdle and J.D. Piro. 847-771-0788.

#9. Question: Do insurance companies spend more money on administrative costs than medical health care?

Answer: No, and this will becomes more clearer, more regulated with the as health care reform legislation provisions that will be implemented in 2014. For most of the uninsured who will gain subsidies to buy coverage, as well as Americans already in state-regulated health insurance plans (sSee Insured Plans), insurance companies will be required to offer health planss will be required tothat spend between 80- and 85 percent of the employees' monthly premium dollars on medical health care.

Statistic: Thirty About half of the 30 million uninsured Americans who will gain medical health care coverage once the Accountable Care Act provides its broadest coverage in 2014. About half of these Americans, will purchase from private health plans on through state-regulated exchanges. The other half will be eligible for expanded coverage under the Medicaid, the health insurance program for the poor.

Statistic source: The U.S. Department of Health and Human Services.

Expert: Sandy Preger, the Kansas Insurance Commissioner and current head of the National Association of Insurance Commissioners. URL: www.naic.org

Myth: Insurance companies can spend whatever they want on administration, salaries and marketing. ve care. WE WILL NEED TO STATE WHY THIS IS A MYTH Note to EJ —Ppeople often think insurance companies shirk their responsibilities to for providing care by through excessive spending loads on such costs as salaries, administration and, marketing, etc. IWhile nsurance they companies certainly do have shareholders, profits and administrative costs, but for the first time, health care reform it—for the first time—mandates that they is part of health reform that they spend a certain so muchamount on care (See Above) for their insured businesses (see question 9). Perhaps we should write the myth differently. Something like: Insurance companies can spend whatever they want on administration, salaries and marketing.

#10. Question: Will the Obama administration decide which health insurers do business in 2014?

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Comment [SR15]: Experts: Aon Hewitt Associates has a couple of Medicare expert consultants. Frank McArdle and J.D. Piro. 847-771-0788.

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Comment [G17]: Website?

Comment [SR18]: Expert: Sandy Preger, the Kansas Insurance Commissioner and current head of the National Association of Insurance Commissioners. URL: www.naic.org

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Comment [SR19]: Link back to question 9?

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Answer: No, insurance companies will work with individual state-regulated health insurance exchanges that will provide consumers with options for coverage. Private ~~health plans~~insurance companies will agree to provide certain basic benefits and to provide prices in the “exchange” marketplace.

~~Experts: Legislative sources: Check individual state departments of insurance, the National Association of Insurance Commissioners. www.naic.org for updates on this as well as state exchanges.~~

#11~~.~~ Question: What is the Blue Cross and Blue Shield Association and are all Blue Cross Plans owned and run by the same company?

Answer: Blue Cross and Blue Shield insurance companies are independent licensees of the Blue Cross and Blue Shield Association, an 80-year-old trade group based in Chicago. The association works with 39 Blue Cross branded community-based and locally operated Blue Cross and Blue Shield insurance companies. The association’s member Blues P~~p~~lans provide health coverage in all 50 states. There are many health plans that license to sell Blue Cross policies and coverage across the country and they predominately have three ownership structures. Some are for-profit or investor-owned, such as Anthem/Wellpoint, which has shareholders and sells coverage in many states. Some plans, called "mutual plans," are owned by policyholders. These include Health Care Service Corp., the nation’s fourth-largest health insurance company, which operates Blue Cross and Blue Shield Plans in Illinois, Texas, New Mexico and Oklahoma.

Comment [SR21]: Experts: Legislative sources: Check individual state departments of insurance, the National Association of Insurance Commissioners. www.naic.org for updates on this as well as state exchanges.

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Comment [SR22]: Policyholder fits Medicare.gov and cms.gov style.

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