

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-09

Subject: Components of Health Insurance

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1 At the 2008 Annual Meeting, the House of Delegates adopted amended Resolution 111, which
2 called for the American Medical Association (AMA) to study and describe to what extent a prepaid
3 health service component and a risk-based component contribute to the costs of health insurance.
4 The Board of Trustees referred the requested study to the Council on Medical Service for a report
5 back at the 2009 Annual Meeting.

6
7 This report, presented for the information of the House, defines the risk-based and prepaid
8 components of health insurance, presents available estimates of the share of health insurance
9 premium revenues going to each component, summarizes relevant AMA policy, and discusses
10 policy implications.

11 12 COMPONENTS OF HEALTH INSURANCE

13
14 Health care services cannot always be neatly classified into either the prepaid or risk-based
15 component of health insurance. In particular, the ongoing treatment of chronic medical conditions
16 shares characteristics of both risk-based and prepaid services. Like prepaid services, use of chronic
17 care services is generally predictable at the individual level. Like risk-based services, chronic care
18 is limited to subsets of the population and is generally more expensive than preventive and routine
19 care at both the individual and aggregate levels. Isolating the chronic care component of health
20 insurance is difficult because the relationship between chronic illness and premiums depends on
21 premium rating regulations, which differ widely by state in the individual and small-group
22 insurance markets. Recognizing the existence of a chronic care component of health insurance,
23 and the difficulty of sharply delineating it from other components, this report attempts to isolate the
24 prepaid component of health insurance and makes the simplifying assumption that the remainder
25 can be classified as risk-based health insurance.

26 27 *Risk-Based Health Insurance*

28
29 A primary function of insurance is to provide financial protection against low-probability, high-
30 cost events. In the case of pure risk-based health insurance, an individual pays an insurer a certain
31 premium in exchange for payment toward uncertain medical expenses in the event of unforeseen
32 illness. In the simplest case, each policy holder pays an “actuarially fair” premium that is sufficient
33 to cover his or her likely medical expenses but less than potentially catastrophic medical expenses.
34 The premiums and subsequent insurer payments of enrollees’ unforeseen medical expenses
35 constitute the risk-based component of health insurance.

1 *Prepaid Health Insurance*

2
 3 In addition, health insurance typically covers certain predictable health care expenses, most
 4 notably, preventive services, early-detection screening tests, and routine care. Services such as
 5 vaccinations and annual exams are often relatively inexpensive on a per-person basis,
 6 recommended for the general population, and utilized at similar rates across groups of people with
 7 different health risk or health status. The portion of premium revenues and insurance payment of
 8 predictable or common medical expenses constitute the prepaid component of health insurance.

9
 10 PROS AND CONS OF PREPAID COVERAGE

11
 12 Risk-based health insurance is often called catastrophic or “bare bones” coverage, whereas health
 13 insurance payment for routine, predictable health care expenses is considered more comprehensive.
 14 Proponents of more limited coverage argue that the prepaid component of health insurance
 15 unnecessarily drives up premiums and, correspondingly, the rate of uninsured. Mandated coverage
 16 of routine medical care may reduce the availability of relatively inexpensive, catastrophic coverage.
 17 Direct out-of-pocket payment for routine care has the potential to eliminate the administrative costs
 18 of adjudicating many relatively small medical expenses. Accordingly, health savings accounts
 19 (HSAs) and similar forms of high-deductible coverage provide options for individuals preferring to
 20 accept less comprehensive coverage in exchange for lower premiums.

21
 22 Proponents of more comprehensive coverage argue that some recommended preventive and
 23 screening services are investments that pay for themselves over time in the form of reduced costs
 24 of future illness and increased productivity. Even services that do not yield monetary savings can
 25 be worthwhile by improving quality of life. Some preventive services also confer societal benefits
 26 by stemming the spread of communicable disease. Proponents of more comprehensive health
 27 insurance coverage are concerned that high out-of-pocket payments and bare bones coverage will
 28 discourage lower-income individuals from seeking high-value care. Accordingly, third party
 29 payers sometimes use value-based, targeted benefit design, whereby patient cost-sharing
 30 requirements are reduced for high-value care such as maintenance medications, particularly when
 31 non-compliance poses a high risk of adverse clinical outcome or high medical costs.

32
 33 AMA POLICY

34
 35 A large body of AMA policy supports insurance coverage of preventive and/or routine care, and
 36 adequate payment for such services. AMA Policy H-165.848 (AMA Policy Database) advocates
 37 that individuals and families who can afford to should be responsible for obtaining health insurance
 38 coverage of, at a minimum, catastrophic and evidence-based preventive health care. Numerous
 39 policies advocate insurance coverage of recommended immunizations, screening exams, and other
 40 preventive services (Policies H-425.987, H-185.954, H-185.960, H-185.965, H-185.969,
 41 H-185.970, H-185.955, D-185.997, H-440.875, H-440.928[6], H-440.952, H-425.983, H-440.860,
 42 and D-440.953). Additional policies promote coverage of recommended preventive and screening
 43 services under public programs, including Medicare (Policies H-425.992, H-330.896, D-390.993,
 44 D-330.977, D-330.935, D-330.967, H-330.904, H-330.905, H-525.986, H-425.981, D-330.950, and
 45 D-330.929) and Medicaid (Policies H-290.985[6], D-290.987, H-290.987[2], D-290.985[3], and
 46 D-290.983). AMA Policy H-425.997 specifies that patients should have access to preventive and
 47 early-detection screening services, provided the services are cost effective, and that any preventive
 48 service being considered for insurance coverage should have evidence-based data to demonstrate
 49 improved outcomes or quality of life and the cost effectiveness of the service. AMA Policy
 50 H-290.972[2b], which advocates that Medicaid HSAs provide first-dollar coverage of preventive
 51 services regardless of whether the beneficiary has met the deductible, was modeled after previous

1 AMA policy that successfully advocated that insurers be permitted but not required to offer HSAs
 2 with first-dollar coverage of preventive services. Additionally, AMA policy encourages private
 3 and public insurers to use targeted benefit design and to consider tailoring cost-sharing
 4 requirements to patient income and other factors known to impact compliance (Policies
 5 H-155.960[7] and D-330.928[2]).

6
 7 Extensive AMA policy also promotes the general principles of pluralism, individual choice, and
 8 government neutrality toward different forms of health insurance, so that coverage options can be
 9 determined through market competition (H-180.995, H-285.998, H-165.997[6], H-165.985,
 10 H-165.846, and H-330.912). Many of these policies explicitly advocate less comprehensive, more
 11 affordable coverage. AMA Policy H-185.982 recognizes that there are proportionately large
 12 administrative costs associated with health insurance coverage of relatively small claims.
 13 longstanding AMA policy supports minimizing benefit mandates in order to expand individual
 14 choice and allow market experimentation to find the most attractive combinations of plan benefits
 15 and cost-sharing features (Policies H-165.856[9b], H-180.978, and H-165.997), and Policies
 16 H-165.882[2] and H-185.964] oppose new mandates unrelated to patient protections. An extensive
 17 body of AMA policy supports HSAs and similar forms of coverage as an option in the health
 18 insurance marketplace (Policies H-165.852, H-180.957, D-165.963, H-165.865, H-165.852,
 19 H-330.898, D-280.990, D-165.962, H-290.972, H-290.982, H-165.854, D-165.967, and
 20 D-165.954).

21
 22 **COVERAGE TRENDS FOR PREVENTION AND SCREENING**

23
 24 As a long-term historical trend, both private and public insurance coverage has expanded from
 25 catastrophic care coverage to include more routine and preventive benefits. At the same time,
 26 technological innovation has increased the availability of preventive services and screening tests.

27
 28 *Private Health Insurance*

29
 30 Historically, preventive coverage in employer-sponsored health plans grew more generous with the
 31 shift toward managed care (Kaiser Family Foundation/Health Research and Educational Trust,
 32 *2003 Employer Health Benefits Annual Survey*, September 2003). Most employer-sponsored plans
 33 now offer adult physicals and well child care, and nearly 90% of plans with deductibles cover
 34 preventive services regardless of whether the deductible has been met (KFF/HRET, *2008 Employer*
 35 *Health Benefits Annual Survey*, September 2008). A growing number of employers offer employee
 36 wellness programs through health insurance or as stand-alone benefits. In 2008, more than half of
 37 employers offering health insurance offered a wellness program in at least one of the following
 38 areas: weight loss, gym membership or on-site exercise facilities, smoking cessation, personal
 39 health coaching, nutrition or healthy living classes, web-based healthy lifestyle resources, a
 40 wellness newsletter, or a health risk assessment. As employers have struggled to contain costs of
 41 employee health benefits recently, many have shifted to insurance with higher out-of-pocket cost-
 42 sharing or, less commonly, reduced coverage of services. Between 2007 and 2008, the average
 43 coinsurance rate remained 17% but the average family deductible rose by 30% to \$1,344. The
 44 current economic downturn and associated loss of job-based coverage are likely to accelerate the
 45 shift toward less comprehensive coverage.

46
 47 Most health plans sold on the individual market cover preventive and routine services, though less
 48 commonly than for employer-sponsored plans. More than 90% of individual market policies cover
 49 cancer screenings, including annual obstetrics/gynecology visits, about 85% cover well-child visits,
 50 and about two-thirds cover annual physical exams for adults (AHIP, *Individual Health Insurance*
 51 *2006-2007*, December 2007). The average family deductible was \$2,753 for a PPO and \$5,329 for

1 an HSA plan. In some states, “bare bones” health plans are available on the individual market.
 2 These plans may have steep patient cost-sharing requirements and not cover physician visits,
 3 laboratory tests, or preventive services (www.eHealthInsurance.com). Other plans known as
 4 “limited-benefit” or “mini-medical” plans cover routine services but not unpredictable, expensive
 5 care such as hospitalization. Such plans have come under scrutiny for providing consumers with a
 6 false sense of security that they are insured against catastrophic medical expenses.

7
 8 *Medicare*

9
 10 Although traditional fee-for-service Medicare coverage has never included routine physical exams,
 11 the number of covered preventive services has grown steadily during the last decade. Most
 12 notably, Medicare Part B coverage now includes a “Welcome to Medicare” visit. New enrollees
 13 have one year to obtain the initial preventive physical examination, which is covered at 80%
 14 without being subject to the Medicare Part B deductible. The visit includes a comprehensive
 15 physical examination, medical and social history, review of risk factors for depression, evaluation
 16 of functional ability, end-of-life planning, counseling and referral based on exam findings, and a
 17 brief written plan for follow-up with additional appropriate screening and preventive services.

18
 19 In addition to the Welcome to Medicare Visit, Medicare coverage of periodic screenings includes
 20 Pap smears and pelvic exams every two years, annual mammograms, annual prostate cancer
 21 screening, colonoscopy every 10 years, other colorectal cancer screenings more frequently, and
 22 cholesterol and triglyceride blood tests every five years. Pneumococcal and annual influenza
 23 vaccinations are also covered by Medicare. In addition, Medicare beneficiaries identified as being
 24 high-risk for certain conditions are eligible for more frequent screenings or additional preventive
 25 services, such as diabetes monitoring, a one-time ultrasound screening for abdominal aortic
 26 aneurysm, bone mass measurement, glaucoma screenings, hepatitis B vaccinations, and counseling
 27 for smoking cessation.

28
 29 Two other developments have also increased the preventive and screening coverage in the
 30 Medicare program: rapid enrollment growth in private managed care plans and the introduction of
 31 a prescription drug benefit. Between 2003 and 2008, the number of Medicare beneficiaries
 32 enrolled in managed care plans under the Medicare Advantage program (Medicare Part C) nearly
 33 doubled from 5.5 million to 10.2 million (KFF, *Medicare: A Primer*, January 2009). Nearly a
 34 quarter of all Medicare beneficiaries are now enrolled in Medicare Advantage plans. In addition to
 35 all benefits covered under traditional fee-for-service Medicare, some Medicare Advantage Plans
 36 offer additional benefits such as preventive dental care, disease management programs, and
 37 prescription drug coverage. Since the establishment of Medicare Part D in 2006, all Medicare
 38 beneficiaries have had the option of prescription drug coverage. To the extent that maintenance
 39 medications for chronic conditions play a role in the prevention of acute illness, the Medicare drug
 40 benefit represents an expansion of preventive care coverage.

41
 42 *Medicaid*

43
 44 State Medicaid programs must cover specified early and periodic screening, diagnostic, and
 45 treatment (EPSDT) services for individuals under 21. In addition to diagnostic and treatment
 46 services typically covered by private insurance, EPSDT covers “screening and early intervention
 47 services to promote children’s healthy development, vision, dental, and hearing services,
 48 scheduling and other administrative services, and care to ameliorate acute and chronic physical and
 49 mental health conditions.” Nearly two-thirds of all Medicaid beneficiaries are enrolled in managed
 50 care plans (KFF, *Medicaid: A Primer*, January 2009).

1 COSTS OF RISK-BASED AND PREPAID SERVICES

2
3 A variety of evidence demonstrates that treatment of disease accounts for the majority of medical
4 spending and cost growth, and that preventive and routine services account for a relatively small
5 portion of medical spending. The ten medical conditions with the greatest national cost burden –
6 mental disorders, heart disease, trauma, cancer, pulmonary conditions, hypertension, arthritis, back
7 problems, kidney disease, and diabetes – account for roughly half of all U.S. medical spending,
8 with preventive services accounting for just six percent (Roehrig et al., *Health Affairs* Web
9 Exclusive, February 2009). Under Medicare, inpatient hospital services comprise the largest share
10 of benefit costs (29%) (KFF, *Medicare: A Primer*, January 2009). Prepaid services are hard to
11 isolate since they are included in payments to Medicare Advantage plans (24%), physician and
12 other outpatient services (17%), and Medicare Part D outpatient prescription drugs (11%).
13 Similarly, under Medicaid, long-term care accounts for 36% of benefit spending and inpatient
14 hospital care 14%. Prepaid services are mixed in with payments to Medicaid managed care
15 organizations (18%), physician and other outpatient services (4%), and prescription drugs (6%)
16 (KFF, *Medicaid: A Primer*, January 2009).

17
18 For purposes of this report, the costs and benefits of prepaid coverage are relevant insofar as they
19 have direct, immediate, monetary impact on health plans and, therefore, premiums. Recent
20 analyses of cost-effectiveness research conducted since the 1970s has shown that preventive and
21 screening services usually increase rather than decrease aggregate medical spending, according to
22 analyses of (Cohen et al., *NEJM*, February 2008 and Russell, *Health Affairs*, January/February
23 2009). For example, the cost of providing preventive medication to patients with hypertension or
24 high cholesterol exceeds the monetary savings to the health care system because of the ongoing
25 costs of providing medication to many patients who would not have developed heart disease or
26 stroke. Similarly, an intensive program of healthy lifestyle change among overweight, at-risk
27 adults that cut the risk of developing diabetes in half, nonetheless, added to net medical costs.
28 Widespread screening for cervical, colorectal, and breast cancer have also been shown to add to net
29 medical costs. Advances in screening can also increase the costs of disease treatment because of
30 earlier detection and lower clinical thresholds for diagnosis and treatment, particularly if
31 accompanied by expensive advances in treatment.

32
33 Nonetheless, one-fifth of preventive and screening measures have been demonstrated to reduce
34 aggregate medical costs, particularly when services are narrowly targeted toward patients at highest
35 risk of developing preventable disease. Examples of preventive services that yield medical cost
36 savings include aspirin therapy for middle-aged men with cardiovascular risk factors,
37 pneumococcal vaccinations for adults with certain chronic conditions, and screening and treatment
38 of osteoporosis for elderly women. Although beyond the immediate scope of this report, it should
39 be noted that services, preventive or curative, that do not reduce aggregate medical costs can still
40 provide value by improving clinical outcomes, quality of life, and productivity. For example,
41 providing the chickenpox vaccine to pre-school children increases medical costs but is very cost-
42 effective, yielding tremendous health benefit at relatively low cost (Russell, National Coalition on
43 Health Care, October 2007).

44 ANALYSIS OF HEALTH INSURANCE PREMIUMS

45
46
47 Comparisons of premiums for health plans with different benefits coverage can be used to estimate
48 the contributions of prepaid and risk-based health care to the cost of health insurance. In 2008,
49 average monthly premiums for employer-sponsored single coverage were \$396 for HMOs, \$400
50 for PPOs, and \$327 for high-deductible health plans, making monthly premiums for PPOs and
51 HMOs about \$70 higher than premiums for high-deductible plans or 18% of HMO and PPO

1 premiums (KFF/HRET, *2008 Employer Health Benefits Annual Survey*, September 2008).
2 Similarly, family premiums for HMOs and PPOs were about \$250 higher than for high-deductible
3 plans, or 23% of HMO and PPO premiums. However, these comparisons do not separate the
4 effects of different cost-sharing from the effects of different coverage of prepaid services. For
5 example, HMOs provide relatively generous coverage of preventive and screening services but also
6 have lower cost-sharing than PPOs and much lower cost-sharing than high-deductible plans. In
7 addition, premiums for employer-sponsored insurance reflect selection of people with different
8 characteristics into different types of health plans, as well as plan benefits. The challenges of
9 measuring the risk-based and prepaid components of health insurance can be addressed by
10 examining detailed data from the individual health insurance market.

11
12 The most readily available information on health plan benefits, cost-sharing features, and
13 premiums is for plans offered on the individual market through www.eHealthInsurance.com, a
14 Web-based health insurance vendor. The tables in the Appendix of this report compare “base”
15 plans that provide relatively bare coverage of prepaid services with “standard” plans that are
16 offered by the same insurer in the same state with the same overall cost-sharing structure, but that
17 provide more generous benefits coverage. So that results would not be confounded by state benefit
18 mandates, health insurance premium rating regulations or terms-of-issue regulations, only plans in
19 states classified as having relatively unregulated individual health insurance markets were
20 considered (Herring, B. and Pauly, M.V., National Bureau of Economic Research Working Paper
21 No. 12504, August 2006; and Matthews, M. et al., Council for Affordable Health Insurance, 2006).
22 Very few health plans were found to exclude or strictly limit coverage of routine physician office
23 visits, preventive services, and early-detection screening tests, thereby qualifying as “base” plans.

24
25 Table 1 of the Appendix shows benefits information on four pairs of base and standard health plans
26 in the following states: Alabama, Arizona, Arkansas, Colorado, Delaware, District of Columbia,
27 Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska,
28 Oklahoma, Pennsylvania, South Carolina, Tennessee, West Virginia, and Wyoming. The four
29 pairs of health plans include three pairs of PPOs and one pair of HSA-qualified health plans. Other
30 than the base and standard PPO A plans, which have a \$2,500 deductible and are offered by Blue
31 Cross/Blue Shield only in Illinois, the plans are offered jointly by UnitedHealthOne and Golden
32 Rule Insurance Company, and are available with a range of deductible levels in multiple states.
33 Coinsurance is 20% for the PPOs and 0% for the HSA plans. In general, the base plans do not
34 cover physician office visits, most preventive or screening services, prescription drugs, or
35 laboratory tests except in conjunction with surgery or hospitalization. None of the base or standard
36 plans shown provide maternity coverage.

37
38 The difference between base and standard plan premiums, in dollars or as a share of the standard
39 plan premium, serves as a rough measure of the cost of the prepaid component of health insurance.
40 Analysis of the premium data shows that the prepaid component generally declines sharply
41 between birth and adulthood and then rises gradually during adulthood, reflecting relatively high
42 utilization of immunizations and screenings by infants and children, and increasing utilization of
43 early-detection screenings by adults as they age. Slight differences between males and females did
44 not follow a discernable pattern. Thus, comparing base and standard premiums for a family of four
45 with two adults and two children is used as a general measure of the prepaid component of health
46 insurance.

47
48 Table 2 of the Appendix shows monthly family premiums for each of the base and standard plans
49 at each available deductible level. Premiums are averaged across all states in which a given
50 plan/deductible combination is available, weighted by the size of each state’s individual health
51 insurance market. It should be noted that base plans have deductibles that are higher than average

1 for both the individual and employment-based markets, making it impossible to fully separate the
2 effects of prepaid coverage from cost-sharing. The gap between base and standard premiums
3 provides a wide range of estimates of the cost of prepaid health insurance, from \$29 (18% of the
4 standard premium) to \$211 (37% of the standard premium). The premium gaps between base and
5 standard plans are smaller the higher the deductible and the higher the coinsurance (PPOs vs. HSA
6 plans), reflecting the fact that higher patient cost-sharing mutes the utilization and cost impact of
7 adding richer benefits coverage. Taking into consideration that the analysis is sensitive to
8 deductible and coinsurance levels, the data in Table 2 suggest that the prepaid component of health
9 insurance accounts for roughly a quarter of the cost of health insurance, and the risk-based
10 component, roughly three-quarters.

11

12 DISCUSSION

13

14 Based on analysis of this report, the Council concludes that the prepaid component of health
15 insurance contributes approximately a quarter of the cost of health insurance, with the risk-based
16 component largely accounting for the remaining three-quarters of health insurance costs. The body
17 of this report demonstrates the challenges of measuring the components of health insurance,
18 particularly separating the effect of the level of prepaid coverage from the effects of other factors
19 such as health plan cost-sharing features and state health insurance market regulations.

20

21 The finding that the prepaid component of health insurance accounts for a substantial portion of
22 health insurance costs suggests that one way to make health insurance more affordable and reduce
23 the number of uninsured would be to reduce insurance coverage of prepaid services such as routine
24 physician visits, annual exams, immunizations, and early-detection screenings. Although reducing
25 the prepaid component of health insurance would likely lower premiums and expand health
26 insurance coverage of the uninsured, at least in the short run, it would also shift financing of
27 payment for prepaid services from insurers to individuals. Because insurers achieve administrative
28 economies of scale, reductions in costs of adjudicating claims for prepaid services might be offset
29 by increased individual costs of negotiating and paying for such services. In addition, reducing
30 insurance coverage of prepaid services would reduce utilization of such services, including some
31 high-value services that improve health, quality of life, and productivity.

32

33 The Council believes that the finding that the prepaid coverage accounts for approximately one
34 quarter of the cost of health insurance reinforces longstanding AMA policy advocating individual
35 choice of health insurance, with market experimentation being allowed to determine the most
36 attractive combinations of health plan benefits, cost-sharing features, and premiums.

References for this report are available from the AMA Division of Socioeconomic Policy
Development.

APPENDIX

Table 1 Comparison of Benefits Coverage of Selected Individual Market Health Plans

| | Physician Office Visit | Annual Physical Exam (Adult or Child, inc. Ob/Gyn) | PAP, Mammogram, PSA Test | Other Preventive Lab, X-Ray, | Childhood Immunizations | Prescription Drugs - Generics | Prescription Drugs - Brand | Emergency Department Visit | Outpatient Lab & X-Ray – with surgery or hospitalization | Outpatient Lab & X-Ray - Other | Outpatient Surgery | Hospitalization | Mental Health | Chiropractic |
|-------------------------|----------------------------|--|--------------------------|------------------------------|-------------------------|-------------------------------|----------------------------|----------------------------|--|--------------------------------|--------------------|-----------------|---------------|--------------|
| PPO A – Standard | ✓✓ \$30 | ✓✓ \$30 | ✓✓ \$0 | ✓✓ \$0 with visit | ✓✓ \$0 | ✓ | ✓ | ✓✓ \$75 +20% | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| PPO A – Base | No | No | No | No | No | No | No | ✓✓ \$125 +20% | ✓ | No | ✓ | ✓ | No | No |
| PPO B – Standard | ✓✓ \$35 | ✓✓ \$35 | ✓✓ | ✓ | ✓ | ✓✓ \$15 | ✓tiered | ✓+\$100 except injury | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| PPO B – Base | ✓✓ \$35 2 visit maximum | ✓✓ \$35 | ✓ | No | No | ✓✓ \$15 | No | ✓+\$500 | ✓ | No | ✓ | ✓ | No | No |
| PPO C – Standard | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓+\$100 except injury | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| PPO C – Base | No | No | ✓ | No | No | No | No | ✓+\$500 | ✓ | No | ✓ | ✓ | No | No |
| Standard HSA | ✓ | ✓ | ✓ | ✓ | ✓✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Base HSA | No | No | ✓ | No | ✓✓ | No | No | No, unless admitted | ✓ | No | ✓ | ✓ | No | No |

Key: ✓ - covered at applicable coinsurance after deductible (20% for PPOs, 0% for HSAs)
 ✓✓ - coverage not subject to deductible; patient pays applicable coinsurance or copayment (dollar amount shown when applicable)

Notes: Comparison plans have the same annual out-of-pocket maximums, lifetime coverage limits, and networks. All plans exclude maternity benefits and cap prescription drug, chiropractic, and mental health benefits. In some states, health plan benefits differ slightly from those shown. PPO A Plans offered by Blue Cross/Blue Shield of Illinois with a family deductible of \$2,500 (IL only). PPO B Plans offered by UnitedHealthOne/Golden Rule with family deductibles of \$5,000, \$10,000 (CO only), \$15,000, and \$20,000. PPO C Plans offered by UnitedHealthOne/Golden Rule with family deductibles of \$3,000, \$5,000, and \$10,000. HSA Plans offered by UnitedHealthOne/Golden Rule with family deductibles of \$2,300, \$3,850, \$5,800, \$7,500, and \$10,000. For all plans, per family member deductible is half of family deductible with a two person maximum.

Sources: www.eHealthInsurance.com and plan literature.

Table 2 Monthly Premiums of Selected Individual Market Health Plans for a Family of Four by Benefits Coverage Level and Deductible, April 2009

| Plan | Family Deductible | Premium | | Difference | Difference as % of Standard Premium |
|----------|-------------------|----------|-------|------------|-------------------------------------|
| | | Standard | Base | | |
| PPO A | \$2,500 | \$387 | \$294 | \$93 | 24% |
| PPO B | \$5,000 | \$294 | \$220 | \$74 | 25% |
| | \$10,000 | \$260 | \$200 | \$60 | 23% |
| | \$15,000 | \$193 | \$154 | \$39 | 20% |
| | \$20,000 | \$163 | \$134 | \$29 | 18% |
| PPO C | \$3,000 | \$528 | \$366 | \$162 | 31% |
| | \$5,000 | \$449 | \$309 | \$140 | 31% |
| | \$10,000 | \$370 | \$281 | \$89 | 24% |
| HSA Plan | \$2,300 | \$574 | \$362 | \$211 | 37% |
| | \$3,850 | \$382 | \$298 | \$84 | 22% |
| | \$5,800 | \$313 | \$243 | \$70 | 22% |
| | \$7,500 | \$268 | \$208 | \$59 | 22% |
| | \$10,000 | \$228 | \$178 | \$49 | 22% |

Notes: Premiums are for a family of four, ages 35, 35, 10, and 5.

Premiums averaged from AL, AZ, AR, CO, DE, DC, IL, IN, KS, KY, LA, MI, MS, MO, NE, OK, PA, SC, TN, WV, and WY, weighted by size of state's individual market.

Not all plans available in all states.

Coinsurance is 20% for the PPOs and 0% for the HSA plans.

Sources: www.eHealthInsurance.com and US Census Bureau Current Population Survey, March 2008 Supplement, Table HI05.