Summary of Proposals for Reference

- **Selected Members of the Insurance Industry –** Increased private market coverage options (Health Savings Accounts and Consumer-Directed Health Plans), Medicaid reform and expansion to childless adults, Medicaid/SCHIP-funded premium assistance program
- **Campaign for Better Health Care and Health & Disability Advocates** – Employer "play or pay", expansions of Medicaid/SCHIP and state-only funded programs, use of small group purchasing pool
- **Healthy Illinois** – State self-funded insurance plan funded by "windfall profit assessment" from insurers
- **Illinois Hospital Association** – Two employer-sponsored initiatives that use a safety net benefit package, Medicaid/SCHIP expansions, state-subsidized premium subsidies, expansion of State high-risk pool
- **Single Payer** – Consolidation of administration and financing of Illinois' health care system into one public program that covers all Illinois residents with a comprehensive benefit package

Proposal:	Recommendations from Members of the AHCTF Associated with Insurance Industry	*Proposal Summary*
Submitted By:	AHCTF Members Associated with Insurance Industry	

Overview: This proposal expands access to care by building on current private market coverage; it includes a Medicaid expansion for very poor single childless adults, requires Medicaid managed care and modifies Medicaid and SCHIP coverage to include personal health accounts and consumer-driven health care. Strategies involve implementing a mechanism to mainstream high-risk individuals into the private health insurance market, encouraging the use of health savings accounts and consumer-driven health care, and providing tax incentives to employers, employees and carriers to make coverage more affordable.

1. Access	• *New populations covered* – All uninsured in Illinois may have additional coverage options. • *Number of uninsured covered* – Not included in proposal. • *Increasing enrollment in current public programs* – Increase funding to finance additional enrollment outreach programs, and expand Division of Insurance Ombudsman program by offering a "health insurance and medical assistance decision tree," an interactive website that will provide health insurance options to Illinois residents.
2. Methods of Coverage	• *Medicaid and SCHIP expansion* – Increase eligibility to single childless adults below 100 percent of the federal poverty level (FPL). • *Medicaid reform* – Explore feasibility of vouchers to permit employed Medicaid eligibles to participate in employer coverage. Provide personal health accounts to Medicaid beneficiaries who enroll in a consumer-engaged (i.e., "consumer-driven") option and default Medicaid enrollment to a state-run managed care Medicaid program for those enrollees who choose not to enroll in a consumer-engaged option. Implement long-term care partnerships as allowed in the recently passed federal budget reconciliation law, which allows for an income and resources disregard equal to the insurance benefit payments into a qualified long-term insurance policy. Inventory current public insurance and medical assistance programs to determine which current state government-sponsored programs could be modified or even eliminated. • *State-sponsored health care program* – Limit coverage provided through Illinois' high-risk pools (Illinois Comprehensive Health Insurance Plan or ICHIP) and implement a mechanism to mainstream high-risk individuals into the private health insurance market. Require the two principal CHIP pools to offer a consumer-driven health plan option that incorporates a Health Savings Account (HSA)-compatible high deductible health plan. Evaluate the cost-effectiveness and feasibility of a voluntary, federally-subsidized individual and/or small group reinsurance pool established strictly for high-risk individuals. • *State-subsidized premium assistance program* – Provide premium subsidies to individuals and families similar to Oregon's Family Health Insurance Assistance Program.

Members of the AHCTF Associated with Insurance Industry, continued

3. Methods of Coverage	• *Purchasing pool* – Not included in proposal. • *Employer "pay or play"* – Not included in proposal. • *Individual mandate* – Not included in proposal. • *Other* – Encourage the use of HSAs and consumer-directed health care by eliminating legislative barriers and eliminating the state premium tax on high-deductible plans offered in conjunction with HSAs. Provide tax incentives to employers, employees and carriers to make coverage more affordable (i.e., federal tax credits or refundable and/or advanceable state tax credits). Encourage product innovation in the private sector to expand choices to lower-cost options (specifics not provided in proposal). Develop a multi-faceted public awareness campaign to educate individuals on the availability of coverage, and to educate small employers on the tax treatment of insurance, rate protections and the availability of coverage in Illinois on a guarantee issue basis. Inventory current public insurance and medical assistance programs to determine which current state government-sponsored programs could be modified or even eliminated.
4. Means Testing	Used for Medicaid expansion for single childless adults (100 percent of the FPL).
5. Crowd-out policies	• Limit Medicaid expansion to single childless adults to those who have been uninsured for more than one year. • Explore feasibility of vouchers to permit employed Medicaid eligibles to participate in employer coverage.
6. Financing	• Federal Medicaid and SCHIP funding. • Source of additional State Medicaid and SCHIP funding not discussed in proposal. • State tax credits and federal subsidies through tax credits through federal legislation. • Realized savings from mandatory Medicaid managed care program for Medicaid would fund the cost of fair reimbursement rates to physician and hospital providers. • Natural State revenue growth above three percent applied to fund state-subsidized premium assistance to individuals.
7. Cost Containment Incentives	• Reduce use of managed care for services and populations covered under Medicaid. • Reduce excessive, unnecessary regulation and litigation.
8. Estimated Cost	Not included in proposal

Members of the AHCTF Associated with Insurance Industry, continued

9. Benefits	• Non-Medicaid benefit package content not specifically addressed. • *Long term care* – Medicaid expansion and reform would include the implementation of long term care partnerships; specific long term care benefit package content not specified or further addressed. • *Preventive care* – Not specifically addressed in proposal. • *Acute care* – Not specifically addressed in proposal.
10. Preventive Medicine Component	Not specifically addressed in proposal.
11. Program Administration	State government will administer and manage high-risk pools and implement the “health insurance and medical assistance decision tree.” Additional information not included in proposal.
12. Quality Improvement	Accelerate adoption of health information technology and related infrastructure needed to improve quality, patient safety and efficiency and reduce treatment variation. Increase use of pay-for-performance, implement an on-going consumer-targeted patient safety initiative and increase consumer involvement in health care decisions.
13. Capital and Technology	Accelerate the adoption of health information technology and establish health information technology infrastructure.
14. Provider Reimbursement	Use the savings from implementing a true managed care Medicaid system to reimburse providers more fairly.
15. Implementation	• *Federal Medicaid or SCHIP waiver required* – Yes. • *Other federal waiver or federal legislation* – Yes. • *State government responsibilities* – Apply for Medicaid or SCHIP waivers. Apply for grant monies; provide state funding for Medicaid expansion to maximize federal matching funds. Fund-high risk pools. Implement the “health insurance and medical assistance decision tree”. Improve speed to market for heath insurance products. • *State legislative actions* – Eliminate state premium taxes on high-deductible health plans offered with HSAs. Implement Medicaid Personal Health Accounts and mandatory managed care. Adopt uniform small group standards. • *Provider responsibilities* – Accept and encourage pay-for-performance initiatives. Implement evidence-based care. Disclose cost and quality information. • *Health plan responsibilities* – Conduct marketing campaigns and availability and affordability of health insurance. Educate consumers on health issues. Develop flexible products for different types of consumers.

Members of the AHCTF Associated with Insurance Industry, continued

Source:

Presentation by Members of the AHCTF Associated with the Insurance Industry, “Recommendations Concerning the Uninsured, Health Care Access and Affordability of Health Insurance in Illinois,” (May 9, 2006).

Proposal:	Consumer Health Care Access Strategy	
Submitted By:	Campaign for Better Health Care and Health & Disability Advocates	**_Proposal Summary_**

Overview: This proposal expands access to heath care coverage by making it easier for individuals and small businesses to purchase insurance, requiring that employers contribute to health care coverage, and expanding Medicaid and SCHIP and state-only funded programs, Strategies include requiring that employers pay a fee for employees who do not have health care coverage, using sliding scale subsidies for low-income individuals to make COBRA premiums more affordable, and creating a purchasing pool for individuals, sole proprietors and small groups who cannot afford insurance in the private market.

1. Access	• *New populations covered* – The plan provides coverage options for all of the 1.4 million uninsured adults, ages 18-64, in either private employer-based coverage, the new purchasing pool or public program expansions. The plan assumes that children (ages 0 -18) will be covered under All Kids, and that individuals, age 65 and older are covered by Medicare and Medicaid. • *Number of uninsured covered* – The plan provides access to coverage for all of the 1.4 million uninsured Illinois adults. • *Increasing eligibility for current public programs* – Explore innovative ways to increase enrollment for individuals eligible for but not enrolled in Medicaid and other state- and federal-funded program (i.e., marketing, branding, outreach). • *Access to providers* – Encourage provider participation through: targeted provider rate increases, medical school repayment options, increased funding for public health districts, community health centers, free clinics and other safety net providers.
2. Methods of Coverage	• *Medicaid and SCHIP expansion* – Various expansions to cover children and adults based on current programs funded by Medicaid and SCHIP. • *State-sponsored health care program* – Expand coverage to the medically indigent up to 300 percent of the FPL and make *ICHIP* (Illinois' high risk pool) premiums more affordable by using sliding scale subsidies for individuals with high expected medical costs. • *Purchasing pool* – Establish a pool for individuals, sole proprietors and for small groups (2-50 employees) who cannot afford insurance in the private market, including a State-subsidized reinsurance program for all carriers in the pool. Also, consider the implications of reinsurance for all carriers in the small group market. • *Employer "pay or play"* – Employers must pay a fee for employees that do not have health care coverage, which could be calculated using a percentage of the employer's payroll or the cost (or 50 percent of the cost) of the average premium for a PPO family plan in Illinois, multiplied by the number of employees in a firm. The fee would be reduced by the amount the employer spends on health care coverage.

	• *Individual mandate* – Consider only if proposed options have been implemented and a significant portion of the uninsured population does not obtain health care coverage in spite of availability and affordability of proposed options. • *Other* – Use sliding scale subsidies for low-income individuals to make *COBRA* premiums more affordable.
3. Means Testing	• Used for Medicaid and SCHIP expansion, State-sponsored health care programs and sliding scale subsidies for COBRA premiums.
4. Crowd-out policies	• Use waiting periods for coverage. • Limit eligibility to uninsured or underinsured populations.
5. Financing	• *Medicaid and SCHIP* – Federal funding and limited cost-sharing on individuals between 200 - 300 percent of the FPL that excludes preventive and primary care health services and is capped at two percent of family income. Financing for state share of expansion not specifically addressed in proposal. • *Purchasing Pool and State-Sponsored Health Programs* – Use funding from "pay or play" provision. • *Employer Responsibility* – Employers will be responsible for either covering their employees (see "Methods of Coverage" above) or paying a fee which will be used to offset the cost of health coverage. • *Other funding sources* – ICHIP subsidies funded by federal grants.
6. Cost Containment Incentives	• *Medicaid* – Limited cost-sharing (on individuals between 200-300 percent of the FPL) may promote cost containment. • *Purchasing Pool* – Competitive structure among health plans with standardized benefit packages will encourage them to keep costs low to attract enrollees. Reinsurance will reduce uncertainty for health plans, potentially allowing them to reduce their reserve requirements and premiums charged. Combining the individual and group markets may reduce administrative costs. • *Other* – Technology Development Advisory Task Force will consider improvements in data collection, quality of care and patient safety that will promote efficiencies in the health care delivery system.
7. Estimated Cost	Not provided
8. Benefits	• *Medicaid and SCHIP-based coverage* – Medicaid benefit package, with expanded dental and vision benefits for adults. • *Purchasing pool for individuals, sole proprietor and small groups* – Illinois State Employee benefit options. • *Long-term care benefits* – Not specifically addressed in proposal. • *Preventive care* – Not specifically addressed in proposal. • *Acute care* – Not specifically addressed in proposal.

Campaign for Better Health Care and Health & Disability Advocates, continued

9. Preventive Medicine Component	• Proposal excludes preventive and primary care health services from cost-sharing. • Prevention and Health Education Advisory Task Force will develop a multi-faceted disease prevention and health education program to be lead by community health centers and public health districts.
10. Program Administration	• "Guaranteed Health Security" (GHS) Task Force (housed under the Illinois Department of Public Health) will oversee implementation of health access plan, assess changes and develop future plans. • Regional and Advisory Task Forces under the GHS Task Force will monitor implementation and address issues related to technology development, capital and network infrastructure, health professional expansion, and prevention and health education.
11. Quality Improvement	IDPH and other State agencies that monitor health care quality will provide a written assessment every six months to the GHS Task Force and conduct an annual briefing to the GHS Task Force.
12. Capital and Technology	• Technology Development Advisory Task Force will assess technological weaknesses and inefficiencies and propose improvements. • Capital and Network Infrastructure Advisory Task Force will assess current infrastructure needs and develop options for improvements.
13. Provider Reimbursement	• Access strategies should include targeted reimbursement rate increases for public program expansions. ICHIP provider reimbursement will stay the same. Purchasing pool provider reimbursement will follow State employee health insurance program.
14. Implementation	• *Federal Medicaid or SCHIP waiver* – Required for implementation of some programs. • *Other federal waiver or federal legislatio*n – Not necessary. • *Other implementation issues* – Under the purchasing pool, consultant will need to consider potential changes to the insurance rating rules in the individual and small group markets.

Sources:

Campaign for Better Health Care and Health & Disability Advocates Presentation to the Adequate Health Care Task Force, "Options for a Consumer Health Care Access Strategy in Illinois," (May 9, 2006).

Campaign for Better Health Care and Health & Disability Advocates, "Options for a Consumer Health Care Access Strategy in Illinois: A Proposal to the Adequate Health Care Task Force," (May 1, 2006).

Proposal:	Healthy Illinois Plan
Submitted By:	The Healthy Illinois Campaign (See Endnote for Campaign Members)

Proposal Summary

Overview: This proposal would establish a public-private partnership that would develop a voluntary, statewide health insurance plan. Individuals under 300 percent of the federal poverty level and not eligible for Medicaid would receive sliding scale Healthy Illinois premium subsidies. Funding would come, in part, through a tax on health insurance carriers.

1. Access	• *New populations covered* – Individuals not eligible for Medicaid, Medicare, Family Care, Kid Care, or All Kids. • *Number of uninsured covered* – The entire population defined above (i.e., 1 million plus). • *Access to providers* – Analogous to the state employee health insurance plan, the State would leverage its bargaining power to secure the broadest provider network possible. Develop a Health Resource Plan on a biennial basis that provides a comprehensive, coordinated approach to the development of health care facilities and resources and outlines strategies to ensure access to providers.
2. Methods of Coverage	• *Medicaid and SCHIP expansions* – Not included in proposal. • *State-run purchasing pool* – Using a third party administrator, the State would negotiate reimbursement rates (and accordingly, premiums) on behalf of a large self-funded risk pool consisting of small businesses, small municipalities, self-employed, and other uninsured individuals. Beginning one year after the plan begins providing benefits, the State may include larger public or private employers in the plan. • *Employer "pay or play"* – Not included in proposal. • *Individual mandate* – Not included in proposal.
3. Means Testing	Employees and eligible individuals whose household income is under 300 percent of the federal poverty level and who are not eligible for Medicaid would receive sliding-scale Healthy Illinois premium subsidies.
4. Crowd-out policies	The State may require an eligible individual who is currently employed by an eligible employer that does not offer health insurance to certify that the current employer did not provide access to a benefits plan in the 12-month period immediately preceding the eligible individual's application. Business and individuals can keep their current coverage if preferred.
5. Financing	• *State subsidy for employers* – The State pays 50 percent of an employer's total premium. • *Employer contributions* – Employers pay at least 60 percent of what remains after the state pays 50 percent of the employer's total premium. • *Individual contributions* – Premium payments, with discounts based on ability to pay (described under "Means Testing").

	• *Health insurance carrier tax* – Health insurance carriers shall pay four percent of annual health insurance premiums collected on Illinois insurance policies ("windfall profit assessments"). Carriers may petition the Secretary of the Department of Financial and Professional Regulation for an abatement or deferment of all or part of an assessment.
6. Cost Containment Incentives	• Require each health insurance carrier to submit an annual report listing its overall underwriting gain, less federal taxes, on health insurance for the fiscal year. • Require health insurance carriers to justify increases in the index rate for any classification in excess of six percent (specifics outlined in SB 2561). • Determine if health care facilities' major expansions are consistent with state health goals by including the Health Resource Plan (described under "Access to Providers" above) in the current Certificate of Need process. • Require hospitals to submit an annual report listing cost increases and the hospital's operating margin for the preceding fiscal year. • Require each health care practitioner to report gains in net revenue annually.
7. Estimated Cost	• *Health insurance carrier tax* – $400 million (revenue). • *Employer and employee premium discounts in year one* – $192 million. • *Administration in year one (start-up)* – $100 million. • *Remaining reserves after 1st year* – $108 million.
8. Benefits	• Comprehensive package of benefits that includes, at a minimum, hospitalizations, mental health, prescription drugs and preventive care, and meets the requirements for mandated coverage for specific health services and specific diseases for certain providers of health services under the Illinois Insurance Code. • *Long term care* – Not specifically addressed in proposal. • *Preventive care* – Benefits package would include routine doctor visits, disease screenings and contraception. • *Acute care* – Not specifically addressed in proposal.
9. Preventive Medicine Component	Preventive health care services, including, but not limited to, routine doctor visits, disease screenings and contraception must be fully covered with no co-pays and no deductibles. Cost-sharing would be allowed on non-preventive services.
10. Program Administration	• Create a new state agency – Healthy Illinois Authority – in the executive branch of State government to establish the Healthy Illinois Plan and administer the Healthy Illinois Quality Forum (described in additional detail under "Quality Improvement").

	• Plan benefits would be provided by the Authority; plan would be administered by one or more competitively bid entities. • Establish the Healthy Illinois Fund – which will contain the monies from all funding sources – that will be housed and administered by the State Treasury.
11. Quality Improvement	Create a Healthy Illinois Quality Forum, which will: • Promote nationally established best practices to reduce regional, economic and racial health care disparities. • Establish incentives for consumers to adopt healthier lifestyles (e.g., health club discounts and full coverage of preventive care). • By the third year of Healthy Illinois operation, recommend measures that all Illinois providers, insurers and others, as appropriate, should adopt, and develop incentives to encourage the adoption of those measures (i.e., pay-for-performance).
12. Capital and Technology	Create a biennial Health Resource Plan that contains a comprehensive, coordinated approach to the development of health care facilities and resources in the state based on statewide cost, quality and access goals and strategies. The Plan would be included as a criterion in the current Certificate of Need process.
13. Provider Reimbursement	The state would negotiate reimbursement rates with the providers.
14. Implementation	• *Medicaid/SCHIP waiver* – Not required. • *Other federal waiver or federal legislation* – Not required. • The proposer is considering whether – in an effort to achieve an enrollment base of the size and continuity needed to establish and sustain affordable and stable premiums – to phase-in enrollment by capping individual enrollments. The proposer is also considering whether to establish mandatory waiting periods before re-enrollment in the Healthy Illinois Plan for any group, self-employed person, or individual that has enrolled and subsequently withdrawn.

The leading members of the Healthy Illinois Campaign are Citizen Action/Illinois, Illinois for Health Care, Service Employees International Union State Council, American Federation of State, County and Municipal Employees Council 31, Sargent Shriver National Center on Poverty Law, Center for Tax and Budget Accountability, and United Power for Action & Justice.

Sources:

Citizen Action/Illinois Presentation to the Illinois Health Care Justice Act Task Force, (March 29, 2006).

Illinois Senate Bill 2561 (Please note that SB 2561 does not necessarily represent the most up-to-date rendition of the Healthy Illinois proposal.)

Proposal: Submitted By:	Expanding Coverage for the Illinois Uninsured Illinois Hospital Association (IHA)	**Proposal Summary**

Overview: This proposal increases access to health care coverage by making coverage more affordable. The proposal builds on current private market coverage and expands Medicaid and SCHIP. Strategies include the creation of a small employer purchasing pool, Medicaid and SCHIP expansion for low-income parents and individuals 18-22 enrolled full time in college, vouchers for employer-based coverage for low-income individuals, insurance market reforms and pre-existing condition changes to Illinois' high-risk pool (CHIP). Self-employed individuals and small businesses would be able to purchase a limited benefit plan from the State.

1. Access	• *New populations covered* – Working uninsured, college students and unemployed individuals. • *Number of uninsured covered* – 861,900 working uninsured, 72,000 college students and 73,600 unemployed. • *Increasing enrollment in current public programs* – Intensify current enrollment efforts to reach unenrolled eligibles.
2. Methods of Coverage	• *Medicaid and SCHIP expansion* – Expand Medicaid for parents from 185 to 200 percent of the federal poverty level (FPL). • *State-sponsored health care program* ➢ Establish an Employer Sponsored Insurance Initiative (ESI) that would allow self-employed individuals and small businesses (i.e. those with fewer than 25 employees) to purchase a limited benefit plan ("Safety Net Benefit Package") from the State. This plan would cover spouses, assuming they are not eligible for other coverage. Medicaid would fund the premiums for those Medicaid-eligible individuals, with the State share of that payment funded through an employer tax on participating employers. The employer would pay the same amount of tax per employee, regardless of the employee's income level. ➢ Provide premium subsidies in the form of health insurance vouchers to assist employees with incomes at or below 200 percent of the FPL to obtain health insurance through their employers (this option is not available to ESI recipients). If this initiative proves too expensive, limit vouchers to those employees who are currently uninsured. ➢ Expand Illinois' high-risk pool (CHIP) by lowering or subsidizing the premiums for people with pre-existing conditions that are below certain income levels and do not quality for public programs. ➢ Expand KidCare to 18–22 year olds enrolled full time in college with incomes up to 200 percent of the FPL. • *Purchasing pool* – Establish a statewide Small Employer Purchasing Cooperative (SEPC) to assist self-employed individuals and small businesses (i.e. those with fewer than 25 employees) to come together to purchase health coverage. • *Employer "pay or play"* – Not included in proposal • *Individual mandate* – Illinois full- and part-time college students must either purchase the minimum benefit package that Illinois colleges will be required to offer or provide proof that they are covered elsewhere.

	• *Reinsurance* – Implement a reinsurance program to either assist in subsidizing health insurance for small groups and low-income workers based on need or to operate as a risk transfer plan for all carriers providing health insurance in the State or just those participating in the small employer initiatives. • *Modifications to the Illinois insurance market* ➢ Consider modifying the Small Employer Health Insurance Rating Act by further restrictions on underwriting or rates. ➢ Consider reforms to the Health Care Purchasing Group Act to encourage employers to aggregate purchasing power to lower the cost of health care insurance benefits. • *Other* – Require colleges and university to include a minimum health benefit package as part of tuition and fees. Provide bridge loans, which would be used to continue the individual's health coverage under COBRA or the State's Continuation Law, to help workers maintain their coverage when they become unemployed. Expand the Illinois Continuation Law to provide coverage for 18 months after employment ends (instead of current nine month period).
3. Means Testing	Used for Medicaid and SCHIP expansions, vouchers for the and for those in the CHIP high-risk pool.
4. Crowd-out policies	Limit participation in the SEPC or ESI to those self-employed individuals or small businesses that have not offered health insurance for the previous 12 months.
5. Financing	• Federal Medicaid and SCHIP funding. • State share of Medicaid and SCHIP expansion not specified, with the exception of the State share of the ESI program which would be paid, in part, by a tax per employee on participating employers, described in the following bullet. • Employer tax per employee for ESI (participating employers only) – Calculated based on the size of the business and paid prospectively. Use funds to draw down federal matching funds for those ESI participants who are eligible for Medicaid and to pay the full share of costs incurred by those who are not. • Scholarships and college loans will help pay for health care once it becomes part of college tuition and fees. • Employer payment of 60 percent of SEPC monthly premiums. • Individual contributions to pay for additional continuation coverage; individuals would be responsible for paying the entire premium for the coverage, including the portion which was formerly paid by the employer. • General state tax revenue should be used to finance coverage for uninsured persons not connected to the workplace.
6. Cost Containment Incentives	• Employers must commit to 12 months continuous participation, with similar and binding periods of renewal to avoid adverse risk selection. • Include cost-sharing provisions in the safety net benefit package provided to the working uninsured including deductible(s), coinsurance and annual cap on benefits.

7. Estimated Cost	Not described by proposer at this time.
8. Benefits	• *Medicaid and SCHIP-based coverage* – Medicaid/SCHIP benefits for parents from 185 to 200 percent of the FPL. • *SEPC and ESI* – Safety net benefit with preventative care coverage and core components of major medical protection. • *University-based coverage* – Illinois' mandated minimum health benefit.
9. Preventive Medicine Component	The safety net benefit package requires preventative care coverage; additional preventive medicine component not specifically addressed.
10. Program Administration	• *SEPC* – Administered and operated in a manner similar to Illinois' high risk pool (ICHIP). • *ESI* – Administered by the Department of Healthcare and Family Services. • *Premium subsidies (vouchers)* – Administered by the Department of Revenue, which would build on the Department's experience in administering employment taxes and the senior citizen prescription drug program.
11. Quality Improvement	Not described by proposer at this time.
12. Capital and Technology	Not described by proposer at this time.
13. Provider Reimbursement	• *SEPC* – Providers negotiate payment rates with the SEPC and be comparable to existing private market rates. • *Medicaid ESI* – Use the State's Medicaid rates. • Maximize federal funding to increase provider Medicaid rates to cover rising costs and support infrastructure.
14. Implementation	• *Federal Medicaid or SCHIP Waiver* – Yes (Health Insurance Flexibility and Accountability waiver) for ESI. • *Other federal waiver or federal legislatio*n – Not required. • Additional implementation issues not formally described by proposer at this time.

Source:

Illinois Hospital Association Presentation to the Illinois Adequate Health Care Task Force, (April 26, 2006).

Proposal: Submitted By:	Single-Payer Health Insurance Program for Illinois Physicians for a National Health Program and Health and Medicine Policy Research Group	*Proposal Summary*

Overview: This proposal uses the savings from simplified administration of the health financing system to cover all the uninsured in Illinois. Since a single-payer, Medicare, is already the payer for people 65 and over and the disabled, and public funds already pay for a majority of health spending, single payer is also known as "Improved and Expanded Medicare for All" (e.g. HR 676, with 69 co-sponsors). Single-payer would replace the 40 percent of health spending currently raised through "premiums" and "out-of-pocket payments" with income-defined contributions. Existing public and private health care providers would continue to deliver care. Private health insurers would be allowed to sell supplemental or "gap" coverage.

1. Access	• *New populations covered* – All Illinois residents (national implementation would provide coverage to all U.S. residents). • *Number of uninsured covered* –1.8 million in Illinois (46 million if implemented nationwide). • *Number of underinsured with additional benefit coverage* – All.
2. Methods of Coverage	Establish state health insurance plan to cover all residents, folding in Medicare, Medicaid, and other publicly-funded programs (if implemented nationally, expand Medicare to cover all residents). All licensed providers may participate in the program.
3. Means Testing	None.
4. Crowd-out policies	Not applicable – proposal limits sale of private health insurance to supplemental benefits ("gap" coverage).
5. Financing	• Set Illinois budget at level of spending in the year preceding the establishment of the program, adjusted for inflation (if implemented nationally, set budget for total expenditures at the same proportion of the gross national product as health costs represented in the year preceding the establishment of the national health program). • Replace current sources of financing (private insurance premiums and out-of-pocket payments, considered "regressive" tax sources by the proposer) with alternative sources including income-defined contributions by employers and employees (e.g. seven percent employer and two percent employee) – considered "progressive" tax sources by the proposer.
6. Cost Containment Incentives	• Obtain savings through bulk purchasing, negotiated fees, global budgets, streamlined administration, health planning, uniform and inter-operable medical records, and emphasis on prevention and timely primary care. • Implement policies on "supply" and physician side – e.g. increasing the number of primary care providers and limiting the number of new specialists in fields with over-supply; monitoring for extreme practice patterns; setting limits on regional spending for physicians' services; using financial incentives to attract primary care providers to underserved areas.

7. Estimated Cost	• Total Illinois health spending remains the same in first year, with an estimated savings of 8 to 10 percent annually in future years through a decreased rate of growth in health care costs.
8. Benefits	• Covers all medically necessary services including acute, rehabilitative, long-term and home care, mental health services, dental services, occupational health care, prescription drugs and medical supplies, and preventive and public health measures. Unnecessary or ineffective treatments would be excluded from coverage (e.g. cosmetic surgery). If implemented nationwide, expand Medicare benefit package as necessary. • *Long term care* – Expand social and community-based services to use with and as an alternative to nursing homes. • *Preventive care* – Coverage for full schedule of preventive services. • *Acute care* – Comprehensive coverage to free choice of doctor/hospital; need referral by a primary care provider for first visit to free choice of specialist (no referral needed for subsequent visits).
9. Preventive Medicine Component	• Global budgets allow institutional providers to work with public health entities to deliver population-based prevention. • Universal access to prevention and primary care with no cost-sharing.
10. Program Administration	• Establish a state office to administer the plan, which may use Medicare's subcontractor to process claims, Blue Cross Blue Shield of Illinois, if desired. If implemented nationwide, use Medicare's existing system of national and regional offices. • Establish a local public agency in each community to determine eligibility and coordinate home and nursing home long-term care. This agency would contract with long-term care providers for the full range of needed long-term care services.
11. Quality Improvement	The single payer would adhere to the following quality principles: • Creation of a unified, universal system that does not treat patients differently based on employment, financial status, or source of payment (i.e. a "single standard of care") is a prerequisite to (and the best guarantor of) high-quality care. • Continuity of primary care is needed to overcome provider fragmentation and over-specialization. • A uniform, confidential electronic medical record and resulting database are critical to supporting clinical practice and creating the information infrastructure needed to improve care. Use the Veteran's Administration's IT system as a model. • Financial neutrality of medical decision making is essential to reconcile distorting influences of physician payment mechanisms with ubiquitous uncertainties in clinical medicine. • Quality requires both research and prevention. Funding for medical research is maintained. Prevention means looking beyond medical treatment of sick individuals to community-based public health efforts to prevent disease, improve functioning and well-being, and reduce health disparities.

	• Emphasis should shift from micro-management of providers' practices to macro-allocation decisions. • Effective cost control is needed to ensure availability of quality health care both to individuals and the nation.
12. Capital and Technology	• Appropriate funds for the construction or renovation of health facilities and for purchases of major equipment from the national health program budget. Distribute appropriated funds through state and regional health-planning boards. • Pay owners of investor-owned, for-profit hospitals and nursing homes a reasonable fixed rate of return on existing equity until these providers have been converted to not-for-profit status. Finance conversion with bonds over 15-year term.
13. Provider Reimbursement	• Pay physicians a negotiated fee schedule (negotiated through physician representatives, possibly state medical societies); physicians could also work on salary for hospitals or clinics, or for a staff-model health maintenance organization (HMO). • Pay hospitals, nursing homes, community heath centers, non-profit, staff model HMOs and home health care agencies a global budget to cover operating expenses, negotiated annually with the state single payer plan based on past expenditures, previous financial and clinical performance. Fund hospital expansions and other substantive capital investments separately. • Pay each community long-term care public agency a single budgetary allotment to cover the full array of long-term care services in its district. • Pay for all medically necessary prescription drugs and medical supplies using a national formulary. Negotiate drug and equipment prices with manufacturers and purchase in bulk. Where therapeutically equivalent drugs are available, the formulary would specify use of the lowest cost medication, with exceptions available in case of medical necessity.
14. Implementation	• Obtain Medicare and Medicaid waivers for implementation in Illinois. • Enroll all Illinois residents with proof of residence for January 1, 2007 start-date and collect income-defined contributions through (already existing) IRS or, at the state level, the Illinois Dept of Revenue. • Retrain displaced insurance industry and other clerical workers (e.g. as home health and nursing home aides, radiology technicians and in other workforce shortage areas).

Sources:

May 9, 2006 Presentation to the Adequate Health Care Task Force by Steffie Woolhandler, MD

“A Better-Quality Alternative: Single-Payer National Health System Reform.” Division of General Medicine/Primary Care, Cook County Hospital, Chicago, Ill (Dr Schiff); the Division of General Internal Medicine and the Institute for Health Policy Studies, San Francisco General Hospital, University of California-San Francisco (Dr Bindman); and the Department of Health Policy and Management, Harvard School of Public Health, Boston, Mass (Dr Brennan) *JAMA*. September 14, 1994; 272.

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