OPTIONS FOR A CONSUMER HEALTH CARE ACCESS STRATEGY IN ILLINOIS

A Proposal to the Adequate Health Care Task Force
by
Campaign for Better Health Care and Health & Disability Advocates

With Technical Assistance from
Families USA and the National Academy for State Health Policy

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The following options are proposed to meet the requirements of the Health Care Justice Act (HCJA) to provide affordable, accessible and quality health insurance for all Illinoisans. Our ideas are geared toward building upon the current private and public health care systems and developing new private and public sector partnerships to reach additional segments of the uninsured population. We realize that all of these strategies may not be able to be achieved by July 1, 2007 – the deadline recommended by the HCJA. Some components may have to be phased in during the first and second years after the health care access plan is chosen with ongoing recommendations by newly established technical and regional advisory committees.

ILLINOIS' UNINSURED POPULATIONS

The Consumer Health Care Access Strategy is designed primarily to identify uninsured populations and provide them with public and private health insurance. We have identified targeted populations that are disproportionately uninsured and proposed solutions that maximize federal funding as well as coordinate state and private options.

There are approximately 1.7 million uninsured residents in Illinois. Illinois has taken a large first step by providing access to state-funded health insurance coverage for all uninsured children: by July 2006, all of Illinois uninsured children, ages 0-18 (approximately 300,000), will have access to affordable, comprehensive health care through the state's *All Kids* program. The same is already true for almost all of Illinois seniors, aged 65 and older, who are covered by Medicare and/or Medicaid.

As a result, the main focus for the Adequate Health Care Task Force ("Task Force") will be to present a health care access strategy for the remaining uninsured population – the approximately 1.4 million uninsured adults, aged 18-64, in Illinois.[1]

Most uninsured adults in Illinois earn 300% FPL or less.
Of those non-elderly adults without health coverage, over 700,000 (about 50%) have incomes under 200% FPL (i.e., household income of $19,600 for a family of

1 2001-05 Annual Social and Economic Supplements to the Current Population Survey (ASEC-CPS).

1/ $40,000 for a family of 4) and two-thirds have incomes under 300% FPL (i.e., household income of $29,400 for a family of 1/ $60,000 for a family of 4)[2].

Most uninsured adults in Illinois are employed.
Close to half of the uninsured individuals, aged 16-64, in IL (679,347) are employed full-time and another 268,805 are employed part-time.[3] Most uninsured, employed Illinoisans are either self-employed or work for small businesses, for which the cost of providing health insurance (by the employer) or purchasing a policy (by the employee) may be prohibitive. According to a report by several Illinois state agencies funded by the U.S. Department of Health and Human Service Health Resource and Services Administration, cost/affordability was cited as the "single most important reason given for failing to acquire employer-sponsored or private health insurance" in Illinois[4].

A significant number of uninsured adults have high medical needs.
Between 90,000 - 200,000[5] uninsured residents have a health problem or disability, which significantly diminishes their ability to work and, thus, their access to affordable, comprehensive private coverage. While the disabled represent a fraction of the uninsured population, they often have high medical needs. Without insurance coverage, such individuals may delay care resulting in high personal and system-wide costs.

Due to the demographics of the uninsured population in Illinois and the rising costs of coverage, any health care access strategy proposed by the Task Force must prioritize provisions for including both low-income and disabled individuals in the health insurance market. In addition, we believe that any new strategy should build on the strengths of the existing public and employer-based, private systems.

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2 2001-05 ASEC-CPS and Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849. http://aspe.hhs.gov/poverty/06poverty.shtml

3 "Real People Real Stories: A Summary of Illinois' Uninsured Population," Gilead Outreach & Referral Center. Table 1.3 & 1.4. March 2006. http://www.gileadcenter.org

4 "HRSA Illinois State Planning Grant: Final Report to the Secretary," March 29, 2002. http://www.idfpr.com/DOI/spg/

5 The number of disabled individuals in Illinois depends on how the question is asked in the data source used. For example, CPS data reports a lower number of disabled individuals because the survey question asked is whether the respondent has a disability that limits their ability to work. Another data source, the IL BRFSS, reports a much higher number of disabled individuals because it includes a broader definition of disability, i.e., whether someone is limited in any way by physical, mental or emotional problems or whether they have any health problem that requires them to use special equipment, such as a cane, a wheelchair, a special bed or a special telephone.

TARGETED DEMOGRAPHIC DATA PRIORITIES FOR TASK FORCE CONSULTANT:

►We recommend that the Task Force consultant include the following characteristics in their initial demographic profile of the uninsured in Illinois: age, disability status, health status, household income and size, availability and affordability of employer-sponsored health insurance (by employer size), and availability and affordability of high risk pool insurance.

POTENTIAL SOLUTIONS FOR TASK FORCE CONSULTANT TO STUDY:

We propose that the Task Force consultant study the following health care access strategies in order to provide accessible, affordable, quality health care for all Illinois residents:

1. Expansions of public programs (primarily Illinois' Medicaid program) to uninsured populations at marginally higher income levels with individual cost-sharing responsibility.

Medicaid currently provides healthcare coverage for over 650,000 Illinois residents, aged 18-64. Medicaid also provides secondary coverage to over 180,000 dual eligibles (persons who receive both Medicaid and Medicare) who are over age 65 and receive primary coverage through Medicare.

Medicaid offers a significant revenue stream for healthcare financing through federal matching funds, as well as comprehensive benefits for low income people and people with disabilities and other high cost cases. It also offers state discretion to set provider payment rates, establish disease management and other incentives to encourage efficient and effective care. Unlike most private health insurance programs, it does not have pre-existing condition exclusions or a waiting period for coverage. Any new health care access strategies should use the Illinois Medicaid program as its foundation to cover more low income and disabled individuals.

The expansions we propose under this strategy focus on the near low-income population, those between 100% - 300% FPL, because public coverage in Illinois is already largely available to those under 100% FPL (with the significant exception of many non-citizens and those who are not categorically eligible for Medicaid – primarily childless non-disabled adults.) The Task Force should consider imposing limited cost-sharing responsibilities on individuals between 200-300% FPL to contribute to the financing of the provision of health care under these options. This cost-sharing approach follows *All Kids* and the trend in federal programs to extend Medicaid to those working adults with disabilities and children with disabilities with slightly higher income levels in recognition of the difficulty of accessing public coverage and the futility of purchasing comprehensive, private insurance at that income level. Preventive, primary care

health services should be excluded from cost-sharing, so that cost is *not* a barrier for obtaining this type of care.

► Under these public expansion options, we recommend that the contractor study the effect of a cost-sharing sliding scale, capped at 2% of family income for families between 200 - 300% FPL (considering that cost-sharing should be weighted towards non-preventative care services.)

► We recommend that the coverage package under these public program options should mirror current Illinois Medicaid services with the addition of expanded dental and vision benefits for adults. Medicaid, in general, provides reimbursement for preventative, acute, pharmaceutical and long-term care services.

Under any of these public expansion options, the Task Force should also consider strategies to discourage loss of employer coverage and migration to state coverage (i.e., "crowd out") such as instituting waiting periods for coverage, limiting eligibility to uninsured or underinsured populations, subsidizing employer-based coverage through premium assistance, providing third party liability or imposing sliding scale premium contributions.

Specific public expansions for the Task Force consultant to study:

- Expand income eligibility for Aid to the Aged, Blind or Disabled (AABD) program from 100% to 300% FPL. Since this Medicaid program is already geared toward providing comprehensive acute and long-term care benefits to meet the needs of people with disabilities, an expansion of this program to higher income individuals with a cost-sharing responsibility would be an efficient way to cover more low income, high-cost individuals. Options are available to expand income and asset eligibility levels to disabled children and adults under 1902(r)(2) of Social Security Administration; 42 CFR 435.601; CMS SMDL #01-007 in particular in 209(b) states such as Illinois.

- Expand *All Kids* Coverage to Transition Youth (Between 19-23 years of age). Children who become age 19 but who remain in an educational setting, either special education, secondary or post-secondary, often lose coverage under traditional public programs. Illinois insurance mandates provide that some private and group insurance coverage remain available to this population and this provision would extend public coverage to this population.

- Expand FamilyCare eligibility from 185% to 300% FPL and consider a Medicaid buy-in option for parents at higher income levels. FamilyCare offers healthcare coverage to the parents of children under age 18, or to other relatives caring for these children in place of their parents. Similar to

All Kids, an expansion of this program would be an efficient way to cover more low-income families at higher income levels with a cost-sharing responsibility while also receiving additional federal matching funds.

- Increase income eligibility for Health Benefits to Workers with Disabilities (HBWD) from 200% FPL to 350% FPL and remove asset and spousal deeming barriers. This Medicaid buy-in program (individuals pay a premium to receive Medicaid) enables individuals with disabilities to return to work and continue working without losing their full Medicaid health care benefits. Removing income, asset and deeming barriers would allow more people to buy in to Medicaid. Medicaid Buy-in programs also have additional value because 80% of current Illinois HBWD enrollees are also Medicare recipients. Allowing them to access HBWD entitles them automatically to full cost sharing assistance under Medicare Part D – the Medicare Prescription Drug benefit – even though they would be ineligible under regular income guidelines.

- Expand Medicaid Coverage to Former Enrollees of Health Benefits for Workers with Disabilities (HBWD) Program. Options are available to expand income and asset eligibility levels to working adults who are former enrollees of the HBWD program but become income ineligible due to earnings or age under 1902(r)(2) of Social Security Administration; 42 CFR 435.601; and CMS SMDL #01-007. This population can receive Medicaid at higher income levels while they continue to work, particularly in 209(b) states such as Illinois.

- Implement a Medicaid Buy-in for Children with Disabilities. Under the recently passed Family Opportunity Act, states may allow children at higher income levels (up to 300% FPL) to purchase Medicaid if they are disabled and do not have access to affordable private coverage. 42 U.S.C. 1396a (XIX) (cc) (1). Even though Illinois has guaranteed coverage to this population under the *All Kids* program, exercising this Medicaid option would allow Illinois to receive federal financial participation for children with disabilities (generally a high utilization and costly population) who otherwise would be paid for with solely state funds.

- Reinstate Interim Assistance Program. Illinois could cover persons who have applied for Supplemental Security Income (SSI) and have been determined to be "probably eligible for SSI" under the state Medicaid program. This would allow interim recipients to receive necessary medical coverage and help them provide evidence to prove eligibility for SSI thus entitling them to Medicaid. The State could also maximize eligibility for Medicaid by implementing reforms in the state assessment process for disability determinations such as using mental health agency determinations as prima facie evidence of disability. The state can exercise options to receive retroactive federal financial participation for

this population.

- Reinstate the state's Aid to Medically Indigent for individuals up to 300% FPL. This program was repealed in 1991 causing a strain on local governments and public and private health care systems to care for low income, medically indigent individuals. The program could be reinstated to cover low income childless adults and non-citizens who are not eligible to receive coverage under any Medicaid program. This option would be funded solely with state funds.

Premium Assistance: Very few options exist for individuals who do not qualify for public programs but who cannot afford to purchase a policy that is available to them.

► We recommend that the Task Force consultant study two options that would make current insurance options more affordable, including:

- **Sliding scale subsidies for individuals with high expected medical costs that would help make ICHIP (Illinois' high risk pool) premiums more affordable.[6] The cost of ICHIP premiums has been shown to be the primary major barrier to enrollment. Currently, ICHIP premiums are between 135-143% of the current market rate.[7]**

- **Sliding scale subsidies for low-income income individuals that would help make COBRA premiums more affordable for individuals and their families during employment transitions. For example, some states provide health insurance assistance for residents who are receiving unemployment insurance benefits and who make less than 400% FPL ($77K for a family of four).**[8]

Health Care Access Barriers Other than Eligibility:

- Insufficient enrollment into Medicaid for those who are eligible. The consultant should consider how to continue to address barriers to enrollment in Medicaid for individuals who are already eligible but not enrolled, including lack of awareness and stigma, through innovative strategies involving marketing, branding, outreach, and out stationing (e.g., strategies used in the SCHIP – KidCare Program to increase

6 This is supported at the federal level by the Deficit Reduction Act of 2005 and the State High Risk Pool Funding Extension Act of 2006, which establishes the availability of grants for states, such as IL, that have a qualified high risk pool which has incurred losses. These "Bonus Grants for Supplemental Consumer Benefits" can be used for low income premium subsidies, reduction in cost-sharing requirements, and expansion of the pool, among other consumer benefits.
7 Illinois Comprehensive Health Insurance Plan 2004 Annual Report, http://www.chip.state.il.us/downloads/04anrept.pdf
8 http://www.detma.org/wsmsp.htm#Premium

enrollment such as payments to application agents and enrollment in schools and hospitals.)

Strategies should be studied for enrolling both children and adults into Medicaid; persons with disabilities into the Health Benefits for Workers with Disabilities; and older adults and persons with disabilities into the Medicare Cost-Sharing Programs such as Qualified Medicare Beneficiary (QMB); Special Low Income Medicare Beneficiary (SLMB); Hospital Insurance Benefits (HIB); and Supplementary Medical Insurance Benefits (SMIB Buy-in) which pay for Medicare premiums and cost-sharing.

- Provider Access Barriers. We also acknowledge the barriers to access that are created due to the Medicaid reimbursement rates and payment structure in Illinois. The contractor should study the potential barriers to access in the public program options if eligibility is expanded but provider capacity is limited due to reimbursement and payment factors. The contractor should also study measures to increase access to providers such as targeted provider reimbursement rate increases; medical school repayment options; and increased funding for public health districts, community health centers (FQHCs), free clinics and other safety net providers.

2. Private & Public Partnership Pool: Purchasing Pool for Individuals, Sole Proprietors or Small Groups

The HCJA specifically recommends that any health care access plan "promotes affordable coverage options for the small business market." Currently in Illinois, only 40% of private establishments with fewer than 50 employees offer coverage.[9] Individuals who are self-employed or not attached to employment also experience difficulty accessing insurance in the individual health insurance market due to lack of affordability, limited choice, and pre-existing conditions.

► We recommend that the Task Force consultant consider a health care access strategy that would establish a purchasing pool for individuals, sole proprietors and for small groups (2-50 employees), who cannot afford insurance in the private market.

Purchasing pools are strategies that many states and municipalities have considered for obtaining affordable health insurance. Successful ones include public pools, such as the Federal Employees Health Benefit Plan and CalPERS, the plan for public employees in California. These groups are successful because of their large size, which allows them to diminish adverse selection, recruit many health plans, and use market share to influence the levels of

[9] "Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size, 2003" Kaiser Family Foundation, http://www.statehealthfacts.org

service they provide.[10] A purchasing pool that combines the individual and small group market in Illinois could reduce the administrative cost of coverage in the individual market, could offer additional health plan options to individuals and families and offer portability of coverage regardless of employment status.[11]

Within this option, the consultant should study strategies to make the purchasing pool attractive to a broad range of insurers and enrollees.

►We recommend the consultant team consider incentives (e.g., premium assistance, subsidies) for individuals, sole proprietors and small businesses/groups that join the pool. This will help make the pool more affordable (particularly for low-income and high cost individuals) and reduce the chance that the pool will only attract unhealthy individuals and unfavorable risks.

►We recommend that the consultant consider a state-subsidized reinsurance program for all carriers in the pool, which would protect health plans who participate in this pool from unforeseen high medical costs, thereby reducing premium levels among enrollees. New York is one state model to consider since it has established a program ("Healthy New York") with subsidized reinsurance to encourage coverage among small groups, sole proprietors and low wage workers.[12]

We recommend that the consultant also consider the implications of establishing reinsurance for all carriers in the market (even those outside of the pool) to level the playing field among carriers**.**

Currently, in the small group market in Illinois, private health insurance is guaranteed issue, but carriers can medically underwrite rates, and rates may vary by plus or minus 25 percent of the indexed rate based on the health status of the group.[13] In the private individual health insurance market in Illinois, there are no restrictions on medical underwriting, no rate caps and coverage is not required to be guaranteed issue.[14]

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10 "Implementing a Health Plan Purchasing Pool," Massachusetts' Roadmap to Coverage. October 7, 2005. http://www.roadmaptocoverage.org/pdfs/RoadMap_PurchasingPool.pdf
11 Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications," June 2005. http://www.roadmaptocoverage.org/pdfs/BCBSF_Roadmap2005.pdf
12 "Report on the Healthy New York Program 2005," http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf
13 "Illinois Insurance Facts: The Small Employer Health Insurance Rating Act," http://www.idfpr.com/DOI/HealthInsurance/small_employer_rating_act.asp and "Small Employer Groups in IL," Health Care Options Database, National Association of Health Underwriters, http://www.nahu.org/
14 "Traditional Private Health Insurance in Illinois," Health Care Options Database, National Association of Health Underwriters, http://www.nahu.org/

►We recommend that the consultant study the affordability of insurance in the pool, the risk of adverse selection in the pool, and the availability of coverage in the pool under two different scenarios: (1) if the pool were to have the same rating rules as Illinois' current small group and individual markets; and (2) if the pool were to employ community rating and guaranteed issue for both the individual and small group markets.

Other design issues to be considered should include:

- Ensuring that all health plans in the pool offer standard benefit packages so that they have strong incentives to compete on price, service levels and quality. This will also make it easier for consumers to compare plans.

  ► We recommend that the consultant use the IL State Employee Health Benefit Options (including all of the state insurance coverage mandates) as the range of packages to study for this pool. The State offers three types of health plans to its employees: Health Maintenance Organization, Open Access Plan and the Indemnity Plan—Quality Care Health Plan (QCHP).[15]

- Establishing consumer protections and rules of enrollment.

  ► We recommend that the consultant examine performance standards to assure that the pool meets the needs of Illinois residents with chronic health conditions or a medical history of past conditions. Such standards should include guaranteed issue, prohibitions against pre-existing conditions exclusions, and the availability of additional subsidies not tied to income eligibility beyond set limits on premium costs (if community rating approach is not followed.)

- Deciding whether the pool would be run by a private or public entity.

- Setting administrative overhead limits.

  ► We recommend imposing an administrative overhead limit for the pool of no more than 7%, which represents an approximate average of current administrative costs for public and private health insurers.

- Establishing crowd-out provisions

- Setting a reimbursement rate schedule that ensures provider access

[15] State of Illinois Benefits Handbook, Chapter 2, Health Plan Options, July 1, 2004. http://www.state.il.us/cms/download/pdfs_benefits/handbook.pdf

3. Employer Responsibility for Health Care

Since most adults (71%), aged 19-64 in Illinois,[16] obtain health insurance coverage through their jobs, we recommend that the contractor study a health care access strategy that builds on the existing employer-based system.

An employer responsibility strategy can preserve existing employer-provided insurance coverage in the state and generate revenue for health coverage expansions. In addition, it can help Illinois ensure that lower-income workers have access to health insurance on the job instead of paying for them through state-funded programs, and "level the playing field" among employers (since the cost of providing health care is part of the cost of doing business). If designed properly, the funds raised from employers can not only be used to generate new revenue to provide coverage, but can also be used as the state share of spending for the purpose of drawing down federal Medicaid matching dollars.[17]

► We recommend that the consultant study three different options of a "pay or play" approach in Illinois. Generally, under each approach, an employer would be required to pay a "fee" to the state for employees for whom the employer does not provide health insurance. If the employer provides some health insurance, this fee would be reduced by the amount the employer spends on health insurance. If an employer spends more on health insurance than the recommended fee, the employer would not owe the state.

(1) Payroll tax approach. The first approach bases the fee on a percentage of the employer's payroll. We recommend using different payroll percentages for nonprofit employers than for for-profit employers, e.g., a 5% payroll tax for nonprofits and a 7% tax for for-profits. The consultant may also want to consider including a reasonable cap on the payroll tax. The employer fee would be reduced by the amount the employer spends on health care coverage.

(2) Cost of PPO approach. The second approach bases the employer fee on the cost of the average premium for a PPO family plan in Illinois, multiplied by the number of employees in a firm. The employer fee would then be reduced by the amount the employer spends on health care coverage.

(3) 50% of the cost of PPO approach. The third approach bases the employer fee at fifty 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 employer fee would then be reduced by the amount the employer spends on health care coverage.

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[16] The Kaiser Family Foundation, statehealthfacts.org. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

17 "Ideas that Work: Expanding Health Coverage for Workers." Families USA. October 2004. http://www.familiesusa.org/resources/tools-for-advocates/kits/ideas-that-work.html

For each of the three approaches above, we suggest that the consultant estimate: a) the number of employers that would be required to pay a fee and the average amount of the employer fee, and b) how the fee would impact the number of employers who currently provide health care coverage. We also recommend that the consultant study the impact of these approaches on employer groups of varying sizes (e.g., 10 or more employees; 50 or more employees; and 1000 or more employees.)

4. Individual Responsibility with Consumer Protections

Our proposal utilizes a diverse set of tools to ensure that all Illinoisans are provided affordable, accessible and quality health care. If a significant portion of the uninsured population does not obtain health care coverage in spite of the availability and affordability of these proposed options, it may be necessary at a future date to explore imposing a requirement that every resident obtain health insurance. However, any requirement imposed upon individuals to purchase health insurance must guarantee that affordable and comprehensive insurance options are available to low and middle income populations and must provide an exception if affordable coverage is not available for any reason. The definition of affordable must include individual and total family spending protections on all out-of-pocket costs including premium share, deductibles and co-payments. In addition, any individual requirement should incorporate a grievance procedure to allow individuals to challenge adverse action taken as a result of their inability to purchase insurance.

5. Additional Provisions

Establishment of a "Guaranteed Health Security" Task Force.

We recommend that a "Guaranteed Health Security" (GHS) Task Force be established and housed under the Illinois Department of Public Health. It should mirror the existing Adequate Health Care Task Force in terms of its membership (i.e., 29 voting members appointed by the Governor, Senate President and Minority Leader in the Senate and House) and staffing. This Task Force would oversee the implementation of the health access plan selected by the Adequate Health Care Task Force, assess changes, and develop future plans. All proposed Regional and Advisory Task Forces would fall under the auspices of the GHS Task Force.

Establishment of Regional and Advisory Task Forces

One of the main tasks of the GHS Task Force will be to establish regional and advisory task forces and instruct them on their mission. The role of the five regional task forces will be to monitor the implementation of the health access strategies in their region and work with the newly established advisory

committees (see below). The regional task forces will provide a fair and balanced representation of the needs and concerns of Illinoisans throughout the state. The Governor and the Legislative Leaders would appoint members to be on each of the five regional Task Forces. Each regional Task Force would then chose one representative from the five different appointed groups (Governor, Senate President, Speaker of the House, Minority Leader in the Senate and House) who will then compromise the statewide GHS Task Force.

The advisory task forces will consist of at least one member from each of the five appointed bodies. They will make recommendations for the GHS Task Force to consider as follows.

1. Technology Development Advisory Task Force: This task force will undertake a systematic assessment of technological weakness & inefficiencies and propose improvements for quality of care, patient safety and other medical and educational advances.

2. Capital and Network Infrastructure Advisory Task Force: Many geographical areas in Illinois lack basic services and lack the capital infrastructure to provide these services. This task force will assess current infrastructure needs and work directly with the provider and business community to develop options for improvements.

3. Health Professional Expansion Advisory Task Force: This task force will study the expansion of the State Medical Scholarship Program, along with other creative ways to expand the supply of medical personnel. This task force will seek to develop incentives to a wide range of medical personnel to fulfill their educational degrees and training in exchange for locating in medically underserved areas.

4. Prevention and Health Education Advisory Task Force: This task force will develop a multi-faceted disease prevention and health education program to be led by community health centers and public health districts. This educational program shall include, among other things, cultural competence training and strategies to overcome language barriers.

Quality Care: The Health Care Justice Act specifically recommends that the health care access plan "maintains and improves the quality of health care services offered to Illinois residents." The Illinois Department of Public Health is currently overseeing many aspects of quality control measures that the General Assembly has established. On a quarterly basis, IDPH and all other state agencies whose job is to monitor and oversee quality aspects of health care in Illinois will provide a written assessment every six months to the Guaranteed Health Security Task Force and on a yearly basis conduct a briefing before this body.

Conclusion

Thank you for the opportunity to present our recommendations for providing affordable, accessible and quality health insurance for all Illinoisans. Campaign for Better Health Care and Health & Disability Advocates ask the Adequate Health Care Task Force to strongly consider our recommendations, and we look forward to working with the Task Force and its consultants on the issues brought forth in this proposal. Do not hesitate to contact us with any questions.

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Consumer Plan Partners:

Campaign for Better Health Care
http://www.cbhconline.org/

The Illinois Campaign for Better Health Care (CBHC) s a grassroots coalition of more than 300 local and statewide organizations representing consumers, health care workers and providers, community organizations, seniors, religious, labor, disability rights organizations and other citizens concerned about health care and wellness. These groups share the mission that "Accessible, affordable, quality health care is a basic human right for ALL people." In 2002, CBHC established the Health Care Justice Campaign which led to the passage of the Health Care Justice Act in 2004.

Health & Disability Advocates
http://www.hdadvocates.org/

Health & Disability Advocates seeks to assure that low-income older adults, and children and adults with disabilities lead secure and dignified lives. HDA advocates for policies that promote economic security and provide health coverage. HDA's efforts are coordinated with and informed by individuals who rely on government programs, direct service providers, community-based organizations, the private sector and state and federal agencies. HDA advocacy efforts identify systemic barriers to self-sufficiency, employment and access to health care and promote policy solutions to eliminate those barriers.

With Technical Assistance Provided By:

Families USA
http://www.familiesusa.org/

Families USA is a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans. Working at the national, state, and community levels, we have earned a national reputation as an effective voice for health care consumers for over 20 years. We manage a grassroots advocates' network of organizations and individuals working for the consumer perspective in national and state health policy debates; produce highly respected health policy reports; act as a watchdog over government actions; conduct public information campaigns; and provide training and technical assistance to, and work collaboratively with, state and community-based organizations as they address critical health care problems in their communities and state capitals.

National Academy for State Health Policy
http://www.nashp.org/

The National Academy for State Health Policy (NASHP) is a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice. NASHP conducts policy analysis; provides training and technical assistance to states; produces informational resources; and convenes state, regional, and national forums, including our annual state health policy conference. NASHP recognizes that responsibility for health care does not reside in a single state agency or department and provides a unique forum for productive interchange across all lines of authority, including executive offices and the legislative branch.