Recommendations concerning the uninsured, health care access and affordability, and affordability of health insurance in Illinois

Presented on May 9, 2006 by members of the AHCTF who are associated with the insurance industry

This document reflects a collaboration of members of the AHCTF who are associated with the insurance industry. It does not represent the views of any particular firm or professional association.

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Preface

The increasing number of uninsured citizens in Illinois, along with access, cost, and quality concerns related to health care, are multifaceted issues which must be meaningfully addressed. Finding ways to 1) reduce the number of uninsured, 2) increase health care access and affordability, and 3) deal with the affordability of health insurance all are very pressing public policy priorities for Illinois. Clearly, the policy goals and principles spelled out in the 2004 Health Care Justice Act very much reflect these priorities.

We believe that a combination of approaches which include both market and government based solutions will serve to bring real progress toward meaningfully addressing the public policy priorities identified above. To this end we are pleased to present the following set of recommendations.

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Guiding Principles

This proposal for reducing the number of uninsured as well as dealing with health care access and affordability issues and the affordability of health insurance in our state is based on the following set of guiding principles:

- Preserve health plan and provider choice
- Build on the respective strengths of the private market and government
- Maximize the employment-based system of providing health insurance
- Engage consumers in taking a more active role in their health and utilization of health care
- Recognize the diversity of the uninsured

We also wish to make a distinction between the terms “health care” and “health insurance”. “Health care” is the actual care one receives, whereas “health insurance” is a means of financing and managing the financial risk of such care. Too often these terms are used interchangeably which we believe serves to cloud some of the issues related to health system reform.

Simply put, health insurance is expensive because health care is expensive. For every $1 of private sector health insurance expense, only $.14 is used for overhead, and $.86 represents the payment of benefits (See Appendix Exhibit 1 for further third party documentation of these facts.).

Framework for Solutions for Reducing the Number of Uninsured

Our proposal for reducing the number of uninsured is premised on the fact that the uninsured are not a homogeneous group. A variety of solutions are needed to address each of the four general groupings below (statistics are taken from recent national data):

1. ***Public Program Eligible:*** Nationally 14 million[1] are eligible for government-sponsored health coverage, but are not enrolled due to cultural and language barriers, complex enrollment processes, the stigma of a welfare program, or a lack of awareness about the availability of such coverage.

2. ***Non-afforders*:** Approximately 16.2 million[2] low-to-moderate income uninsured in the United States require some form of premium assistance to afford coverage.

3. ***Voluntarily Uninsured:*** An estimated 14.8 million[3] have sufficient resources to buy coverage but are voluntarily uninsured. Some may fail to value insurance protection for cultural, religious, or age-related reasons. Others have misperceptions about the relative availability of affordable coverage.

4. ***The Chronically Uninsurable:*** This category is comprised of individuals across the income spectrum who have been denied coverage in the private market due to a pre-existing high-risk or chronic medical condition, are ineligible for public programs, and either do not have access to coverage where they work or are unable to reasonably afford either employer sponsored coverage or individual coverage through CHIP.

While much of the data we have seen shows a fairly close correlation between our nation and state with regard to the demographics of the uninsured, we should also point out some important differences (please also refer to Appendix Exhibit 2):

- Illinois has a much higher rate of individuals with private insurance and lower uninsured rate by every income category, except those below the poverty limit. Any coverage expansion strategies should not undermine the private market or provide incentives for individuals to swap private coverage for public coverage[4].
- Illinois also has a much higher rate of individuals with private insurance and lower uninsured rate by every age category. Since the vast majority of the uninsured are under 40, any strategies need to be targeted to this traditionally young and healthy population[5].
- Illinois has a very competitive insurance market for small employers. Of the 5 largest states, only Texas (58) has more carriers competing in this market than Illinois (51). Indeed, only six states have more carriers with the average state having about half as

[1] *Previous BCBSA and NICHM Foundation estimates based on FPL analysis.*
[2] *Estimated from U.S. Census Health Insurance Coverage data released August 2004 of people with household income less than $50,000 but not eligible for public programs. Estimates of low-income Americans in this group range from 8.2 million to 20-25 million (e.g., see Gatzer, LA Times, August 2004; Antos, AEI Issue Brief, Sept/Oct 2004; Herrick, NCPA, August 2004.)*
[3] *U.S. Census Health Insurance Coverage data released August 2004.*
[4] *US Census Bureau, 2002-2004 figures*
[5] *US Census Bureau, 2002-2004 figures*

many[6]. Therefore, any coverage expansion strategies should build on Illinois' competitive insurance market.

- The percentage of businesses offering private insurance to their employees and the cost of premiums is about the national average[7].

Recommendations: A Two-Part Strategy

We believe that two challenges should be addressed in any proposal for health insurance coverage expansion:

1) Increase participation and choice in both private and public insurance; and
2) Make coverage more affordable in order to increase participation.

Also, we feel it is very important for policymakers and consumers alike to understand the current health insurance infrastructure in our state. That said, the Illinois State Association of Health Underwriters (ISAHU) has produced a document describing the major public and private programs in our state in addition to listing most of the state-run medical assistance programs that are available to our citizens. The "Illinois Health Care Options Matrix" (http://www.isahu.com/Illinois_Health_Care_Options_Matrix.pdf) has recently been updated, and is found in Appendix Exhibit 3.

Further, we would ask that the AHCTF consultants inventory all of the current public insurance and medical assistance programs that are offered by state government to determine such things as 1) enrollment, 2) costs (overhead and costs of care), and 3) overlap with other programs as part of its review of the current health coverage infrastructure in our state. Following the completion of such an inventory, the AHCTF consultants should be prepared to set forth informed recommendations concerning what current state government-sponsored programs could be modified or even eliminated as part of an overall streamlining and consolidation initiative.

Finally, it should be noted that the Division of Insurance's Omsbudsman program (http://www.idfpr.com/DOI/HealthInsurance/Uninsured_Ombudsman.asp) has a database application that phone counselors use in steering citizens to insurance, public health, and medical assistance programs that are available at state, county, and township levels in Illinois. The Division of Insurance should web-enable this application and provide what amounts to a "health insurance and medical assistance" decision tree. Citizens should be able to enter information about themselves (e.g., name, address, date of birth, marital status, information about dependent children, gross household income, etc.), and receive a "report" showing ALL the programs that the individual/family may be eligible for, along with hyperlinks to websites, addresses, and phone numbers where one may turn for further assistance and counseling.

[6] *Government Accountability Office, 2005*
[7] *Agency for Healthcare Research and Quality, 2003*

Part I: Increase Participation and Choice in both Private and Public Insurance

Our health care access model proposal focuses on increasing coverage by implementing targeted approaches for reaching different segments of the uninsured. Our recommendations to expand coverage for each segment include:

1. Public Program Eligible (but not currently enrolled)

a. Medicaid reform is a necessary component of any initiative to reduce the number of uninsured.

The current dialogue in health care across the nation is that of providing consumers greater choice among plans and programs to engage them in their health care decisions. Medicaid needs to be transformed to embrace this philosophy as well.

The Medicaid program, as it is currently implemented in Illinois, defines the benefits that someone is entitled to irrespective of the cost of the plan. This approach has led to Medicaid benefits being cut in leaner years as well as chronic underpayment of health care providers. This underpayment results in fewer providers accepting patients with Medicaid coverage.

We believe that using a different approach which focuses on consumer choice will engage consumers, encourage provider participation, increase portability of coverage, and provide a more predictable cash flow for providers. Under such an approach enrollees would be able to choose from a variety of competing private health benefit plans that fit their unique needs as well as a state-run, mandatory managed care plan.

In order for Medicaid enrollees to participate in, and benefit from, insurance that meets the market test and evolves as medical science evolves, beneficiaries need access to the same options that are routinely available to other citizens. This flexibility is available to the states through Health Insurance Flexibility and Accountability (HIFA) waivers or block grants. States may use waivers or block grants:

- To reduce some benefits for certain populations in return for increases in other benefits.
- To reduce benefits for certain populations in return for increases in the number of people eligible for those benefits.
- To reduce benefits for some people in order to create a new set of benefits for others.
- To set a goal and include a methodology for monitoring changes in the rate of uninsurance.

We propose that Illinois use this approach to expand eligibility to the population of single childless adults with incomes at 100% or below of the federal poverty level and who have been uninsured for more than one year and have no access to some form of private insurance coverage.

We also want to increase portability of coverage. One of the easiest means to accomplish this is to allow Medicaid beneficiaries to enroll in their employers' plans. We need to consider if a waiver can be used to provide a voucher from the state to fund the employee's contribution toward coverage under employers' plans.

As a part of transforming Medicaid we also propose that Personal Health Accounts (PHAs) be provided, something on the order of what South Carolina is now doing with its Medicaid system, with the use of such accounts being restricted to health care and health insurance premiums. This would allow beneficiaries to manage some of their own health care dollars and get them more engaged in making health care choices. It would also serve as a bridge for beneficiaries to transition from a publicly-financed program to the private system. Currently, these systems are not only financed differently, but the means to access care and the providers who provide care are fundamentally different.

Also, Personal Health Accounts could be designed with sufficient controls to ensure that procedures such as well child care or prenatal care are purchased.

As previously stated, Medicaid enrollees who do not choose to avail themselves of the options outlined above would be automatically enrolled in a state-run managed care Medicaid program. Implementing a true managed care Medicaid system in our state has the potential to improve health outcomes while producing a nearly $1 billion savings in the program that could be used to reimburse providers more fairly. It is for these reasons that the feasibility of these ideas must be seriously evaluated and considered.

Currently, physician providers are reimbursed at approximately 39 cents on the dollar, and hospitals 71 cents by the Illinois Medicaid program. This is clearly inequitable, and places an unsustainable burden on the state's physician and hospital providers. The practical result of this gross level of underpayment is that it creates a substantive cost shift to the rest of the state's health care recipients. The privately insured pay higher premiums because of this cross-subsidy (a hidden "tax"), whereas the uninsured, without the benefit of network discounts, are subjected to much higher costs.

Details about our Illinois Medicaid reform proposal, including items related to the implementation and use of Consumer Directed Health Care tools within the context of Medicaid, may be viewed in Appendix Exhibit 4 of this proposal's Appendix.

A second element of Illinois Medicaid reform is found in Appendix Exhibit 5, having to do with recommendations for the implementation of long term care partnerships in Illinois in view of the recently passed (February, 2006) federal budget reconciliation law.

Long term care partnerships, which heretofore have only been permitted to operate in New York, Connecticut, California, and Indiana, provide a true "win-win" opportunity for Illinois and its citizenry. It is a "win-win" proposition because it expands private long term care insurance coverage while at the same time cost-effectively manage the state Medicaid program's financial exposure with respect to such.

b. Enroll eligible low-income individuals into currently available public programs to significantly reduce uninsurance among people who are eligible for coverage, but are not currently enrolled in such.

In order to achieve such an objective, the State of Illinois should research and evaluate the feasibility of implementation of an aggressive public education/outreach program as a means of maximizing public program participation. Such an initiative may be eligible for federal matching funds. States such as California and Wisconsin have successfully implemented educational outreach efforts utilizing grant funding and federal matching funds, and as a result have substantially increased the participation rates in their existing health programs.

While engaged in its effort to ensure eligible low income individuals are properly availing themselves of the coverage offered through public programs, Illinois should also provide for state income tax subsidies for Health Savings Accounts for citizens who are attempting to transition from public programs to private health insurance coverage.

2. Non-afforders

Policies should be encouraged that allow carriers to develop coverage opportunities for small business and individuals who wish to purchase private coverage but for whom the cost, for all intents and purposes, is out of reach. Therefore, in Illinois we should…

a. Enact refundable and/or advanceable state income tax credits to help these individuals afford private coverage and entice qualifying small employers to offer coverage to their workers.
b. Through the direct advocacy of the Illinois Governor's Office in Washington D.C., encourage the provision of refundable and/or advanceable federal income tax credits to help these individuals afford private sector coverage.
c. The Illinois Governor's Office in Washington D.C. should also engage in direct advocacy efforts to encourage the provision of federal income tax credits to entice qualifying small employers to offer coverage to their workers.
d. Eliminate existing state premium taxes on high deductible health plans (HDHPs) that are offered in conjunction with Health Savings Accounts.
e. Increase competition by expanding the number of insurers offering HDHPs and other cost-effective health plans by removing financial and bureaucratic barriers to new market entrants.
f. Through the NAIC (National Association of Insurance Commissioners), Illinois' Director of Insurance should lobby his fellow commissioners to move toward a more uniform set of health insurance standards nationally that are similar to those that currently exist in Illinois. Small group community rating and individual market guarantee issue, which we do not have in our state, do not solve problems of health insurance affordability.
g. Improve speed to market and give health plans greater flexibility to test new benefit designs in the marketplace in order to identify innovations that expand coverage.

h. Fix any existing state law and regulatory conflicts to the offering of flexible and affordable Health Savings Account arrangements.
i. Create options that allow for the removal of unnecessary benefit mandates and outdated pricing restrictions, and costs that adversely impact premiums and impair product innovation and the ability of consumers to choose the type of coverage that is appropriate to their actual needs.
j. Encourage the development of innovative products to help small employers better afford health insurance.
k. Encourage the development of products designed for low income workers.
l. Encourage the development of programs to help communities, employers and employees work together to access and/or maintain health insurance for small businesses on a local and regional basis (e.g., Three Share Plans).
m. Encourage the development of a program offering state supported subsidies to individuals to help in funding the cost of their private health insurance.

With regard to the last point above ("m."), a real world (and working) example of the idea above is Oregon's **Family Health Insurance Assistance Program** (FHIAP), a state program that helps uninsured Oregonians buy private health insurance. FHIAP provides direct subsidies/grants to help citizens pay their monthly health insurance premiums, be it health insurance at work or an individual health plan when insurance is not available through an employer. To the extent that citizens choose to buy an individual health plan, there is an effective referral program in place for licensed professional insurance agents to participate in provided that they satisfactorily complete a state-run certification course.

Further details about FHIAP, including program rules and enrollment statistics, may be found at http://www.oregon.gov/OPHP/FHIAP/index.shtml. As of March 27, 2006 there were 16,502 "approved and enrolled lives", and 1,311 others who had been approved for the subsidy but were in the midst of the enrollment process.

3. Voluntarily Uninsured

a. Encourage product innovation in the private sector to expand choices of lower-cost options. Marketing efforts should focus on the young "invincibles", self employed entrepreneurs, and other demographic groups that consistently demonstrate a propensity to forego insurance.

Some of these innovative plans are aimed at the active yet perpetually uninsured 19-29 year old demographic. What's most important, though, is the relative affordability of these plans. For example, Illinois plans are priced in a range of $60-$114 per month depending on the level of coverage.

b. 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 our state on a guarantee issue basis (be it because of SEHIRA, or through CHIP and HIPAA-CHIP).

c. Evaluate the cost-effectiveness and feasibility of a voluntary, federally-subsidized individual and/or small group reinsurance pool set up strictly to handle the financial side of insuring high-risk individuals. Such reinsurance pools, if administered correctly, have the potential to become important market-stabilizers.

With regard to item 3.c., we are not talking about a purchasing pool. Coverage would be purchased as it is traditionally in the small group and/or individual market, but when a carrier initially underwrites a case, they purchase extra reinsurance coverage on the unhealthiest risks from the state pool. The pool would be subsidized by the federal government though a grant similar to the funding of the high-risk pool, reducing cost currently paid by small employers today.

Exhibit 6 of the Appendix contains an explanation of reinsurance pools, authored in the fall of 2004 by the Government Relations Department of the National Association of Health Underwriters (NAHU), headquartered in Arlington, Virginia.

4. The Chronically Uninsurable

a. Maintain appropriate funding and management of Illinois' high-risk pools (HRPs).
b. Limit coverage provided through HRPs and implement a mechanism to mainstream high-risk individuals into the commercial market.
c. Require the two principal CHIP pools (Sections 7 and 15) to offer a CDHP (consumer-drive health plan) option that incorporates an HSA-compatible high deductible health plan (HDHP).

Part II: Make Coverage More Affordable

1. Improve Quality of Care and Patient Safety - Accelerating adoption of health information technology (HIT) and establishing an HIT infrastructure are needed to improve quality, patient safety and efficiency. Ultimately, the goal should be an HIT-enabled, knowledge based health care system that ensures quality and value for our health care dollar.

Health plans are uniquely positioned to capitalize on the opportunity to capture, integrate and analyze large amounts of data that can tell what care is effective and who is providing it. Quality tracking and reporting is required to:

- **Reduce Treatment Variation:** A National Committee for Quality Assurance report emphasizes that, "The inconsistency with which physicians and other health care professionals provide appropriate, evidence-based care" is one of the key factors preventing Americans from getting the care they should[8].

  Numerous other studies document the problems with treatment variation. The New England Journal of Medicine reported in March, 2006 that a Rand Corporation study

[8] NCQA, *The State of Health Care Quality: 2003*, (September 2003).

confirmed a 2003 study indicating that patients only receive an average of 55% of recommended care[9]. Effectively addressing the quality issues will result in increased efficiency, more affordable health care and a decrease in the number of the uninsured.

- **Base More Reimbursement on Pay-For-Performance:** Quality improvement should be accelerated by tying performance to payment based on appropriate standards and measures. Rewarding providers for adopting evidence-based practice standards will help achieve the nation's quality goals by promoting competition based on quality. Illinois policy makers should encourage tax credits for providers who implement and utilize state-of-the-art health information technology.

  Further, the Centers for Medicare and Medicaid Services (CMS) has developed demonstration projects related to pay for performance that should be studied carefully for wider application. Bridges to Excellence and Leapfrog are two private entities that reward hospitals and providers based on performance. These types of programs should be fostered and emulated more broadly.

- **Improve Health Literacy Over Time**: There needs to be an ongoing, concerted education effort concerning patient safety that is targeted toward what patients and their loved ones can do from a consumer's perspective to ensure their safety when accessing the health care system. Exhibit 7 of the Appendix provides an example of a consumer-targeted patient safety education initiative.

2. Increase Consumer Involvement in Health Care Decisions – Engaging consumers in health care decision-making will stimulate provider competition at the point of service. Public reporting and consumer tools on cost and quality at the point of service will create a transparency and accountability that rewards providers with lower costs and higher quality.

Current efforts to obtain and disseminate cost and quality information understandable to consumers should be encouraged and expanded. The Department of Public Health should push for implementation of legislation creating the "Consumer Guide to Health Care" that was passed by the Illinois General Assembly more than two years ago (HB2202 –93rd General Assembly).

3. Reduce Excessive, Unnecessary Regulation and Litigation - Health care is among the most heavily regulated sectors in the United States. While some regulations provide clear tangible consumer protection benefits, others add costs but do not further protect consumers or improve quality.

The Cato Institute estimates the net burden of health services regulation at $169.1 billion a year, and further estimates this high cost is responsible for more than seven million

[9] *McGlynn, Elizabeth et al. "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine (June 26, 2003). Among 6,712 medical records analyzed to assess appropriateness of care, only 45% of heart attack patients studied received beta blockers, which can reduce the risk of death by up to 23%, and only 61% of the heart attack patients who should have received aspirin therapy received it.*

(over 15%) of the uninsured[10]. Understanding the burden of regulation and establishing a regulatory framework that reduces unproductive and costly government intervention is essential to maintaining affordable coverage.

Finally, concerning the subject of medical malpractice litigation, Illinois should closely monitor the judicial decisions that arise following the recently enacted Medical Malpractice Insurance Reform law. If necessary, the legislature should be prepared to make additional changes to the law, taking into account proven models that exist elsewhere that limit noneconomic damages and attorney compensation.

Conclusion

The Illinois Health Care Justice Act requires that the plan recommendations put forward by the Adequate Health Care Task Force meet certain criteria and contain very specific characteristics. Section 15 of PA 093-0973 states that the recommended plan must:

1. provide access to a full range of preventive, acute, and long-term health care services;
2. maintain and improve the quality of health care services offered to Illinois residents;
3. provide portability of coverage, regardless of employment status;
4. provide core benefits for all Illinois residents;
5. encourage regional and local consumer participation;
6. contain cost-containment measures;
7. provide a mechanism for reviewing and implementing multiple approaches to preventive medicine based on new technologies; and
8. promote affordable coverage options for the small business market

We believe that the set of recommendations presented above, taken together as intended, actually more than meet the criteria established above. Furthermore, all of the recommendations contained in this document aim to provide for increased access to health care and expanded insurance coverage in keeping with these parameters.

Finally, to the extent that the initiatives outlined above for increasing access to health care and expanding coverage end up requiring, following the AHCTF consultants' analysis, an infusion of new money into the system, two possible sources of revenue are suggested. The first source is the enactment of legislation in our state requiring that natural revenue growth above 3% per year be earmarked for the support of all such initiatives, and the secondary source of revenue being the savings that are realized as a result of the implementation of the Medicaid reform measures that we have set forth above.

In closing, we are pleased to have been afforded this opportunity to present the proposal above for the further consideration by the Adequate Health Care Task Force, and we are looking forward to this proposal being one of the models that is reviewed and analyzed by the AHCTF consultants.

[10] *CATO Institute, Health Care Regulation, A $169 Billion Hidden Tax, (October 4, 2004).*

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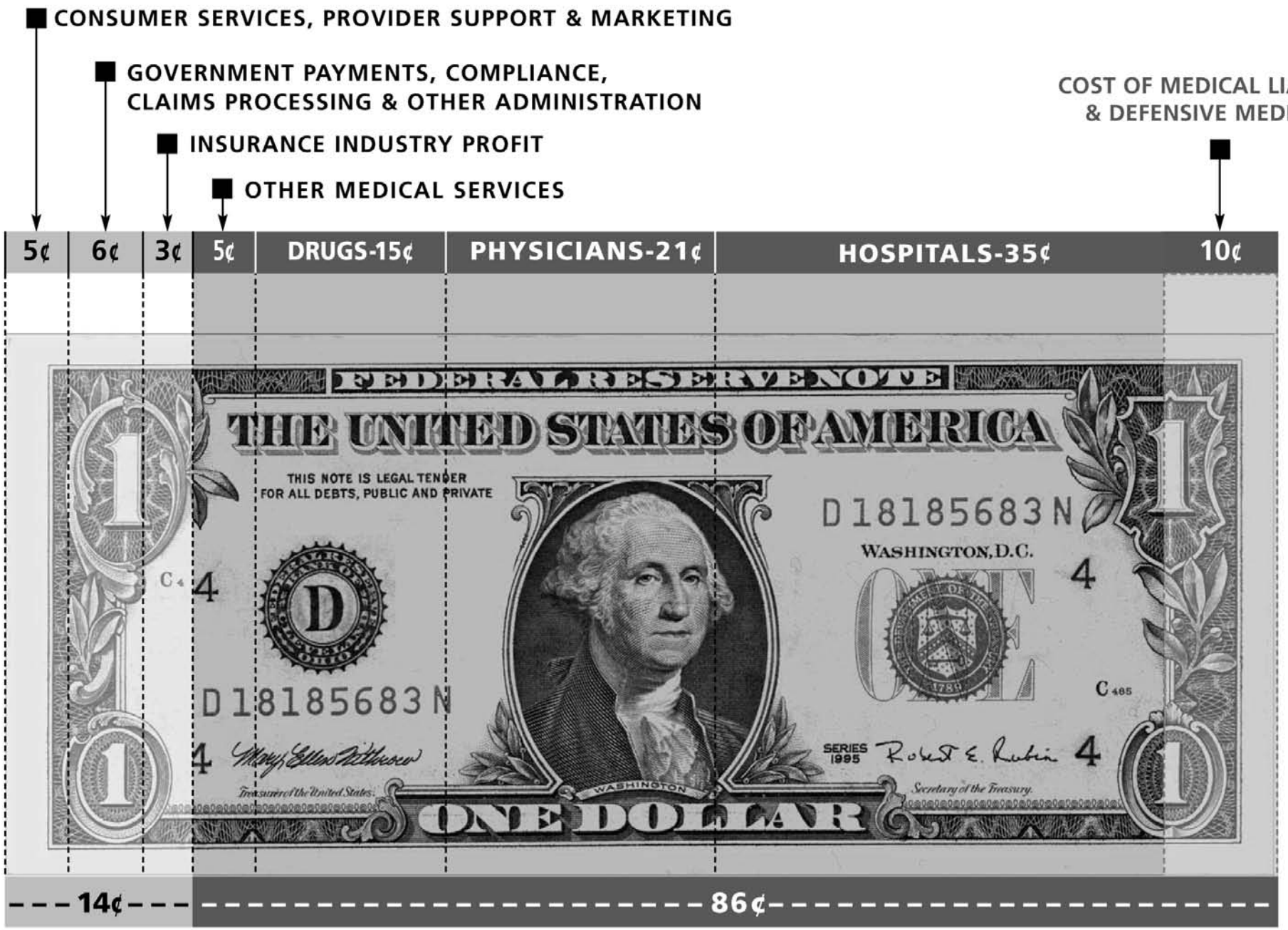
APPENDIX

EXHIBIT	DESCRIPTION
1	Where Does Your Health Insurance Dollar Go?
2	Facts about the uninsured in Illinois
3	Illinois Health Care Options Matrix
4	Illinois Medicaid reform proposal
5	Long term care partnerships
6	Information about reinsurance pools
7	Example of a consumer-targeted patient safety education initiative

Exhibit 1

Where Does Your Health Insurance Dollar Go?

Where Does Your Health Insurance Dollar Go?



Based on a PricewaterhouseCoopers' analysis, *Factors Fueling Rising Healthcare Costs 2006.*

AHIP

Exhibit 2

Facts about the uninsured in Illinois

Facts about the uninsured in Illinois

- Illinois has a much higher rate of individuals with private insurance and lower uninsured rate by every income category, except those below the poverty limit. Any coverage strategies should not undermine the private market or provide incentives for individuals to swap private coverage for public coverage. (Source: US Census Bureau, 2002-2004 figures)

	Total	Below 100% of poverty	100-200% of poverty	200-300% of poverty	300-400% of poverty	400+% of poverty
Covered by private insurance						
US average	70%	24%	47%	71%	82%	90%
Illinois	74%	24%	55%	78%	85%	92%
Uninsured						
US average	18%	34%	30%	20%	13%	8%
Illinois	16%	37%	26%	17%	11%	7%

- Illinois also has a much higher rate of individuals with private insurance and lower uninsured rate by every age category. Since the vast majority of the uninsured are under 40, any strategies need to be targeted to this traditionally young and healthy population. (Source: US Census Bureau, 2002-2004 figures)

	Total	Under 18	18-24	25-39	40-54	55-64
Covered by private insurance						
US average	70%	67%	59%	69%	77%	76%
Illinois	74%	72%	63%	74%	80%	78%
Uninsured						
US average	18%	11%	30%	23%	16%	13%
Illinois	16%	11%	29%	20%	14%	12%

- Illinois has a very competitive insurance market for small employers. Of the 5 largest states, only Texas (58) has more carriers competing in this market than Illinois (51). Indeed, only six states have more carriers with the average state having about half as many (28). (Source: Government Accountability Office, 2005)
- The percent of businesses offering private insurance to their employees and the cost of premiums is about the national average (Source: Agency for Healthcare Research and Quality, 2003)

Exhibit 3

Illinois Health Care Options Matrix

Using the Illinois Health Care Options Matrix

Illinois residents have numerous health care coverage options, both private and public. This matrix document has been designed to help citizens in our state determine which option suits them best.

Please note that the eligibility for a number of the government assistance programs referenced in this brochure is tied to percentages of the Federal Poverty Level (FPL). The following chart reflects the 2006 guidelines as published in February of 2006 by the U. S. Department of Health and Human Services.

2006 HHS Federal Poverty Level Guidelines

Size of family unit	Annual Household Income
1	$9,800
2	$13,200
3	$16,600
4	$20,000
5	$23,400
6	$26,800
7	$30,200
8	$33,600
For each additional person add	$3,400

Source: U. S. Department of Health and Human Services, 2006

Note: There is no universal administrative definition of income that is valid for all programs that use the poverty guidelines. The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program (to the extent that the definition is not already contained in legislation or regulation).

This matrix document was originally developed by the Illinois State Association of Health Underwriters. The Illinois Health Care Options Matrix is a registered trademark of the Illinois State Association of Health Underwriters.

IHCM-0406

Illinois Insurance and Health Care Resources

Laws & Regulations (insurance and employee benefits):

Illinois Department of Financial and Professional Regulation - Division of Insurance
217-782-4515, TTD 217-524-4872
http://www.idfpr.com/DOI/Default2.asp

Employee Benefits Security Administration
www.dol.gov/ebsa

Financial Aid & Free or Low Cost Benefits

Government Benefits Finder
800-FED-INFO

Catalog of Federal Domestic Assistance - www.cfda.gov

Veterans Health Administration
www.va.gov; 877-222-8387

Finding local health care options

Bureau of Primary Health Care
888-ASK-HRSA
www.ask.hrsa.gov/pc

Health Consumer Alliance
www.healthconsumer.org

Department of Health and Human Services
www.hhs.gov
www.healthfinder.gov
(Many different health care search tools)

Finding a health insurance agent

The National Association of Health Underwriters (NAHU) offers an agent search engine to assist consumers in finding a health insurance agent. Go to http://www.nahu.org/consumer/findagent.cfm

Principal state government insurance and healthcare initiatives & resources

Illinois Comprehensive
Health Insurance Plan (CHIP)
217-782-6333, TTY 217-782-6410
www.chip.state.il.us

Illinois Department of Healthcare and Family Services (formerly Department of Public Aid)
217-782-1200, TTY 800-526-5812
http://www.hfs.illinois.gov/

Illinois Department of Human Services
217-557-1601, 800-843-6154
TTD 800-447-6404
www.dhs.state.il.us

State of Illinois All Kids - 866-ALL-KIDS (866-255-5437); TTY: 877-204-1012
http://www.allkidscovered.com/

Illinois FamilyCare Program
866-468-7543
TTY 877-204-1012
www.familycareillinois.com

Senior Health Insurance Program of Illinois
800-548-9034, TTY 217-524-4872
http://www.idfpr.com/DOI/Ship/ship_help.asp

Illinois Cares Rx
(Merger of SeniorCare & Circuit Breaker programs)
http://www.illinoiscaresrx.com/

IllinoisBenefits.org – Free resource for benefits, information and enrollment assistance for people with Medicare and those that assist them (Managed by the Illinois Department of Aging)
Senior helpline 800-252-8966

Health Benefits for Workers with Disabilities
800-226-0768 (TTY 1-866-675-8440)
http://www.hbwdillinois.com/

Other Illinois Medical Assistance Programs:

Illinois Uninsured Ombudsman
Program 877-527-9431
http://www.idfpr.com/DOI/HealthInsurance/Uninsured_Ombudsman.asp

Illinois Rx Buying Club
866-215-3462
TTD 866-215-3479
www.illinoisrxbuyingclub.com

Illinois - Chicago MCH Block Grant
217-785-5900
www.dhs.state.il.us/chp/ofh/MIH/ChiMCH.asp

Illinois Doula Project
217-782-6495
www.dhs.state.il.us/chp/ofh/MIH/Doula.asp

Illinois Family Planning Program
217-782-4527
www.dhs.state.il.us/chp/ofh/MIH/FamPlan.asp

HealthWorks of Illinois
217-557-3105
www.dhs.state.il.us/chp/ofh/MIH/HealthWorks.asp

Illinois - Chicago Healthy Start Initiative
312-793-4651
www.dhs.state.il.us/chp/ofh/MIH/HealthyStart.asp

Illinois High Risk Infant Follow-up
217-785-4526
www.dhs.state.il.us/chp/ofh/MIH/Highriskinf.asp

Illinois Perinatal Care Program
217-785-5900
http://www.dhs.state.il.us/chp/ofh/mih/pcp/index.asp

Illinois All Our Kids (AOK)
Birth to Three Network
217-524-8612
http://www.dhs.state.il.us/chp/ofh/MCH-GPD/AOK.asp

Illinois Universal Newborn Hearing Screening Program
800-843-6154
http://www.dhs.state.il.us/chp/ofh/FN/Newbornhear.asp

Illinois Healthy Women
800-226-0768
www.illinoishealthywomen.com

Illinois Breast and Cervical Cancer Program
888- 522-1282
www.idph.state.il.us/about/womenshealth/owhbccp.htm

Illinois AIDS Drug Assistance Program
217-782-4977
www.idph.state.il.us/health/aids/adap.htm

Illinois Mental Health Services
800-843-6154
www.dhs.state.il.us/mhdd/mh/

Illinois Asthma Initiative Partnership
217-782-3300
www.dhs.state.il.us/chp/ofh/CHN/Asthma.asp

Illinois Health Care Options Matrix

	Individual Market		Group Coverage	
	Individual Insurance	**Serious Medical Conditions / High Risk Pool**	**Small Group (HIPAA definition – 2-50 employees)**	**Large Group (51+ employees)**
Underwriting Requirements	Medical underwriting is allowed without restriction.	Not applicable.	In the small group market rates are based on underwriting consideration of the subject group's health risk pool, which is determined through having employees complete health questionnaires with respect to themselves and their insured dependents, if any.	On the lower (smaller) end of the large group market (i.e., 51-150), risk profiles are typically determined through an employer gatekeeper questionnaire and not through the use of individual questionnaires. Groups with 150+ tend to be principally experience-rated based on the subject group's past claim experience.
Rating Requirements	There are no rate caps in the individual market in Illinois.	Rates are set by the Illinois Comprehensive Health Insurance Plan (CHIP) Board at levels that range from 125-150 percent of the average rates charged individuals for comparable major medical coverage from five or more of the largest health insurance companies in the individual market.	Rates may vary by plus or minus 25 percent of the indexed rate based on the health status of the group.	This market segment is not rate regulated. Depending on the group size, for smaller "large groups", rates are based on a blending of census factors and actual account-specific claims, whereas larger groups (250-300+) tend to be fully experience rated. Many groups above 300 members tend to be self-insured and use stop loss insurance to manage risk.
Guaranteed Issue requirements	Coverage is not required to be guaranteed issue in the individual market. Exclusion riders are also permitted in the individual market.	Coverage is guaranteed for Traditional CHIP (Section 7) applicants provided that enrollment has not been closed or limited by the CHIP Board. Coverage is truly guaranteed for federally eligible individuals covered under Section 15 who enter the pool exercising their HIPAA (Health Insurance Portability & Accountability Act of 1996) group-to-individual portability rights.	As per the federal Health Insurance Portability and Accountability Act of 1996, all group health insurance contracts in Illinois must be issued on a guarantee-issue basis. All group insurance contracts must also be guarantee-renewable, unless there is non-payment of premium.	As per the federal Health Insurance Portability and Accountability Act of 1996, all group health insurance contracts in Illinois must be issued on a guarantee-issue basis. All group insurance contracts must also be guarantee-renewable, unless there is non-payment of premium.
Preexisting Condition Limitations	For individual health insurance policies, there is a 12-month look back period during first two years of coverage. If the condition is determined to be preexisting a 24-month exclusionary period is permitted.	Section 7 coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage if medical advice, care or treatment was recommended or received during the six months immediately preceding the effective date. There are no preexisting conditions waiting period requirements for federally eligible individuals covered under Section 15.	As per the federal Health Insurance Portability and Accountability Act of 1996, all group health insurance carriers in Illinois can impose a 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage.	As per the federal Health Insurance Portability and Accountability Act of 1996, all group health insurance carriers in Illinois can impose a 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage.
Creditable Coverage	Credit for prior creditable coverage is not required for individual health insurance policies.	Credit for prior creditable coverage is required with respect to the coverage of federally eligible individuals covered under Section 15. The look back period ("break in coverage") is permitted up to 90 days.	As per the federal Health Insurance Portability and Accountability Act of 1996, credit for prior coverage required as long as there is no more than a 63-day break in coverage.	As per the federal Health Insurance Portability and Accountability Act of 1996, credit for prior coverage required as long as there is no more than a 63-day break in coverage.
Eligibility	Any citizen may apply for coverage in the individual market, including individuals who are eligible for coverage through their employers but elect to waive employer-sponsored coverage.	To be eligible for the Section 7 pool, participants must: be a US citizen or permanent resident alien; be a resident of the state for at least 180 days; and have received a rejection or refusal to issue coverage for health reasons by one insurer, or have received a refusal to issue coverage except at a rate exceeding the rate available from CHIP. The CHIP pool also serves as the state's guarantee-issue option for individuals exercising the federal HIPAA group-to-individual portability rights and serves as the state-elected purchasing option for individuals who are eligible for the federal Health Care Tax Credit as provided by the Trade Adjustment Assistance Act (TAAA) of 2002. There are separate enrollment and eligibility requirements for both of these classes of individuals. Eligibility rules for the Section 7 and Section 15 pools as well as for individuals applying for the TAAA Health Care Tax Credit are covered in significant detail at http://www.chip.state.il.us.	Employers who on a typical business day employee between 2-50 employees, including part-time employees who are not eligible for the health plan.	51 or more employees regardless of the number of employees who actually elect coverage.
Overview of Benefits	Benefits are subject to both state mandates in the individual market and state regulation.	Benefit descriptions are downloadable at http://www.chip.state.il.us.	Benefits are subject to both federal and state mandates in the small group market, and plans are subject to state regulation.	Benefits are subject to both federal and state mandates in the small group market, and plans are subject to state regulation. Self-insured plans may be exempt from state regulation but are nevertheless subject to the federal law known as ERISA.
Coverage Options	Coverage options vary by carrier, but insurance companies serving the individual market offer a wide range/choice of deductibles, coinsurance levels, and out-of-pocket limits. Most, if not all, of the companies offer plans that are HSA (health savings account) – compatible.	Coverage options are covered in detail at http://www.chip.state.il.us. As of 1Q2005 there is no HSA (health savings account) – compatible option.	Coverage options vary by carrier, but insurance companies serving the small group market offer a wide range/choice of deductibles, coinsurance levels, and out-of-pocket limits. Most, if not all, of the companies offer plans that are HSA (health savings account) – compatible, and there is a big shift toward consumer-driven health plans (CDHPs) that combine HSAs and HRAs with tools for disease management (for the chronically ill), wellness, and medical decision support.	Coverage options vary by carrier, but insurance companies and third party administrators (TPAs) serving the large group market offer a wide range/choice of deductibles, coinsurance levels, and out-of-pocket limits. The bigger the plan (in terms of enrollment), the more custom it tends to be. Also, the large group market is driving innovation (CDHPs, HSAs, HRAs, etc.) as employers look for ways to balance cost management with the benefit needs of the covered population.

Side-by-side comparison of the federal COBRA continuation law

alongside the Illinois coverage continuation laws (which apply to all health insurance contracts with an Illinois contract situs)

	Federal law known as COBRA	Illinois Continuation	Illinois Spousal Continuation	Dependent Continuation Effective July 1, 2004
Applicability	Applies to employer groups with 20 or more employees.	Applies to employer groups of any size. Applies to insurance companies and HMOs.	Applies to employer groups of any size. Applies to insurance companies. **Effective Jan 1, 2004 -- applies to HMOs.**	Applies to employer groups of any size. Applies to insurance companies and HMOs.
Who Is Eligible	Employees and/or covered dependents.	Employees and covered dependents.	Divorced or widowed spouses (any age) and covered dependent children. Spouses (age 55 or older) of retired employees, and covered dependents.	Covered dependent children of deceased employee, who are not otherwise covered under the Spousal Continuation Law. Covered dependent children who attain the limiting age under the insurance policy or HMO certificate.
Coverage Requirements	Must be covered by the group plan on the day prior to the qualifying event.	Employees must be covered for 3 continuous months before qualifying event.	Spouse and dependents must be covered on the day prior to the qualifying event.	Dependent child must be covered on the day prior to the qualifying event.
Qualifying Events	**Must be offered to employee & covered dependents upon:** 1. Termination of employment; 2. Employee's retirement; 3. Reduction in employee's hours. **Must be offered to spouse, former spouse & covered dependents upon:** 1. Employee's eligibility for Medicare; 2. Divorce or legal separation from employee; 3. Death of employee; 4. Loss of dependent child status under plan.	Must be offered upon termination of employment or membership unless termination is due to theft or commission of work-related felony. Must be offered to an employee whose insurance is terminated due to a reduction in hours worked. (Effective January 1, 2004)	Must be offered to divorced spouse or widowed spouse and dependent children upon divorce from or death of employee. Must be offered to spouse (age 55 or older) and dependent children of retiree upon employee's retirement.	Must be offered to dependent child after death of insured if coverage is not available under the Spousal Continuation Law. Must be offered to dependent child upon attainment of limiting age under the insurance policy or HMO certificate.
Benefits	Coverage must be the same as under the group plan.	Coverage must be the same as under the group plan but need not include extra benefits such as dental, vision or prescription drugs.	Coverage must be the same as under the group plan.	Coverage must be the same as under the group plan.
Length of Continuation Coverage	**Loss of employment or reduced hours** -- for employee & covered dependents, maximum of 18 months. May be extended to 29 months if disabled. **Divorce or legal separation from employee, death of employee or employee entitled to Medicare** -- maximum of 36 months for spouse, former spouse and dependent children. **Loss of dependent child status**-maximum of 36 months.	Coverage is provided for a maximum of 9 months.	**Spouse under age 55 -- Divorced or widowed spouse (not spouse of retiree) and dependent children** --Coverage is provided for maximum of 2 years. **Spouse age 55 or older -- Divorced or widowed spouse or spouse of retiree and dependent children** -- coverage is provided until spouse is eligible for Medicare.	Coverage is provided for a maximum of 2 years.
Premiums	Premium may not exceed 102% of group rate. Plan may charge 150% after 18 months if the 11-month extension for disability is granted.	Premiums may not exceed the group rate.	**Spouse under age 55** -- Divorced or widowed spouse premium may not exceed the group rate. **Spouse age 55 or older** -- Divorced or widowed spouse or spouse of retiree, administration fee may be added to group rate after first two years of coverage.	Premiums shall not exceed: the amount that would be charged to an employee if the dependent child was an employee **PLUS** the amount the employer would contribute toward the premium if the dependent child were an employee.

Government / Public Health Care Programs

	HIPAA Coverage Portability	All Kids	Federal Health Care Tax Credit	Illinois Medicaid
Explanation	Individuals who have been in enrolled in a group health plan for at least 12 months have certain rights under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). **Group-to-group portability**: If one loses group health coverage but becomes insured under another group health plan, the new plan must permit such person an opportunity to enroll without any underwriting or preexisting condition limitations provided that there is no more than a 63 day "break in coverage" between the termination date of the former plan and the effective date of the new plan. **Group-to-individual portability**: In Illinois the vehicle for such is the Illinois Comprehensive Health Insurance Plan (CHIP) through a program called HIPAA-CHIP. For more information go to http://www.chip.state.il.us/.	The federal Balanced Budget Act of 1997 created a new children's health insurance program called the State Children's Health Insurance Program (SCHIP). This program gave each state permission to offer health insurance for children, up to age 19, who are not already insured. In Illinois, the federally qualified SCHIP program is called Illinois KidCare. Illinois' SCHIP program until recently has been known as KidCare and has included the following plans: • KidCare Assist; • KidCare Moms & Babies; • KidCare Share; • KidCare Premium; and • KidCare Rebate Benefits and covered services under KidCare have included doctor and nursing care, shots and preventive care, hospital and clinic care, laboratory tests and x-rays, prescription drugs, medical equipment and supplies, medical transportation, dental care, eye care, psychiatric care, podiatry, chiropractic care, physical therapy, mental health and substance abuse services, and prenatal care and other medical services for pregnant women. **All Kids** House Bill 806 ("All Kids") was passed by the General Assembly in late October of 2005, and signed into law by Gov. Blagojevich on November 15, 2005. The All Kids program, which includes the aforementioned KidCare plans, as of July 1, 2006 extends coverage to all children regardless of medical conditions or income and provides enrolled children with access to comprehensive health care that includes doctor's visits, hospital stays, prescription drugs, vision care, dental care and medical devices like eyeglasses and asthma inhalers. Parents pay monthly premiums for the coverage, but rates for middle-income families are typically lower than they are in the private health insurance market. For example, a family of four that earns between $40,000 and $59,999 a year will initially pay a $40 monthly premium per child, and a $10 co-pay per physician visit. There is an online application linked from the front page of the website – http://www.allkidscovered.com - and assistance with completing applications may be sought from All Kids Application Agents, which include faith-based organizations, day care centers, local governments, unions, medical providers and licensed insurance agents	The federal Trade Adjustment Assistance Act of 2002 provides health insurance benefits for eligible individuals in the form of a tax credit for 65% of qualified health insurance premiums. The premium amount is not capped, and eligible individuals are responsible for payment of the remaining 35% of the premium. The tax credit is refundable which means that eligible individuals do not have to owe income taxes in order to qualify. Individuals who are eligible for the federal Health Care tax Credit may use their credit funds to purchase private individual health insurance coverage through the state's high-risk health insurance pool, the Illinois Comprehensive Health Insurance Plan (CHIP).	**Title XIX** of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. There are a wide range of benefits and covered services including but not limited to coverage for … Inpatient hospital services; Skilled nursing facility services; Intermediate care facility services; Care for individuals under 21 years of age in psychiatric hospitals; Chiropractic services; Christian Science sanatoria; Clinic Services; Dental services; Diagnostic services; Early and periodic screening, diagnosis and treatment for individuals under 21 years of age; Emergency hospital services; Extended services to pregnant women; Family planning services; Hospice care services; Inpatient hospital care; Nurse-midwife services; Occupational therapy; Optometry services & eyeglasses; Other laboratory and x-ray services; Other practitioner services; Outpatient hospital care ; Physical therapy; Physician services; Podiatry services; Prescribed drugs; Preventive services; Private duty nursing; Prosthetic devices; Rehabilitative services; Services provided by rural health clinics and federally qualified health centers; Services provided through a managed care entity; Skilled nursing and home health services for individuals 21 years of age and older; Skilled nursing facility services for individuals under 21 years of age; Speech, hearing and language therapy; and Transportation (medically necessary)
Cost of Coverage	Varies. The current cost of HIPAA-CHIP coverage may be found at http://www.chip.state.il.us/Rates.html.	Full details concerning benefits, costs, eligibility, etc. may be viewed at http://www.allkidscovered.com. The All Kids Income Standards & Cost Sharing Chart may be viewed at http://www.allkidscovered.com/income.html.	The *after* tax credit rates for TAA/PBGC-certified Individuals may be found at http://www.chip.state.il.us/Rates.html.	$0 or very minimal share of cost. For a full description of the program, go to… http://www.dpaillinois.com/agency/#medical
Eligibility Requirements	Individuals must exhaust their COBRA benefits if COBRA is available to them before exercising their HIPAA rights. Individuals must have at least 18 months of prior creditable coverage. The most recent prior coverage must have been group health insurance coverage offered by a health insurance issuer, group health plan, government plan or church plan. Individuals may not have had a prior coverage break of more than 90 days.	Children age 18 or younger who live with their families in Illinois and who need health insurance can get All Kids. If your monthly income qualifies your family for FamilyCare/All Kids Share, Premium Level 1 or Rebate, and you already have other health insurance, or you can get it, you can choose either... The FamilyCare/All Kids Rebate plan, which helps you pay the premium for your private or employer health insurance for your family. The FamilyCare/All Kids Share and Premium plan, under which one receives a card each month that can be used when your family needs medical services subject to the payment of a small co-pay for services. With Premium, you also pay a monthly fee whether or not your family uses the card. For both Share and Premium you have to go to a doctor who sees FamilyCare/All Kids participants.	Two basic categories of eligibles under TAA. 1. Those individuals and their families certified as eligible for benefits under TAA because they are impacted by US trade agreements. 2. The second category is individuals age 55-64 and their families who are receiving benefits from the Pension Benefit Guarantee Corporation (PBGC). Eligible individuals must not be covered by other specified coverage, which is coverage for which more than 50% of the premiums are paid for the eligible individual by an employer or spouse's employer. The benefit period is for two years or the remainder of the TAA certification period, if less than two years, or the period of time a person is in an eligible category for PBGC eligibles, which could be up to 10 years depending on their age. All people who meet the qualifications to receive the federal Health Care Tax Credit are eligible to receive it, even if they weren't previously insured. Such individuals are considered to have basic eligibility.	Parents and/or caretaker relative (and their spouse) of children, and the spouse of a pregnant woman may be eligible for medical assistance. • Non-working parents if family income is at or below 49% FPL. • Working parents if family income is at or below 83% FPL. • Children ages 1-19 with family incomes at or below 133% of the FPL. • Infants in families with income at or below 200% FPL who are born to mothers enrolled in Medicaid and infants not born to Medicaid enrolled mothers in families with income at or below 133% FPL. • Individuals receiving Supplemental Security Income assistance qualify if family income is at or below 41% FPL. Disabled SSI recipients are allowed to "spend down" into Medicaid eligibility by deducting incurred medical expenses from income. • Aged, blind and disabled people qualify if family income is at or below 85% FPL.

Exhibit 4

Illinois Medicaid reform proposal

EXHIBIT A: Illinois' Medicaid Reform Proposal:
Executive Summary and Recommendations

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Illinois Policy Institute, Springfield, Illinois

Medicaid was created by Congress and the Johnson Administration as part of the 1966 Social Security Act. The program was designed to cover healthcare costs for low-income individuals and families. The federal government mandates a minimum level of services that must be covered in order for states to participate. Other than those minimum levels of services states enjoy some flexibility in structuring their own programs. They can add benefits and change eligibility guidelines. Therefore, Medicaid programs across country vary from state to state.

The minimum requirements that states must provide to receive federal matching dollars include:

- Inpatient/outpatient care
- Skilled nursing facility care
- Physician services.
- Lab and X-Ray services
- Health center & rural health clinic services
- Home health services

In addition to these minimum services, Illinois offers other services through the state's Medicaid Program. These include:

- Prescription drug coverage
- Intermediate care facilities for the mentally ill
- Home and community based services
- Respiratory services for ventilator-dependent individuals in the home
- Chiropractic services
- Dental care
- Optometrist services
- Hospice service
- Podiatric services
- Speech and language therapy
- Prosthetic devices

These optional services accounted for 38% of Medicaid costs in Illinois in 2004.

Individuals and families covered by Medicaid include the elderly, blind, the disabled, pregnant women, parents and many covered children. Governor Blagojevich has stated that his intentions are to expand eligibility for the FamilyCare Program up to 200% of the Federal Poverty Line (FPL). FamilyCare eligibility can reach up to 200% of the FPL and families can receive assistance up to 200% of the FPL.[1]

Who is in Medicaid?
Parents, children and families comprise of 70% of the state's Medicaid population while about 30% is made up of the elderly, blind and disabled. While they aren't the bulk of the Medicaid population, it is the elderly, blind and disabled that take up the lion's share of the costs – about 70% in 2004. As of 2004, there were 1.8 million Illinoisans enrolled in the program. One in seven Illinoisans were covered in 2004, including two out of three nursing home residents and one of every three children in Illinois. A family of three bringing in $31,000 per year is Medicaid eligible and a family of six qualifies at $50,000 per year.

The Blagojevich Administration has embarked on an aggressive program to expand those services up to 200% of the FPL. During the 2005 year 2005, Governor Blagojevich pushed through his "All Kids" program that offers every child in the state health insurance reimbursed at Medicaid rates. **In fact, in each of the last seven years Medicaid eligibility has expanded in Illinois.**

The Structure of Medicaid is flawed
The first thing that must be understood about Medicaid is what it is and what it does. Medicaid is a welfare program. It was created out of Lyndon Johnson's "Great Society" as a way of alleviating poverty by providing services or direct aid to the poor. And just as welfare had perverse incentives, Medicaid- as currently structured- has a number of failings that make it economically and morally destructive.

Economically, Medicaid has poor incentives. It encourages politicians to spend more and duck accountability. Medicaid also creates incentives for beneficiaries to utilize care in an inefficient and wasteful manner. Given the low and chronically late reimbursement rates, doctors have a deterrent to treat beneficiaries, thus denying them access to quality care. Medicaid discourages work and savings creating a dependency mentality. Hence, the program discourages or otherwise raises the costs of private insurance for the rest of us.

Generally, Medicaid funding is split between the state and Federal government. 50 percent of the program is provided with federal dollars and the other half is picked up by the state. Programs such as FamilyCare and KidCare receive a more generous contribution from the Federal government of 65 percent.[2]

This arrangement creates an incentive to spend ever greater amounts on Medicaid. Just as it's difficult to resist a great deal at a 50 percent or 65 percent sale, it's very difficult for elected officials to leave Federal dollars "on the table"- lest they be criticized for missing an opportunity to bring federal dollars into the state.

Moreover, advocacy groups have become adept at promoting the specious idea that more federal spending in the state leads to greater economic growth. This, despite the fact that the money comes from Illinois taxpayers, is sent to Washington via federal taxes. Part of that money is then returned to Illinois state government. Had the money stayed in the more efficient private sector where jobs and economic growth occur, there would be less need for Medicaid dollars in the first place!

The federal matching of Medicaid dollars also creates a disincentive for elected officials to trim the program if required. This is because every dollar cut by state government results in a loss of matching funds. That means the Medicaid beneficiary; the state and local officials administrating the

program will see a $2 cut in services. Thus, a 5% reduction in Medicaid funding becomes a 10% cut. So, what at first glance seems reasonable becomes draconian rather quickly.

As structured, the Medicaid program also gives state officials an incentive to game the system in order to artificially raise federal matching funds. The Medicaid Bed Tax passed in 2003 is one such example. Here, the state taxed hospitals based upon the number of beds they filled, thus artificially raising the costs of Medicaid which are then passed on to the federal government for reimbursement. The Bush Administration in 2000 vowed to end these practices, but has instead allowed them to occur in exchange for cost cutting measures in other areas.

Because the program is a state-Federal partnership, accountability and responsibility is easily brushed aside. Federal legislators can easily point the finger at state legislators and vice versa for any reductions in service. It is easy for members of Congress to consider Medicaid a state program and thus place the impetus for reigning in the programs unsustainable growth (discussed below) squarely on the shoulders of state officials. State officials, in turn, can rail against even the modest $10 billion in cuts over the next 5 years currently working its way through the budget process – even though these federal Medicaid reductions do not even amount to a drop in the bucket when compared to $2 trillion the federal government is expected to pay out over that same period.[3]

Another aspect of Medicaid's flawed structure is its incentive to utilize health care in an inefficient and wasteful manner. Part of the problem is simply price illusion. Price illusion is single greatest contributor to the over utilization of health services in the US. Simply stated, when a third party – in Medicaid's instance the taxpayer – is paying for a service, it gives the beneficiary the illusion that using that service is free or costs little. Price illusion gives the consumer the incentive to use more healthcare services than they need because there is no diminishing returns for using too much of a service. Another term often heard to describe the same phenomena in health care is a third party payer system.

As a defined benefits program, a Medicaid beneficiary in entitled to all benefits in the program as long as they meet the criteria for eligibility. While provider rates and benefits are determined by the state there is no limit on how many services a beneficiary can utilize. The state government simply sets the parameters and beneficiaries are allowed to utilize as much as they want.[4]

For example, Medicaid beneficiaries can seek emergency room care for minor injuries or illnesses without regard to the higher costs associated with emergency care. Unlike a patient in a private Preferred Provider Organization, a Medicaid beneficiary can walk into an emergency room without the hassles of setting up an appointment and the taxpayers pay the bill. It's very convenient for the Medicaid beneficiary but not for the taxpayer, who in the end picks up the tab.

Another incentive for Medicaid beneficiaries to use the most expensive forms of care is the state's low reimbursement rates. Because of the budgetary pressures, Illinois has some of the lowest reimbursement rates in the country. Moreover, the state is chronically late paying its Medicaid reimbursements. The low reimbursements rates, coupled with chronic late payments, has led to doctors refusing to accept Medicaid patients. But this is not to say that Medicaid beneficiaries are manipulating the system for their convenience. In many instances, emergency care is all they can get for minor ailments and injuries.

Fewer doctors treating Medicaid patients forces Medicaid beneficiaries into over crowded clinics and emergency rooms. As a result of over crowded clinics, the nature of emergency care and access to fewer quality physicians, Medicaid beneficiaries do not receive the quality care people receive in the private insurance market, nor do they have access to quality preventive care that lowers health costs in the long run.

Policymakers, doctors, patients and tax payers are all losers under the current structure of the state's Medicaid Program. Policymakers find themselves trapped between Washington and state capitals, thus giving policymakers no real accountability for success or failure. Doctors are poorly compensated and payments are chronically delayed. Patients, because many doctors no longer will see Medicaid beneficiary, find themselves channeled into clinics and emergency rooms that neither provide the quality care nor provide care in a cost effective manner. Taxpayers are simply left holding the bill. But these are not the only negative consequences of Illinois' Medicaid Program. There are other societal costs as well.

One such cost surrounds inheritance. In many circumstances the elderly will give away assets to family members in order to become Medicaid eligible. Many times this is to preserve the family's wealth for inheritance. In some instances, the elderly will even choose not to pay for long term health insurance and instead hide assets. In this sense, Medicaid gives otherwise law abiding citizens an incentive to break the law in order to protect their children's inheritance.

Two other negative consequences stemming form the state's Medicaid Program are the program's impact on the economy and the negative normative impact of welfare dependency.

As public health insurance, the Medicaid Program doesn't exist in an economic vacuum. It has an impact on how much we pay for medical services and health insurance. Economists use terms such as *price illusion* and *crowding out* to describe the impact the Medicaid Program has on health care outside the parameters of the program itself. Dependency is the term used to describe the impact the welfare program has on the incentives to climb the economic ladder. The cumulative impact of these phenomena, then, drive up the costs of government services and private insurance, in turn leading to slower economic growth, fewer jobs, more uninsured and a greater need for state assistance.

Take Up and Crowd Out

Two factors that generally measure the success of a public health insurance are take up rates and Medicaid's effects on private insurance. Take up rates, very simply, are the percentage of eligible people who take advantage of public insurance offerings such as Medicare and Medicaid. "Crowding out," on the other hand, addresses the number of people who have taken up public insurance in lieu of private insurance.[5]

In the 1980's and 1990's many states eligibility of public health insurance programs in an attempt to alleviate the perceived problem of the uninsured. In the United States, it is estimated that 44.7 million Americans are without health insurance. Of those 44.7 million, nearly one-third of the uninsured are eligible for public health insurance. One-fifth earn $50,000 or more per year but cannot afford insurance. Almost half earn less than $50,000 and work for small firms who do not provide coverage.[6] 4.8 million of the nationally uninsured earn $75,000 or more per year.[7]

The uninsured are a diverse lot. While 89% of the uninsured come from working families, 40% are under 35 and may simply feel they do not need to pay for insurance coverage. They, in a sense, self insure because they are willing to assume the risk based on their age and health status. Others, though, may not be aware of coverage available to them or the tax advantages of acquiring coverage. In other words, different people have different needs.

The development of programs such as SCHIP, known as KidCare and FamilyCare in Illinois, were intended to address the category of families who were not Medicaid eligible, but still couldn't afford insurance. Yet, the expansions of the 1980's and 1990's didn't have their intended result. As Medicaid expansion moved up the economic ladder, more and more of the SCHIP eligible declined the offer of Medicaid.[8] At first glance, this suggests that lower take-up rates would mean that expanding public health insurance into the middle-class would not be that expensive. However, the evidence tells us differently.

In their study of children's public health insurance's impact on health coverage, LoSasso and Buchmeuller found that SCHIP programs enrolled between 4% and 10% of eligible children nationally [9] In other states we see similar small take up rates in their public insurance programs. Yet, it's this expansion of Medicaid enrollment that has been the largest driver in the growth of Medicaid costs since 2000.[10]

One specific example of how low take up rates incur big costs is Maine's Dirigo Program. A recent report from The Council for Affordable Health Insurance points out that Dirigo, an insurance program designed to reduce health care costs while providing health insurance to uninsured Mainers, hasn't even put a dent into Maine's uninsured, but has spent a lot of money trying:

> "In the first nine months of 2005, the Dirigo Health Agency spent $19.5 million to enroll 1,600. At this low rate of reaching the uninsured, Dirigo Health would cost taxpayers $16,000 per uninsured life annually. Furthermore, reaching all uninsured Dirigo-style would cost over $2 billion annually, or more than one and [a] half times the total raised by Maine's income tax."[11]

In expanding coverage to every higher point on the economic ladder, the Medicaid experience has not been efficient or successful. Sure, more people have garnered health care coverage as a result, but the price paid has been high considering the paltry take up rates. Even Governor Blagojevich's own promotion of "All Kids" admits that not all who are eligible want to enroll in Medicaid. In his announcement of "All Kids, the press said as much:

> *"In Illinois, 253,000 children are without health insurance.* ***More than half of Illinois' uninsured children come from working and middle class families who earn too much to qualify for programs like KidCare, but not enough to afford private health insurance****."*
> *(Emphasis added)*

Of the 253,000 uninsured children in the state, a sizable chunk of the population is eligible for KidCare but not enrolled. Empirical research and anecdotal examples can lead us to predict that the Governor's expansion of the state's welfare rolls by some 300,000 plus people and his "All Kids" Program will have a negligible impact on public insurance take up rates. Moreover, as we shall soon see, those taking up public health insurance aren't necessarily uninsured.

In many instances those entering public insurance come from the previously insured. This is usually for one of three reasons:

- **A family may opt for public coverage over private coverage because public coverage is less expensive.** In other words, if public insurance didn't exist, they would have private health insurance.
- **A beneficiary may not accept private insurance and opt to stay in public coverage.** They may have an offer of private insurance and refuse it. They may even refuse an employment out of fear of losing public coverage.
- **Employers may induce crowd out.** Employers may not offer coverage for employees if public insurance can take over the burden. Employers may choose to drop coverage; or create incentives (higher premiums) to not participate in employee health coverage.

Researchers David Cutler and Jonathan Gruber found extensive evidence of crowding out during the period 1987-1992 when Medicaid eligibility increased by 50 percent for children and pregnant women. They found that between 50 and 75 percent of the increase in Medicaid enrollment was associated with a reduction in private coverage. Cutler and Gruber established that employees didn't take up employer based insurance, or employers contributed less to insurance to create an incentive to turn down coverage. Evidence suggests that workers dropped coverage for their families and switched to individual policies.[12]

A Robert Wood Johnson Foundation review of the research literature reviewed 22 studies of the crowd out effect and found the effect to be inevitable.[13] So it isn't really a matter of whether crowd out exists, it is to the extent which crowd out exists. Proponents of the Medicaid status quo argue that the 50 percent to 75 percent crowd out rate for SCHIP's actually drops down to approximately 22 percent when we compare SCHIP take up rates to the entire Medicaid population.[14] How you look at the number, however, depends on whether you are measuring the efficacy of Medicaid overall or SCHIP expansions. And a crowd out rate of better than 1 in 5 is hardly an endorsement of the overall Medicaid Program.

Within the Medicaid program, numerous incentives work to undermine it.. Whether it is the perverse incentives that keep people on welfare, the low rates paid to doctors, the state's inability to pay in a timely fashion, price illusion or the lack of access to quality care, these endogenous factors are endemic to a broken program. Exogenous to the program are, the wider implications of take up rates, crowding out and other societal costs.

Despite Medicaid's internal and external problems, the program is popular with the public. Six in ten voters view the program favorably. In many respects, this is because the program touches so many of us either directly or indirectly. Indeed, six out of ten Americans believe that system needs to be reformed. However, the traditional fixes for Medicaid such as limitations of eligibility, rationing services, raising co-pays, cutting doctor reimbursements and other fixes that limit access to care are not looked upon favorably by the public.[15]

Politically, more Democrats continue to support the program and consider health care an important political issue than Republicans. Conversely, Republicans tend to view Medicaid in terms of a fiscal issue, or rather, how to pay for those unable to afford health insurance in a fiscally responsible

manner. Expanding access to care at the expense of other priorities – most notably economic growth – limit the willingness to expand public insurance beyond where it lies today.[16]

What is often not recognized by those with insurance coverage is the price they pay for health care is negatively affected by the price illusion and lack of access to care. Since most individuals get their health coverage through work and those services are paid by a third party payer, patients fall into the trap set by price illusion. The lack of access to quality care on the part of Medicaid beneficiaries means they often miss out on preventative measures that could be taken before poor health becomes a serious or emergency situation. That vicious cycle drives costs higher for all us. The cost shifting involved in our overall health care system and the over utilization of health services, raises the costs of health care for everyone.

For example, the rising cost of health care is the primary reason why wages in the US have grown slowly in recent years. What would have been higher pay for wage earners has instead gone to health benefits, leaving little leftover to take home. Since much of this economic activity occurs where the average worker doesn't see it, or withholding, the economic impact is abstract at best. But, the negative consequences of health care inflation are real and all of us are stakeholders in the system.

Principles of Medicaid Reform

So far this report has outlined the basic structure of Illinois' Medicaid program, its costs, who is enrolled and why the system doesn't work. It also notes the program is popular, and that we are all stakeholders. Medicaid is not going to go away. So, how do we fix it?

Any discussion of what a Medicaid reform proposal should look like should begin with the principles and goals of a reformed system. In other words, what are we trying to accomplish and why?

Nina Owcharenko, of the Heritage Foundation, suggested last June that Congress use the highly successful Federal Welfare Reform as a model for Medicaid Reform. To spur experimentation in the states, Congress simply identified its objectives for welfare reform in the 1990's and gave states the flexibility to reform the welfare programs as they saw fit.[17]

Goals Congress should establish for Medicaid reform according to Owcharenko, are:

- "Restoring integrity to the program by ending state financing gimmicks, making a programmatic distinction between the provision of welfare services and the provision of medical services, and closing the loopholes on asset transfers.
- Allowing Medicaid beneficiaries to assume personal responsibility for and individual control of their own health care by promoting consumer-directed care models.
- Streamlining and expanding the federal waiver process, which allows states greater flexibility to experiment with innovative approaches to improve health care access and quality for low-income Americans; and
- Helping individuals and families 'mainstream' into private health care coverage through refundable tax credits and giving states greater flexibility in further supplementing tax credit with Medicaid dollars."

Once clear goals are established, then principles may be identified. The principles for Medicaid Reform would be:

Competition – In every other sector of the economy competition keeps costs low and improves the quality of goods and services. Right now, Medicaid rations services to keep costs low – and as explained above, it does not work. Making private networks and insurance providers compete for Medicaid customers means providers will have to design attractive products for Medicaid beneficiaries at competitive prices.

Choice – Any Medicaid reforms should allow Medicaid beneficiaries access to the care they need. Ideally, nothing should interfere with the doctor-patient relationship. Right now, the Medicaid bureaucracy determines what services can be used, what drugs can be taken and what doctors patients can see. By making funding, counseling and other tools available any Medicaid reform should maximize choices to ensure patients get the care they need.

Stability – The largest problem faced by Medicaid today is the unsustainability of its growth. Any reforms must tackle the program's exploding growth. As a defined benefits program, the state is responsible for any amount of approved services a beneficiary chooses to use. A defined contribution plan, however, would make a pot of funds available for beneficiaries to be used in any health care related manner in which the beneficiary wished.[18]

By taking advantage of the flexibility given to states, or even further enhanced flexibility by Congress, state policymakers can reform the system to restore its integrity, improve the quality of care, enhance consumer choices, and bring Medicaid beneficiaries into the mainstream of private insurance. By implementing reforms consistent with these principles, Illinois policymakers can fix our state's Medicaid program in ways that improve health care outcomes and save taxpayers billions in future costs. The term used describe this model is consumer driven health care.

Consumer Driven Health Care Model

Consumer driven health care isn't really a new model. Health Savings Accounts (HSA's), the first real attempt to make health care more consumer friendly, came from the Medicare Modernization Act of 2003. HSA's are tax free savings accounts for everday health care needs coupled with comprehensive catastrophic health insurance. They are saving money for consumers and businesses, and they have induced some of the previously uninsured to buy insurance. While HAS's are the first generation of consumer driven plans in the 21st Century, they are by no means the first time health care was consumer driven.

The model was actually used prior to World War II when health insurance was used to cover catastrophic illnesses and emergencies. Day-to-day care was paid for out-of-pocket. That changed during the war when labor shortages led to wage caps on workers. To compete for workers, businesses began offering health insurance as a benefit. What evolved after that was a system in which employer based health care was subsidized by the Federal Government by allowing businesses to deduct health benefits from their taxes. This is what tied insurance to your job and led to a third payer system that has created the illusion that health care is an entitlement and that there is little to no cost to be paid for by over utilization of health care.

The new generation of consumer driven health care, however, is not exactly that old time health insurance. In the new version, incentives are used to a far greater degree. The consumer is not only

in charge of first dollar health expenditures. The consumer is also a participant in an incentive framework, in which participants can be rewarded for making good decisions involving prevention, wellness programs and disease management programs. According to Ronald Bachman of the Center for Health Transformation, "In a 21st Century Intelligent Health System, the individual has accurate, timely, personalized knowledge about their health and treatment options. Cost and quality options are easily known, including the assurance that their treatment is based on the most up-to-date outcome based medicine."[19]

Two states where this is all ready occurring are Florida and South Carolina. Their consumer driven models are excellent examples of what Illinois can and should do.

The Florida Medicaid Modernization Demonstration Proposal

In January 2005, Governor Jeb Bush of Florida put forward a proposal whose goal it was to reign in double digit growth rates and Medicaid Program deficits. Past attempts to curb Medicaid spending growth had failed to effect spending and, in fact, had the unintended consequence of expanding both costs and complexity.

Under the Florida Medicaid program there are seventeen eligibility categories based on age, gender, income, and medical conditions. There are 47 different types of benefit packages that often outdid private coverage. Attempts at reform, led to the establishment of 20 district waivers from federal regulation that include some districts with more than 20 programs. Florida literally had hundreds of state initiatives; more than 90 contracts with vendors and nearly 70,000 enrolled providers requiring oversight and management from the state.[20]

In approaching Medicaid Reform, the Bush Administration in Florida addressed both the criteria based upon the federal welfare reform and the principles of competition, choice and stability. In fact, the program is modeled on the Federal Health Employee Benefits Program (FHEBP), a program which enjoys a large amount of popularity among federal employees.

Under FHEBP, federal employees choose from competing service providers for services. The vendors entering into the program are vetted to ensure they meet minimum standards and then compete for the affection of employees. Employees can choose from innumerable qualified providers based on price and quality. Vendors, to compete, must make their offerings as attractive as possible in order to attract federal retiree dollars.

The program has high customer satisfaction because of its ability to deliver more choices for employees. In addition, the program is flexible enough to take advantage of new practices and innovations in health delivery. This is something that current Medicaid Programs cannot do.

Governor Bush's proposal seeks to redefine how the Medicaid Program delivers services to beneficiaries in Florida. The system, like the private market, is premium based and patients will have a "home" from which care can be coordinated. It addresses both the needs of children and families, as well as those in long-term care. It does this by restructuring the Medicaid program to patients first; use the marketplace to keep costs manageable; and bridge the public insurance with private insurance.

The key elements of the program are patient responsibility and empowerment; marketplace decision-making; an effort to bridge public and private coverage and provide a sustainable growth rate. The

program is a premium-based system in which the state will provide beneficiaries with the funds to pay premiums.

The premiums will comprise both comprehensive and catastrophic care. The coverage will be actuarially equivalent to all services in the current system. Enhanced benefit accounts will be created to provide incentives for beneficiaries to practice wise decision-making in their care. Any funds in the enhanced benefit accounts left over after leaving the program will remain in the account for up to three years. This, for example, will allow beneficiary to accept employment in a non benefits position without fear of losing coverage.

Today's Medicaid		***Florida's New Medicaid***
Government as consumer	→	***Patients as participants***
Complex programs mandated by	→	***Clear choices made by participants***
government Centralized planning	→	***Marketplace decisions***
"Blank Check"	→	***Defined investment***
Unsustainable growth	→	***Predictable growth***

The plan addresses the principles of competition, choice and sustainability while at the same time improving quality and access to care. We can illustrate how this works by placing the various components in context of their corresponding principle, and explaining how each one can be applied to the principles.

Competition
The old Medicaid structure relies on centralized government determining what services will be provided, how much will be paid for them, and the program sets the parameters for access to those services The nature of the program has all the hallmarks of a centralized scheme: poor services, lack of access and few choices.

Governor Bush's Medicaid Modernization Program uses competition among vendors and providers to bring innovation and efficiency to the system. As an incentive, the program uses Medicaid dollars in the hands of beneficiaries to encourage diverse and distinct products and services for Medicaid participants. In turn, they reward the best vendors and providers for providing the best product for the dollar. According to the proposal, three strategies will guide competition:

- "Vendors offering coverage additional services in return for the Medicaid premium will be allowed to define the amount and scope of benefits they will offer
- The redesigned benefit structure will provide for further flexibility allowing participants to direct different portions of their Medicaid premium to different vendors; and
- An upper limit will be established on Medicaid benefits, similar to the maximum benefit limits found in private insurance"[21]

Under the plan different kinds of providers; health insurance, networked organizations, preferred provider organizations as well as alternative services such as a community based services will be allowed to compete for Medicaid beneficiaries' business. Competition, then, will spur innovation in the way it provides services and interacts with patients.

Choice

The current Medicaid system is a government monopoly that will as much seek to serve its own institutional interests as it does Medicaid enrollees. The program, through the legislative process, determines who gets what, when and how. The Florida proposal's goal is to create a viable marketplace where Medicaid participants can choose from a number of providers.

The market is the most efficient means we have to allocate resources. A system in which consumers have choices creates incentives for providers to produce the best service at the lowest prices. Consumers with choices can identify what they need and use their limited resources wisely. Under current Medicaid programs there are no incentives to behave wisely because beneficiaries are entitled to as many services as they wish, and the taxpayer will be paying the bill as long as the government approves the services.

The Florida proposal actually envisions using only minimum guidance to health providers to manage the program. The scope of services, the amount of services and the duration of services are the only areas in which the government interferes. The goal is to give beneficiaries as many choices as possible based on individual need and desire. Beneficiaries will also have the option of mixing services, systems or plans in order to obtain the best coverage for themselves.

Stability

Medicaid reform in Florida is designed to create a more sustainable health system, not cut services or eliminate Medicaid. Borrowing from President Clinton's phrase on affirmative action, the goal is to mend Medicaid not end it. The premium based coordinated system of care is designed to make Medicaid expenditures more predictable. In Florida Medicaid spending growth has outpaced Illinois' 9% growth per year with a whopping 13% per annum growth.

Under the Florida proposal, the Medicaid Program would continue to grow but that growth would be more predictable. The idea is to use the incentives to maximize one's lot in life to provide the highest quality at the lowest possible cost. Health insurers and providers will compete for the limited resources being offered by Medicaid beneficiaries in order to maximize their profits. Medicaid enrollees, through extra benefits derived from spending wisely, have incentives to maximize the utility they get from insurers and providers.

By providing a bridge to private coverage, the system also eliminates the disincentive to accept a pay raise, a better paying position, or even a job. This will also ease the demand on the Medicaid Program.

Other Elements of the Program

Because the program relies on the private sector and market based incentives to stabilize Medicaid pricing and provide benefits, that doesn't mean the state will not have a strong role to play. Under the program Florida does three things:

- Qualify provider groups – Providers will be subject to a thorough vetting process where they must demonstrate an acceptable network of providers, adequate managed care and disease management programs for the Medicaid population.
- Grievance process – Establish a patient friendly transparent grievance process in order to make it extremely difficult for a provider group to systematically deny beneficiary services. It will aid in measuring outcomes. The program also provides expedited processes in some instances. Pregnant women and children will not be governed by benefit limits; and
- Assess Beneficiaries – The state will assess and counsel beneficiaries to ensure that an actuarial risk based assessment is completed and that a beneficiary chooses the right programs to meet their needs.

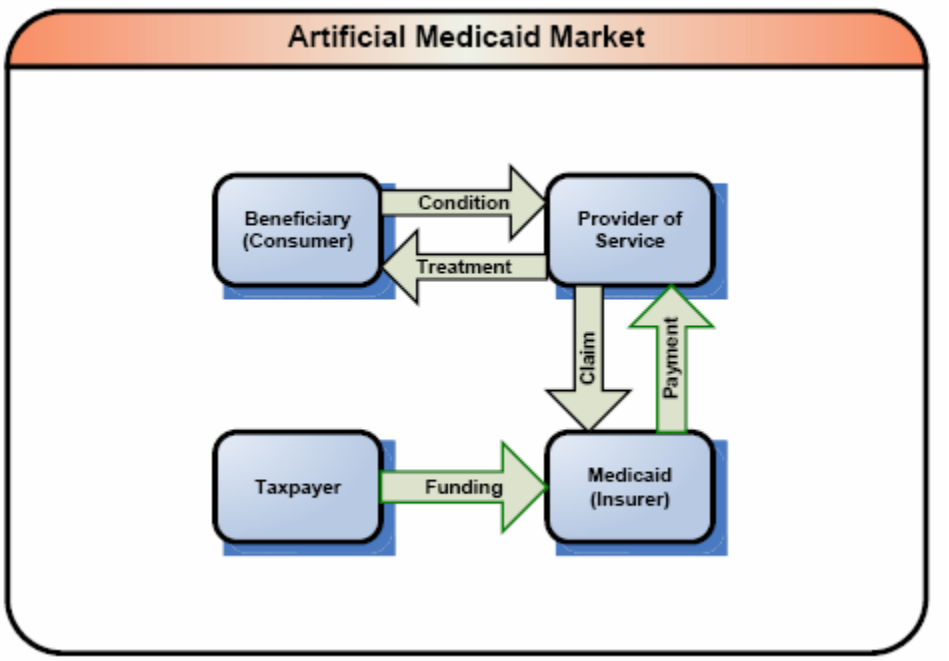
As a demonstration project, the program does not yet provide coverage for long term care patients. but in years three and four of the five year demonstration project, the program will be expanded to provide long term care.

Florida's Medicaid reform demonstration project is a perfect example of how the state can build a social safety net that can address the health care triangle (cost, access, quality) of providing better quality care to more people in a cost effective manner. It also addresses the triangle in a manner than enhances both choice and competition in a way that financially stable. The FHEBP has a proven track record and is extremely popular with Nation's federal employees; it is unlikely the outcome in Florida will be any different.

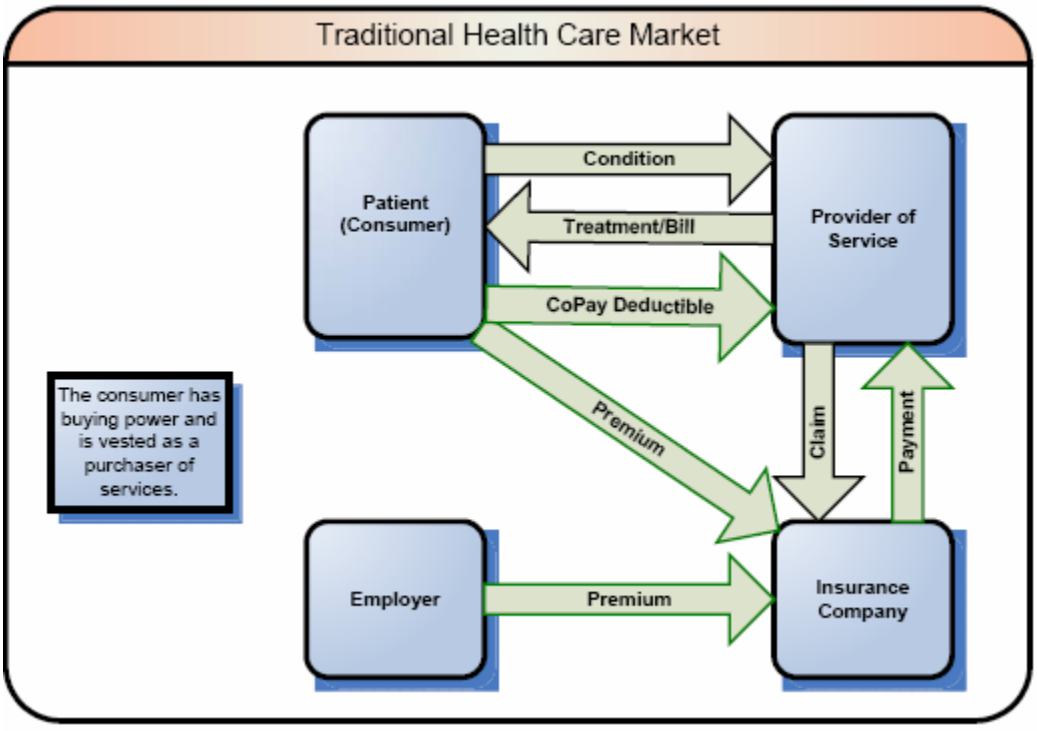
Florida is not the only state experimenting with market incentives to improve access to quality care in a more cost effective manner. Last year South Carolina's Medicaid Choice was introduced. This model of reform looks even more like the private health insurance marketplace than Florida's demonstration program.

South Carolina Medicaid Choice (SCMC)

Unlike the Florida demonstration project, the SCMC Waiver calls for even more direct participation in the marketplace. Through the use of Personal Health Accounts (PHA's), a South Carolina Medicaid beneficiary is personally vested with an actuarial determined amount of value based on the current fee for service average expenses. According to the 1115 waiver demonstration proposal submitted by South Carolina to the U.S. Dept. of Health & Human Services, "The amount is risk adjusted for eligibility categories and health status as well as age and gender."[22]



The goal of PHA's are to move Medicaid beneficiaries into a market oriented environment and away from the traditional Medicaid market. The problem, says the SCHHS's waiver, is that, "Under this traditional program, beneficiaries and providers are isolated from the basic economic forces that drive most markets." Because in the traditional Medicaid market, the beneficiary's incentives are the exact opposite of the normal incentives in a marketplace, the traditional Medicaid model results in the perverse economic incentives described previously. The SCMC Program works to put the Medicaid beneficiary back into the market, making them an active health consumer. In sum, they become vested in the economic outcomes of their decisions, which allow them to better control the services they receive; manage costs; and induce competition and innovation on the part of providers.



Under the program, beneficiaries are given the option of choosing from a panoply of programs ranging from Self-Directed Care, private insurance, Medical Home Networks (MHN's) and alternative coverage options. Money is deposited directly into the beneficiaries account, and with the aid of a counselor, the beneficiary picks the program best suited to their needs. If they choose comprehensive health insurance or a managed care provider; the state pays the premium and deposits the residual funds into the account. In turn, these funds can be used to purchase other medical services as needed. The money for the account is distributed every quarter and funds are allowed to roll over if they are not used as long as the beneficiary is Medicaid eligible. After that, the funds revert back to the state.

Under the self directed option, the beneficiary – should he or she meet the eligibility requirements – is free to use the account for any health related expenses a necessary. The beneficiary pays for services with a debit card at the point of service. This has the added benefit of reducing red tape and overhead.

The program adheres to the principles of competition, choice and stability in many of the same ways as Florida's demonstration program:

Competition
The SCMC program is more ambitious than the Florida program because part of its purpose is to serve as a space for consumer driven innovation: "While SCMC will include current market choices such as MCO's [managed care organizations], and the Self-Directed Plan, it will also serve as an incubator of sorts for the innovative forces in the market place to develop new approaches to the delivery of health care."

According to the waiver, current health models are unduly burdened with red tape and restrictions that hinder the market place. By breaking down those barriers, yet undeveloped models of health care delivery that improves the quality and delivery of health care can be brought to market. Thus, "This will be a true demonstration program that produces results that redefine health care in the United States."[23]

Choice

Florida uses a program based on the FHEBP that creates a marketplace within the guidelines of a program. And while the SCMC programs does adhere to services requirements to programs such SCHIP, it goes farther with the PHA's than the Florida Program. Instead of participating as a member of a program, SCMC vests the money directly into the beneficiary's personal account and allows the beneficiary more freedom to use funds for health care purposes.

The only parameters in designing a program for SCMC is that they must provide a minimum amount of coverage determined by the "scope of services" and that the PHA is actuarially determined. Budget neutrality must also be assured.

The program allows the beneficiary to "opt out" of the Medicaid system and purchase private health insurance and services. This creates an incentive for traditional insurance providers and services to compete for beneficiary dollars. One example given is a pharmacist who offers discounts to Medicaid enrollees to purchase prescriptions or over the counter drugs. The Self-Directed Plan, with the use of a debit card, can be used as a flexible spending account to customize health care to the beneficiary's unique needs. The example given here is a person using alternative transportation to treatments in order to purchase an extra prescription. Under the private insurance option a Preferred Provider Organization or other managed care organization can be used.

Stability

Just as in the Florida demonstration project, incentives such as wellness programs, roll over amounts, and counseling are used to teach beneficiaries to use health resources in a cost efficient manner and in a way that maximizes their utility. Eliminating bureaucratic red tape and restrictions on services and multiple vendors competing for the attention of individuals, means they will be forced to innovate and offer competitive prices to attract Medicaid dollars.

Other Elements of SCMC

While relying on a more market oriented Medicaid model is important to providing access to higher quality health care in a more cost efficient manner, the SCMC is still accountable to the tax paying public. To ensure that taxpayers are being properly served, it will be the role of the state to evaluate the efficacy of the program. According to the waiver proposal, assessments will be ongoing and occur on a number of different levels. Among the other elements of the program are:

- Customer satisfaction requirements – 24/7 user friendly access; timely access for office appointments, consumer education and customer service evaluations of a representative mix of patients will be required.
- Provider performance measures – Compliance with national best practices, number of Board Certified Physicians and in-hospital infection rates will demonstrate improved quality. Health status surveys are also important indicators.

- Incentives for Health life styles – Rewards that can be in the form of cash, gift certificates, and co-pay forgiveness for complying with meds and treatments, smoking cessation and exercising regularly.
- Services to beneficiaries -- such as disease management program, pregnancy and newborn programs and lifestyle programs.

The SCMC program offers a broad array of opportunities for Medicaid beneficiaries and providers that extend the Medicaid Program into the private sector. SCMC better serves beneficiaries, providers and the taxpayer. Like Florida, the program offers bridges to private insurance and helps combat welfare dependency. The program also places emphasis on teaching beneficiaries how to be better consumers of health services. As consumer driven health care becomes more prevalent in the United States – and it will – this will put South Carolina's Medicaid beneficiaries at a competitive advantage over many already in the traditional health insurance market.

Both programs offer Illinois some lessons on how to improve the state's Medicaid system, both individually and in conjunction with one another. If Illinois is to tackle Medicaid reform in the coming years, South Carolina and Florida offer forward looking models that improve access to quality care in a cost efficient manner – which in the end should be the goal of all policymakers.

Recommendations

Governor Blagojevich's recent expansions of KidCare, FamilyCare and his "All Kids" Program have put tremendous strain on the state's long term fiscal health. In just four years Governor Blagojevich, for example, has double the state's bonded debt. It took 185 years for that debt to accumulate, and it's taken the Governor four short years to double it. On the other hand, he has raised stature of health care as a political issue in Illinois. While polling has long indicated that health care is not a major concern to Republican voters; Illinois' democratic Governor has brought the issue to the forefront. That's a good thing.

The Governor's expansions, coming at the price of fiscal health, offer free market advocates an opportunity to offer an alternative to the top down, centralized model of health care prevalent in Europe and Canada. By changing incentives within the system, stabilizing Medicaid inflation and improving access and quality of care, opportunities are arising to improve the system and put the state's fiscal house in order.

The first step might be to seek an 1115 waiver from the US Dept. of Health & Human Services to offer beneficiaries in KidCare, FamilyCare and "All Kids" personal health accounts whereby funds could be put directly into participants accounts to be used to purchase private coverage, pay for traditional fee for service programs, Self-Directed Programs or managed care. Like South Carolina, the state's role would be to monitor, to evaluate, and to certify vendors and counsel beneficiaries. Beneficiaries other than acute care and long term care patients could also be given personal health accounts.

A reformed Medicaid program would be revenue neutral so as to ensure with the goal of making the program financially stable. It would discourage welfare dependency, improve quality of service, and end the state's underpayment and chronic late payments. It would do so by allowing the over 70% of Medicaid beneficiaries that account for about 30% of the budget to enter the same health insurance market that we enjoy.

For the more difficult cases of acute care and long-term care, a program modeled on the FHEBP might aid providers, patients and taxpayers – such as the chronically bankrupted nursing home industry – and beneficiaries who need more help from state case workers. It too, could be revenue neutral and be designed more to address the Medicaid inflation and improve health care outcomes than simply limiting benefits, budgets and services.

Reforms for the mentally ill could also be developed out of the FHEBP as well.

Illinois' Medicaid system is based on an outdated industrial age economy where health care was a labor intensive and technology was secondary. Today, in our 21st Century economy technology and science have replaced much of the labor intensive treatments. A health emergency that used to mean two weeks in the hospital can now be treated with prescription drugs. Surgery patients can be released from the hospital within days of major surgery and outpatient surgery is becoming more the norm. Government has simply not caught up with these developments and Medicaid beneficiaries suffer as a result.

Illinois should embark on a comprehensive Medicaid overhaul that improves access to care, health care quality and thus providing it in a more cost efficient manner . A restructured Medicaid Program, in the end, will be far better for doctors, patients, and taxpayers.

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[1] See. Department of Health Services website: http://www.hfs.illinois.gov/annualreport/kidcare.html.
[2] See. US Dept. of Health & Human Services http://aspe.hhs.gov/health/fmap.htm
[3] Dept. Health & Humans Services. National Health Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Selected Calendar Years 1999-2015, in "National Health Care Expenditures Projections: 2005-2015"
[4] See "Medicaid: A Flawed Program: The Case for Change" Prepared for the Senate Republican Caucas. December, 2004.
[5] Anthony T. LoSasso and Thomas C. Buchmueller. "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage" NBER Working Paper 9405. December 2002. JEL No. 11. pp. 2
[6] Blue Cross Blue Shield Association, "The Uninsured in America," 2005: p. 3
[7] Ibid. p.6
[8] J Curre, J Gruber. "Health Insurance Eligibility, Utilization of Medical Care, and Child Health. *Quarterly Journal of Economics.* Volume 111 Issue 2, 1996: pp. 431-466.
[9] Anthony T. LoSasso and Thomas C. Buchmueller. "The Effect of the State Children's Health Insurance Program on Health Insurance Coverage" NBER Working Paper 9405. December 2002. JEL No. 11: pp. 22
[10] John Holahan and Arunabh Ghosh. "Understanding The Recent Growth In Medicaid Spending, 200-2003" Web Exclusives: A Supplement to Health Affairs. Volume 24 Supplement 1: pp. W-52.
[11] Adam Brackemyre. "Maine's Dirigo Health: A String of Broken Promies" *The Council for Affordable Health Insurance's Issues and Answers.* January 2006: No. 132, p. 2.
[12] Jonathan Currie and David M. Cutler. "Does Public Insurance Crow our Private Insurance?" *Quarterly Journal of Economics.* Volume 112 No. 2 1997: 431-466.
[13] Gunther Davidson, Lynn A. Blewett, Kathleen Theide and SHADAC. "Public Program Crowd-Out of Private Coverage: What are the Issues?" Robert Wood Johnson Foundation Research Synthesis Report No. 5. June 2004: p 13.
[14] Ibid.
[15] See Kaiser Family Foundation Poll (LOOK UP CITATION)
[16] See Heritage foundation backgrounder on topic
[17] Nina Owcharenko. "A Road Map for Medicaid Reform." The Heritage Foundation, June 21, 2005. Backgrounder #1863. p. 1
[18] Nina Owcharenko. "Florida and South Carolina: Two Serious Efforts to Improve Medicaid." November 18, 2005. WebMemo #920
[19] Ronald E. Bachman, FSA, MAAA. "Healthcare Consumerism: The Basis of a 21st Century Intelligent Health System." Center for Health Transformation, 2006: p. 14.

[20] Jeb Bush. "Florida Medicaid Modernization Proposal" State of Florida. January 11. 2005
[21] Ibid. p.5
[22] SC Dept. of Health & Human Services "South Carolina Medicaid Choice" June, 2005 p. 10.
[23] Ibid. p. 13

Exhibit 5

Long term care partnerships

National Association of Health Underwriters

America's Benefits Specialists

The Deficit Reduction Act of 2005 included provisions to expand state long-term care partnership programs beyond the current four partnership states (CA, CT, IN, NY)

What The Federal Bill Includes:

- Allows partnerships programs to be created through a state Medicaid plan amendment
- The amendment would allow for the disregard of any assets or resources in an amount equal to the insurance benefit payments into a qualified long-term care insurance partnership policy. (dollar for dollar model)
- A qualified plan is defined by Section 7702 (B) of the Internal Revenue Code of 1986 as a HIPAA, tax-qualified plan
- A qualified plan must meet the following requirements
    - Policyholder must be a resident of the state when coverage becomes effective
    - Policy must meet NAIC model regulations (Oct. 2000) and consumer protections
- Inflation protection is unspecified but listed according to age
    - Less than 61 – policy must provide compound annual inflation protection
    - 61-76 – policy must provide some level of inflation protection
    - 76 or above – not required to provide some level of inflation protection
- There is no cap on the amount of asset protection (assets would be protected in an amount equivalent to the dollar amount of insurance protection purchased)

Next Steps:

- Determine the appropriate state Medicaid agency and contacts
- State Medicaid plan amendments need to be filed with HHS (this process is similar to applying for a waiver)
- HHS along with industry assistance is diligently working to develop plan amendment templates for the states
- In the majority of states the process of implementing a partnership program can strictly be done through the regulatory authority and state Medicaid agencies
- State plan amendments must be approved by the state insurance commissioner and HHS Secretary

When Legislative Activity May be Necessary:

- If a state has previous laws and/or statutes related to long-term care partnership programs that may have to be overridden. (i.e.: states that previously passed enabling legislation that does not mirror the federal language)
- Some states may require that the legislature promulgate authority to the state Medicaid agency to file a state plan amendment
- The Industry is collaborating efforts to develop model language that will mirror the federal provisions and move forward with progress on partnership implementation

For more information on this subject, contact:

Megan Mamarella, Director of State Affairs, mmamarella@nahu.org, (703) 276-3818, (list states)
Janice Kupiec, Director of State Affairs (703) 276-3808, jkupiec@nahu.org, (list states)
Jessica Waltman, Director of Health Policy Research, jwaltman@nahu.org, (phone number) (list states)

For information on federal implications of this legislation, contact John Greene, Sr. Director of Federal Affairs, (703) 276-3807, jgreene@nahu.org.

Section 6021: EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM
S-1932
Deficit Reduction Act of 2005

COMPONENTS AND WHY THEY WERE INCLUDED	STATUTORY REQUIREMENTS
Definition of qualified plan Dollar-for-Dollar: for every dollar of benefit used, a dollar of assets is added to the amount of assets the state allows to be retained for Medicaid eligibility. Tax qualified policies constitute 98% of the market and allow for uniformity in the program nationwide. The NAIC 2000 model has been adopted by 37 states.	❑ Approved state plan amendment under this title that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are used on behalf of the individual. Must meet these requirements: ❑ Resident of the State when the coverage first became effective under the policy. ❑ Policy is a tax qualified long-term care insurance policy and issued no earlier than the effective date of the State plan amendment (see effective date). Meets October 2000 NAIC model regulations and requirements for consumer protections.
Requirement of inflation protection Most people will not gain access to their policy for many years. Inflation protection is important so that the value of the benefit remains meaningful when the benefit is needed.	❑ Has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection. ❑ Has attained age 61 but has not attained age 76 as of the date of purchase, the policy provides some level of inflation protection. ❑ Has attained age 76 as of date of purchase, the policy may (but is not required to) provide some level of inflation protection.
Plan reporting requirements The goal is to have a uniform set of reporting rules to reduce unnecessary paperwork and encourage plans to participate. This will keep product costs	❑ The issuers will provide regular reports to the HHS Secretary (regulations to be determined) and include the following information: ❑ Notification of when benefits have been paid and the amount of benefits paid ❑ Notification of when the policy terminates.

COMPONENTS AND WHY THEY WERE INCLUDED	STATUTORY REQUIREMENTS
down, ensure product diversity and increase prospects for reciprocity.	❑ Other information as determined by the Secretary. ❑ The State may not impose any requirement affecting the terms or benefits on partnerships policies it does not impose on non-partnership policies. ❑ States may require issuers to report additional information beyond those specified by the Secretary.
Development of Regulations on Tracking and LTC Education Efforts Will allow states access to verify partnership status and other information needed for Medicaid eligibility determinations. Note that Medicaid eligibility varies from state to state and people with partnership policy remain subject to the state eligibility rules of the state in which they reside. State and the Federal government would like to quantify the amount of savings or costs to the Medicaid program. The clearinghouse is an attempt to provide objective information to consumers to consider their LTC options based on their particular circumstances.	❑ To be developed by the Secretary after consultation with NAIC, issuers (carriers), current partnership states (CA, NY, IN and CT) and consumer representatives. ❑ The Secretary, in consultation with other Federal agencies, issuers, NAIC, state insurance commissioners, current partnership states, and consumer representatives will develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of LTCi to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access. ❑ Secretary to report annually to Congress the extent to which the partnerships expand or limit access to LTC and impact on Federal and State expenditures under Medicare and Medicaid. HHS is appropriated $1,000,000 from FY-06 through FY-10 to carry out this task. ❑ National Clearinghouse for LTC Information is established to educate consumers on availability or limitations of coverage for LTC under Medicaid. Will also provide contact information for obtaining State-specific information on LTC coverage, including eligibility and estate recovery requirements, provide objective information to assist consumers with decision-making process for determining whether to purchase LTCi or pursue other private market alternatives including contact information for additional

COMPONENTS AND WHY THEY WERE INCLUDED	STATUTORY REQUIREMENTS
	objective resources on planning for LTC needs. The clearinghouse will contain information about the partnership program and states that provide reciprocal recognition. $3,000,000 is appropriated for this purpose.
State Plan Amendment Preferred option employed by states to modify their Medicaid program and does not require state legislative action.	❑ Policy is deemed to meet applicable requirements of the model regulation or the model Act, if the State plan amendment is certified by the State insurance commissioner in a manner satisfactory to the Secretary, that the policy meets the requirements. ❑ Changes, revisions, updates or other modifications of the model regulation or model act will be made no later than 12 months by the Secretary after consultation with the NAIC.
Reciprocity Recognition by one state for another states' partnership program for the purposes of asset protection.	❑ The Secretary, in consultation with the NAIC, issuers, States with partnership experience and representatives of consumers will develop standards for uniform reciprocal recognition of partnership policies between states. This will include: ❑ Benefits paid under these policies will be treated the same by all states. ❑ Opt out provision in which a state would notify Secretary in writing.
Effective Date	❑ Qualified State long-term care insurance partnership policies issued on the first calendar quarter in which the plan amendment was submitted to the Secretary.

Exhibit 6

Information about reinsurance pools

Reinsurance Pools (Fall, 2004)

Insurance carriers who operate in the small employer health insurance market currently pool similar small employers together in each of the states where they do business. Although they may be allowed some limited initial pricing flexibility based on underwriting of each small employer, and even though they are pooling many small employers together, it is often difficult to adequately spread the risk for individuals with significant health problems. The result is higher claims for the whole "pool" of small employers, which in turn results in higher premiums for all small employers.

In the individual health insurance market in the majority of states, insurance carriers can underwrite based on health status, and can decline to issue coverage on the sickest of individuals. This keeps rates affordable in the individual market, absent other regulations that impact premiums. Those who are turned down for coverage can obtain coverage in a state high-risk pool in thirty-two states, and most other states have some other mechanism to guarantee coverage to those with significant health conditions. A key element of these mechanisms is that the sickest individuals are pooled separately from those that are healthy.[1]

HIPAA does not allow this type of high-risk pool arrangement in the small employer market, even though the small employer market shares many of the characteristics of the individual market. HIPAA does not allow individuals to be excluded from a group, or rated separately based on their individual health status. For this reason, each small employer's claims, including the claims from high-risk individuals, are included when calculating the total claims expense incurred for the whole "pool" of small employer business. This claims cost is the largest component of small employer health insurance premiums.

One way to mitigate the risk of less healthy individuals without violating HIPAA is through a small employer reinsurance pool. This is not a purchasing pool, but rather a pool set up at the state level strictly to handle the financial side of insuring high-risk individuals. Small employers purchase coverage through carriers as they normally do, but when a carrier initially underwrites a case, they purchase extra reinsurance coverage on the unhealthiest risks from a state reinsurance pool. This is transparent to the covered individual, who continues to receive benefits exactly the same as all other members of the

[1] States that guarantee issue all individual health insurance policies do not pool sick individuals apart from those who are healthy, but prices are significantly higher for all individuals in those states.

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employer group. If claims on the individual exceed a certain level, the reinsurance pool reimburses the carrier for their losses above that level. The carriers continue to retain a small part of the risk at that point, to ensure that incentives to control claims cost are retained.

Today there are nineteen active reinsurance pools, and another eleven pools that are either inactive or in the proposal stage. Reinsurance pools are currently funded by premiums paid by participating carriers. Up until this time, reinsurance pool success has been marginal in terms of its ability to produce cost savings in a given state market, primarily due to the size of current pools. The main reason for this is that the pools are largely voluntary and small. Many large carriers have decided not to participate in the pools, because they felt they were large enough to absorb more risk, or because they had already developed their own source of internal or external reinsurance. Their feeling was that they had no need to pay premiums to a reinsurance pool. So, some, but not all, carriers in a market participate in the current state reinsurance pools. For this reason, the pools have been small, with fewer participants to share in the cost of the reinsurance. As a result, savings have been less than they would have been in a larger pool, and the cost of reinsurance passed back to consumers has been greater than it would have been with more participation by more and larger carriers with more risks to reinsure.

Making participation in reinsurance pools mandatory is not the answer, and would at best only be a partial help anyway. It would appear from the premium rate increases we have seen from carriers of all sizes that the larger carriers have not been able to adequately handle the risk of unhealthy individuals in small employer groups on their own either. Because claims cost has increased, the cost of reinsurance has increased, both for carriers participating in the reinsurance pools in existence today and for larger carriers pursuing reinsurance on their own.

What is needed first is a means of enticing all players in a state small employer market to participate in the state's reinsurance pool. If all carriers participated in state reinsurance pools, more unhealthy risks would be removed from the "regular" small employer pools maintained by each carrier, and the cost of coverage would go down for small employers. However, due to the characteristics of the small employer market, even if all carriers participated in the reinsurance pool, there would still be a cost for reinsurance premiums to the carriers. This cost would be passed back to consumers. A real incentive that would significantly reduce the cost of coverage to small employers would do so by removing the cost of reinsurance premiums from carriers participating in a state's small employer reinsurance pool. Rather than a slight reduction and a rearranging of premium, this would completely remove a cost component now included in health insurance premium calculations and could significantly reduce the cost of coverage to small employers.

If the federal government subsidized small employer reinsurance pool premiums, this would remove part of the cost of coverage currently paid by small employers today. The

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amount of savings would depend on the amount of subsidy provided by the government. There are many degrees of unhealthy individuals. Reinsuring more of them would result in lower premiums to small employers but greater cost to the federal government. In any event, regardless of the standard set for what level of unhealthy individuals would go to the pools, the bottom line is that if there was a federal subsidy equal to the cost of a carrier's reinsurance premiums, the reinsurance costs would never trickle back to the cost of coverage paid by the small employer. This would reduce the cost of coverage to small employers, reduce the cost of the employee's share of the cost of coverage, and encourage more small employers to offer coverage to their employees.

This would seem an appropriate role for the government, and one that is consistent with other roles appropriately taken on by government. It would mean that the federal government would be subsidizing the cost of coverage for those who are sick. It would not create a new government-run bureaucracy, but merely provide financial assistance on behalf of those who most need help. The government would subsidize reinsurance premiums, but not become the reinsurer itself. It would bolster the private system, and make coverage more affordable for all small employers.

This type of system would also be fairly simple to initiate. Nineteen states already have pools that could easily be modified to work with this system. The NAIC already has a reinsurance pool model that with minor modifications would work in the scenario described and most of the pools in operation today are based on that model. Many other states with inactive models could simply activate the pools they already have "on the shelf." In fact, it is not overly ambitious to estimate that twenty-eight to thirty pools could begin this operation with the pool model they have, and that another twenty to twenty-two could adopt a modified NAIC model. With federal subsidies on the table, a state's incentive to move forward would be strong. The federal subsidies could be provided quarterly or annually to "qualified pools" based on their net losses and these subsidies would be used to either reduce or eliminate assessments and premiums to small employer carriers participating in the pool. The federal subsidies could be disbursed through the Treasury Department, or though HHS/CMS like the high-risk pool grant money is currently being distributed.

Some Democratic candidates have suggested that reinsurance coverage only be provided to participants in government-sponsored purchasing pools. This is not necessary, would create an unlevel playing field by subsidizing only a portion of the small employer market, waste unnecessary time while the purchasing pools are developed, and create unnecessary bureaucracy on an unproven entity. Any reinsurance subsidy considered should be universal across a market segment (all small groups for example) or not used at all, otherwise ultimately access to affordable coverage could be reduced, rather than increased.

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Exhibit 7

Example of a consumer-targeted
patient safety education initiative

Survival Guide for Better Health Care:
Health Care Safety 101 Training & Resources

Awareness is growing about medical errors, dangers and tragedies stemming from poor quality health care – but, first learning about the true scope and severity of errors, risks, harm and costs is often stunning to most people.

Without effective training or tools, the risks can be significant for deaths, disabilities, injuries, prolonged recoveries and initial and ongoing financial losses. *Survival Guide for Better Health Care* training and tools are designed to help employees and their families avoid medical errors, complications and other forms of poor quality care that can be prevented.

HPN's health care safety resources and services include:

- *Survival Guide for Better Health Care* manual and DVD (with main program plus 30 key topics/stories)
- Group-specific resource reminder (e.g. 800#s, web site), *Ask-the-Doctor* visit tools and wallet cards
- Worksite trainers, train-the-trainer and mail options
- Support for strategy development, customization, implementation and evaluation

Features & Benefits

Survival Guide resources empower and help employees and families:

- Build effective health teams – with a good main doctor
- Improve visits with doctors to improve quality of care, efficiencies and results
- Avoid medical test/diagnostic-related errors, unwanted risks and complications
- Prevent medication/supplement errors, needless risks and complications
- Prevent surgery-related errors, infections and complications
- Improve use of key resources available through the employer and health plan
- Avoid financial and other losses – personal, family, health plan and employer

Results & Returns

With *Survival Guide* resources and initiatives, your organization can:

- Help employees and family members improve the use and quality of health care, prevent needless medical errors, risks, complications, related

tragedies and related expenses, missed work (absenteeism) and loss of income

- Avoid financial losses due to medical errors, poor care, lack of proper planning, other health care consumer competencies and related consequences
- Realize added savings via improved quality of care, healing and consumer skills
- Conserve health care funds by avoiding errors, poor care and related costs – to free up dollars for needed quality care and to offset rising health costs