"Expanding Coverage for the Illinois Uninsured"

Presented to: The Adequate Health Care Task Force
April 26, 2006

By: The Illinois Hospital Association

Overview of IHA Plan*

- Universal/continuous access
- Population based
- Illinois market
- Voluntary compliance
- Funding

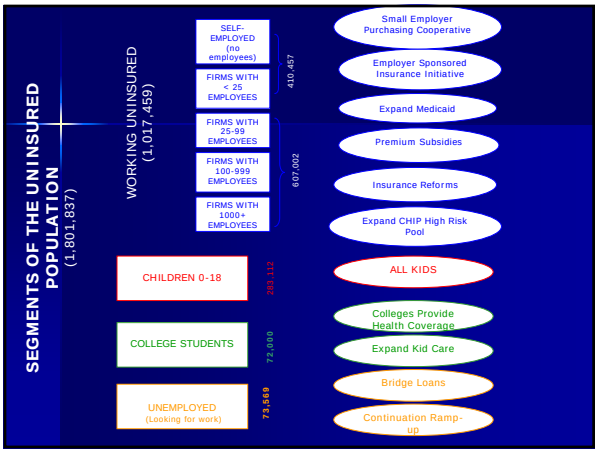
- **Slides are excerpt of detailed proposal given to AHCTF*

IL Uninsured by FPL

- 100% or less = 474,206
- 101-200% = 496,072
- 201-300% = 328,459
- 301-400% = 208,197
- 400%+ = 294,903
- Total = 1,801,837

IHA Plan Building Blocks

- Working Uninsured
- Children 0-18
- Non-Workers/College Students
- Unemployed



WORKING UNINSURED

Employer Size	Uninsured
<25/self-emp	410,457
25-99	181,744
100-999	169,360
1000+	255,898
	1,017,459

5 Solutions

- Small employer purchasing pools
- Expansion of Medicaid for parents
- Vouchers
- Insurance market reforms
- Preexisting condition CHIP pool changes

CHILDREN 0-18

283,112 uninsured

1 SOLUTION:
-All Kids

NON-WORKING & COLLEGE STUDENTS

427,697 non-workers/72,000 college uninsured

2 SOLUTIONS:
-College requires health coverage
-Expand Kid Care

UNEMPLOYED

73,569 uninsured

2 SOLUTIONS:
-Bridge loans
-Continuation extension

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EXPANDING COVERAGE FOR THE ILLINOIS UNINSURED:
A PROPOSAL BY THE ILLINOIS HOSPITAL ASSOCIATION

EXPANDING COVERAGE FOR THE ILLINOIS UNINSURED: A PROPOSAL BY THE ILLINOIS HOSPITAL ASSOCIATION

March 21, 2006

INTRODUCTION

The Illinois Hospital Association (IHA) represents 200 hospitals, institutions that are the foundation of our state's health care system. Our core principles include protecting and expanding access to health care and health care coverage. Expanded access to and coverage for health care benefits must be achieved without eroding coverage for those currently insured. This report presents IHA's approach for covering the uninsured. It will be the measure by which we evaluate other health care reform proposals. **This report forms the basis of IHA's plan to be considered by the Adequate Health Care Task Force (AHCTF) as prescribed by the Health Care Justice Act (HCJA).**

The primary and overwhelming reason for individuals not being insured is the cost of insurance. Rather than recommending an approach that forces coverage on the uninsured through employer or individual mandates, the IHA proposes to remove the financial barriers to coverage. We believe that by making insurance affordable to the uninsured and educating them about the benefits and availability of coverage, a substantial portion of the uninsured population will become insured. This plan would help society meet its obligation to make affordable coverage available to the uninsured, while encouraging the uninsured to take personal responsibility to obtain coverage to protect their health and well-being.

Accordingly, IHA's plan on covering the uninsured offers several market-based strategies that are targeted at specific segments of the uninsured population. It has been crafted based on today's economic, political and insurance environment. It is our belief that this plan presents realistic strategies that can be achieved in the current environment. Other, more aggressive options could be pursued. However, they likely lack the widespread public support necessary to be viable.

Making coverage affordable and available to the Illinois uninsured population, even on a voluntary basis, will still entail significant funding requirements. Funding will need to come, in part, from state tax revenues. In addition to the funding needs outlined, adequate reimbursement rates must be offered to health care providers by state programs, including Medicaid. Otherwise, Illinois would essentially replace the coverage problems of the uninsured with access problems for everyone as more and more health care providers would be unable to serve any other population under such severe financial constraints.

HEALTH CARE JUSTICE ACT (HCJA)

It is the goal of the HCJA to ensure that all residents have access to quality health care at affordable costs and that by July 1, 2007, the State will be strongly encouraged to implement a health care access plan that:

- provides access to a full range of preventive, acute, and long term health care services;
- maintains and improves the quality of health care services offered to Illinois residents;
- provides portability of coverage, regardless of employment status;
- provides core benefits for all Illinois residents;

- encourages regional and local consumer participation;
- contains cost-containment measures;
- provides a mechanism for reviewing and implementing multiple approaches to preventive medicine based on new technologies; and
- promotes affordable coverage options for the small business market.

While not every area required in the HCJA is addressed in the IHA proposal, this plan represents a significant and practical step toward insuring the uninsured in Illinois.

FORECAST

This proposal is based upon the following assessment of the environment.

- **General.** Having health insurance is associated with receiving appropriate care and better health outcomes. In Illinois, about 56% of health insurance coverage is employer based; 4% individual coverage; 13% Medicaid; and 13% Medicare, leaving 14% uninsured. Coverage varies significantly by employer size, with 55% of the smallest employers and 92% of the largest employers offering coverage. Employer-based coverage is expected to continue to decline over the next five years as part-time and temporary workers increase; public program coverage will remain stable even under substantial state budget pressures.

- **Uninsured.** The erosion of employer-sponsored coverage and the increase in population will lead to growth in the uninsured population. While the public, by a 2-1 margin, prefers a universal health insurance program to the current employer-based system, that support becomes conditional if it means limited choice of physicians or waiting lists for non-emergency treatment. Additionally, a majority of Americans are not willing to pay more in taxes or premiums to achieve universal coverage. Illinois hospitals serve as the safety net for 1.8 million residents who are uninsured. The growth of the uninsured population will further strain the resources of safety net hospitals/providers and emergency rooms.

- **Employer-Based Insurance.** Health and retirement benefits for Illinois workers will decrease over the next 10 years as more companies seek to reduce costs and premiums continue to rise. Because the wage base is not keeping up with health spending, employers and patients alike will feel the pressure and workers will increasingly likely decline coverage. Smaller employers will elect to continue dropping health benefits altogether or discontinue subsidized dependent coverage. The fundamental shift of cost bearing from the employer to the consumer and provider of services will increase. Consumer-driven health plans paired with Health Savings Accounts (HSAs) will likely gain market share.

  Active employees currently pay 23% of the health care burden and will likely pay greater percentages in the next 5-10 years given insurance cost increases. The rise in out-of-pocket payments cause delays in seeking health care and many may not buy insurance at all. Increased costs will disproportionately affect sicker patients, patients with chronic conditions, and patients who require expensive medications or are hospitalized. As employers and insurers lobby to have maximum flexibility in coverage, seek repeal of mandated benefits and changes to out-of-pocket and lifetime benefit maximums, pressure will be put on patients and providers to pick up those costs. In the end, the uninsured and underinsured populations will increase significantly.

- **Individual Insurance.** Individual-based coverage in Illinois is sparse and expensive. The HIPAA-CHIP pool provides a safety net for those who cannot buy insurance in the individual market; but this coverage is expensive. The size of the HIPAA-CHIP pool will grow with economic downturns. There will be public pressure to make this coverage more affordable and expand it (or other state insurance pools) as employers, especially self-insured employers, move people from the private employer-based insurance system to the public pool.

- **Medicare.** On average, the Medicare program covers 91% of hospital costs in Illinois. Further pressure will build as the population grows and spending as a percentage of gross domestic product doubles in 25 years. In addition to a population growth of 1% per year, the baby boomer generation will start impacting Medicare significantly in 2010.

- **Medicaid.** The Medicaid program covers most beneficiary costs and, on average, 73% of hospital costs in Illinois. Initiatives to expand Medicaid eligibility, maintain current payment rates and stabilize payment cycles will be challenged by the State's budget deficit. Illinois will continue to try to maximize federal dollars to increase Medicaid rates and increase coverage. Providers will continue to be underpaid by the Illinois Medicaid program and pressure will build to redefine medical benefits or restrict eligibility.

ILLINOIS' UNINSURED

To analyze and recommend solutions for reducing the number of uninsured, IHA looked at the uninsured population as a percentage of the total number of uninsured. In 2004, the number of Illinoisans without health insurance stood at 1.8 million or 14% of the population with the following characteristics[1]:

Illinois Uninsured by Age

Age	*% of Uninsured*
0-18	19.5%
19-29	32.2%
30-49	34.3%
50-64	14.0%

Illinois Uninsured by Educational Status

Level of Education	*% of Uninsured*
Less than High School	25.0%
High School Graduate	62.0%
College Graduate	13.0%

[1] The following tables are based on an analysis of the March 2004 ASEC Supplement of the Current Population Survey.

Illinois Uninsured by Employment Status

Employment status	*% of Uninsured*
Full time	52.0%
Part time	14.7%
Non-worker	28.5%
Unemployed	4.8%

Illinois Uninsured by Income

Income Level	*% of Uninsured*
Under $25,000	40.2%
$25,000-$50,000	27.6%
$50,000-$75,000	16.0%
Over $75,000	16.2%

Illinois' Uninsured by Federal Poverty Level

Category	*100% Or <*	*101 to 200%*	*201 to 300%*	*301 to 400%*	*401%+*	*TOTAL*
Workers at firms<25 empl	80,323	118,667	94,735	29,533	87,198	410,457
All other workers	98,822	153,596	118,712	110,353	125,519	607,002
Children 0-15	73,816	89,619	51,125	28,481	40,071	283,112
Non-workers	191,531	111,346	56,364	38,167	30,289	427,697
Unemployed	29,714	22,842	7,525	1,662	11,826	73,569
TOTAL						1,801,837

PRINCIPLES FOR EXPANDING HEALTH CARE COVERAGE

IHA believes it is not acceptable to allow our current health care delivery system to become less and less able to meet patient needs. This plan is based upon the following principles:

- Move Illinois towards universal and continuous access to health insurance coverage, using the strengths of a pluralistic private and public system. Begin with a population-based plan that focuses on those sectors that need greatest assistance and choices.

- Provide access to affordable health insurance benefits for all individuals, whether employed or not.

- Develop an insurance product that provides basic coverage, including emergency care, inpatient hospital and physician care, outpatient services, mental health and substance abuse services and has reasonable out-of-pocket expenses.

- Maximize federal funding for state health care programs to improve access for the uninsured while paying providers enough to cover rising costs and support the infrastructure.

- State health care programs, such as Medicaid must be adequately funded and paid in a timely fashion. Investing in this system improves the health of our state's children and families as well as the economic and social stability of our communities.

- General tax revenues are the preferred way to finance coverage for uninsured persons not connected to the workplace, whose coverage is society's responsibility.

- Provide access to care in rural and underserved areas so that it is available in every community without extensive travel.

COVERAGE EXPANSION PROPOSAL

Because the uninsured population is multi-faceted we are proposing a population-based plan based on market reform and voluntary compliance. The chart at the end of this report outlines the building blocks for providing access to segments of the uninsured population. It is suggested that while ultimately universal coverage may in fact require employer and individual insurance coverage mandates, we begin with proposing voluntary coverage approaches. The State's uninsured issue cannot be solved overnight and therefore an infrastructure must be created to provide universal coverage by first addressing different sectors of the uninsured.

I. Working uninsured

(A) Establish small employer initiatives providing access to a safety net benefit package.
(B) Expand Medicaid for parents from 185% to 200% of the federal poverty level.
(C) Implement premium subsidies for the working uninsured at or below 200% of the federal poverty level.
(D) Review and implement regulatory and legislative changes that can lower the price of insurance.
(E) Expand the CHIP high-risk pool for those with pre-existing conditions.

II. Children 0-18 (*already addressed by All Kids Program)*

III. College students

(A) Illinois colleges and universities should be required to include at least a basic benefit package as part of tuition and fees.
(B) Expand Kid Care to 18 – 22 year olds enrolled full time in college with incomes up to 200% of the federal poverty level.

IV. Unemployed

(A) Bridge loans
(B) Expansion of continuation coverage

I. THE WORKING UNINSURED

IHA proposes that the initial emphasis of the State's Plan to increase insurance coverage should be to build on the existing employer-based system by focusing on strategies that will expand access to coverage for the working uninsured. The following strategies for doing so are suggested.

(A) SMALL EMPLOYER INITIATIVES[2]

Provide Access to Coverage for up to 410,457 Uninsured Employees of Small Firms (Self-Employed and Firms with <25 Employees)[3]

(1) SMALL EMPLOYER PURCHASING COOPERATIVE (SEPC)

It is proposed that the State establish a statewide Small Employer Purchasing Cooperative (SEPC) to assist self-employed individuals and small businesses (i.e., those with fewer than 25 employees) to come together to purchase health coverage, thereby reducing their costs. To further assist in making this coverage affordable, the SEPC would be allowed to purchase a limited benefit plan – the Safety Net Benefit Package described below. The SEPC would be administered and operated in a manner similar to programs currently offered under the Illinois Comprehensive Health Insurance Plan (CHIP).

The key characteristics of the SEPC include:

- Participation is limited to self-employed individuals and employers with less than 25 employees, provided that the employer has not offered health insurance for the previous 12 months (to avoid crowd out).
- Employers must commit to 12 months continuous participation, with similar and binding periods of renewal in order to avoid adverse risk selection and promote program stability.
- Employers may not offer another health plan and participate in the SEPC.
- The SEPC will offer the Safety Net Benefit Package, as described below. More comprehensive benefit plans or additional benefits to the Safety Net Benefit Package (e.g., dental, vision) may also be offered by the SEPC.
- Employers must pay at least 60% of the monthly premium of the Safety Net Benefit Package for each participating employee.
- Employees and their spouses are eligible to participate in the SEPC, provided that they are not eligible for any other private or public health coverage (e.g., spouse's health plan, Medicare, Medicaid, etc.)
- Employees may use vouchers for low-income, uninsured employees (described below) to pay for their share of the monthly premium.
- The SEPC is to be administered in a manner similar to the existing Illinois CHIP. To enlist sufficient providers and thereby enhance access to care, payment rates to providers would be negotiated by the SEPC Administrator and be comparable to existing private market rates.

[2] After evaluating the impact and effectiveness of these proposals during a pilot period, it is possible that they could be expanded to larger employers.

[3] Where possible, estimates of the potential impact of a proposal are included, however uninsured individuals may benefit from more than one strategy.

(2) EMPLOYER SPONSORED INSURANCE INITIATIVE (ESI)

It is proposed that the State establish an Employer Sponsored Insurance Initiative (ESI) that would allow self-employed individuals and small businesses (i.e., those with less than 25 employees) to purchase through the State a limited benefit plan – the Safety Net Benefit Package described below. This proposal (patterned after a similar Arkansas program that was recently approved by the federal government) could be structured to enable the State to receive federal Medicaid funds to make the program more affordable. Because this program would be operated under the State's Medicaid program, the rates paid to health care providers would be the same as the State's Medicaid rates.

The key characteristics of the Employer Sponsored Insurance Initiative include:

- Employer participation in the ESI is voluntary.
- Participation is limited to self-employed individuals and employers with fewer than 25 employees, provided that the employer has not offered health insurance for the 12 months prior to enrollment in the program (to avoid crowd out).
- Employers must commit to 12 months continuous participation, with similar and binding periods of renewal in order to avoid adverse risk selection and promote program stability.
- Employers participating in the program must have all employees, regardless of income, participate in the plan, unless the employee demonstrates health coverage through another source (e.g., through a spouse or parent).
- Employees and their spouses are eligible to enroll in the ESI.
- The ESI will provide the Safety Net Benefit Package, as described below, to participants in the program who do not qualify for the State's traditional Medicaid program (e.g., because their income is too high).
- To fund the program, participating employers will pay an amount to the State in the form of a tax. The employer will pay the same amount of tax per employee, regardless of the employee's income level. This pool of funds will be used to draw down federal matching funds for those ESI participants who are eligible for Medicaid and to pay the full share of the costs incurred by those ESI participants who are not Medicaid eligible.
- The amount of each employer's tax will be calculated based on the size of the business and will be paid prospectively on a quarterly schedule to coincide with existing State and Federal tax commitments. Employee coverage will be initiated on the first day of the month following the tax payment from the employer.
- The ESI program will require the approval of the federal government under either a Health Insurance Flexibility and Accountability (HIFA) waiver under Title XXI of the Social Security Act or a Section 1115 Demonstration Waiver under Title XIX of the Social Security Act. The ESI program would be administered by the Department of Healthcare and Family Services.
- ESI participants are not eligible for the premium subsidy described below.

(3) SAFETY NET BENEFIT PACKAGE

To provide health care benefits while keeping the premiums affordable, a safety net benefit package for employers who have not previously offered health insurance should be available under the Small Employer Purchasing Cooperative (SEPC) and Employer

Sponsored Insurance Initiative (ESI). The safety net benefit package is not intended to provide comprehensive protection, but is designed to provide coverage for preventative care and reflect the core components of basic major medical protection. By limiting the benefits covered, it will be more affordable, thereby enabling small employers to at least provide basic health coverage to their employees.

Since the uninsured in small firms have relatively moderate incomes, it is suggested that the monthly premium for the safety net benefit package not exceed $150. Ultimately, if federal approval is obtained for the employer sponsored initiative, the cost of this benefit package will likely be less because the ESI is based on the payment of Medicaid rates, whereas the SEPC is based upon the use of private sector provider payment rates.

In designing this benefit package, there are three mechanisms that can be used to keep the cost at the desired level:

- Deductible(s)
- Coinsurance
- Annual cap on benefits

It is suggested that the deductibles for the safety net benefit package be $100-$250 based on a sliding scale of federal poverty level. In addition, it is suggested that coinsurance be no more than 15%-20% for in-network services. The deductible and coinsurance would apply to everything except pharmacy where there would be a three tiered co-pay structure.

Given the above, reducing the cost of the "typical" Illinois PPO plan benefit package (inpatient, outpatient, physician services, emergency room, wellness benefits and a prescription drug card) to $150 per month, will likely require service/unit restrictions and an annual cap on expenditures. While there will need to be further analysis and consideration before finalizing the Safety Net Benefit Package, it is suggested that three methodologies be considered in developing an actuarially sound rate at or below $150 per month:

- One methodology would be to use service/unit restrictions such as:

7 inpatient days per year
2 outpatient visits per year
6 physician/clinic visits per year
    Associated laboratory, x-ray services only associated with one of the visits outlined above
2 prescriptions per month

- A second methodology would be to apply an aggregate annual cap to coverage. For example, the total benefits for a year could be limited to $25,000 or $50,000.

- A third methodology would be to use a combination of service/unit restrictions with an aggregate annual cap.

Once the benefit package is fully defined, the State should consider implementing a reinsurance pool to provide a second layer of coverage over the annual benefit cap, i.e.,

reinsurance for $50,000 - $100,000 of coverage. Skilled nursing facility, dental and vision services are not to be included in the Safety Net Benefit Package and could be made available for purchase from both programs for an additional fee.

(B) EXPAND MEDICAID FOR PARENTS FROM 185% TO 200% OF FPL

Currently, the State of Illinois provides Medicaid coverage for parents of children with incomes at or below 185% of the federal poverty level (FPL). Children are eligible for Medicaid if their family's income is at or below 200% of the FPL. Consequently, it is proposed that the eligibility standard for parents be increased from 185% to 200% of the FPL. Not only would this cover more lives, but it would also mirror the FPL used to determine the children's eligibility in the same home.

(C) PREMIUM SUBSIDIES FOR LOW INCOME, UNINSURED EMPLOYEES

Provide Access to Coverage for up to 451,410 Uninsured Employees

There are approximately 450,000 individuals who are currently employed with incomes at or below 200% of the federal poverty level (FPL), but who do not have health insurance. Many of these persons have access to health coverage through their employers, but cannot afford the employee portion of the monthly premium.

The State should provide premium subsidies in the form of health insurance vouchers to assist employees with incomes at or below 200% of the FPL to obtain health insurance through their employers. The key characteristics of this voucher system would include:

- Available to employees with incomes at or below 200% of FPL.
- Recipients must have applied for the State's medical assistance program.
- Voucher can only be used to purchase health insurance.
- The voucher amount would be about $37 per month. This amount is equal to 25% of the Safety Net Benefit Package offered under the Small Employer Purchasing Cooperative described above, which is estimated to cost no more than $150 per month.
- This voucher system could be administered by the Department of Revenue building on its experience in administering employment taxes and the senior citizen prescription drug program.

Two options for structuring this voucher program were considered. First, the vouchers could be available to all qualified employees, even if they are currently insured. Alternatively, the vouchers could be limited to only those employees who are currently uninsured. IHA is recommending the former approach because it does not penalize those low-income individuals who have purchased insurance, recognizing that it will cost significantly more. However, if it were necessary to limit eligibility for these vouchers because of cost concerns, IHA could support that approach.

(D) INSURANCE MARKET REFORMS

In addition to the specific programs described above, further analysis of three legislative/regulatory issues that could lower insurance rates is strongly encouraged. These approaches are voluntary and focus on insurance market dynamics. Therefore, it is

difficult to predict the precise extent to which these reforms will assist in making health insurance more affordable for the uninsured population. The three insurance market reforms include:

(1) GOVERNMENT FUNDED REINSURANCE

The State should consider the creation of a reinsurance program in Illinois to assist in subsidizing health insurance for small groups and low-income workers based on need. Reinsurance is “insurance for insurance companies.” In theory, government-based reinsurance rests on the principle that insurers need relief from the risk of "adverse selection," which occurs when a disproportionate share of the people applying for insurance policies expect to have extraordinarily high medical costs in the coming year. When this happens, insurers could be forced into bankruptcy. But if the state or federal government creates a program that assumes responsibility for the bulk of these extreme expenses, insurers have less reason to fear adverse selection. With such programs in place, insurers can significantly lower premiums.

Reinsurance can be linked to several strategies to make coverage more affordable, such as purchasing pools and small business insurance products. For example, the State could provide subsidies to make insurance more affordable for small businesses and low-income workers. Reinsurance can serve as a vehicle for the subsidy. If the state does not choose to apply a subsidy using reinsurance, reinsurance has other advantages. Reinsurance can smooth price volatility in existing markets by spreading or transferring risk. Specifically, the pool could operate as a risk transfer plan for all carriers providing health insurance in the State or just those participating in the small employer initiatives. Under this program, carriers would be able to forward claims above a certain level to the pool for payment. The process would be invisible to the enrollee. The carrier ceding the risk would pay premium into the pool per rules established by the pool itself that take into account a risk corridor for the carrier and proportional assessments on carriers. Thus, reinsurance in Illinois must be reviewed both in terms of an overall reinsurance program for the small group market, and also one that is specifically targeted at the Small Employer Purchasing Cooperative and the voucher programs described in this paper.

(2) REGULATION OF THE SMALL GROUP MARKET

Small employers face unique challenges in purchasing affordable coverage for their employees. In general, these employers may purchase coverage from companies that can vary premiums due to the age, gender, and health status of a company’s workforce. Premiums can also be raised when these employers try to renew their plans. To reduce the cost and access issues associated with the small-group insurance market, further changes in current insurance law may be helpful.

Specifically, the Small Employer Health Insurance Rating Act is designed to improve the "efficiency and fairness of the small group health insurance marketplace" by reducing the magnitude of increases charged to small employer groups when one or more of their members develop a costly medical condition. To help control costs, the Act restricts the range of rates which can be charged to groups that have similar policy coverages and demographic, geographic, or other objective group characteristics. It also restricts the amount by which small group carriers can increase rates for a particular group due to its claims experience. Although there are no specific numerical caps on premium rates or

premium increases, the overall effect of the Act is to compress the range of rates and rate increases that can be charged for all small employer groups of a particular class. In order to cover more uninsured individuals and small groups, further restrictions on underwriting or rates can be pursued.

(3) IMPROVE THE HEALTH CARE PURCHASING GROUP ACT

The State should examine possible reforms to the Health Care Purchasing Group Act. This law allows the formation of a health purchasing group in Illinois by two or more employers with no more than 500 covered employees by a sponsor or risk bearer. This Act has not been used extensively in Illinois. A first step in considering its reform would be to seek input from employers to determine why it has not been widely utilized. If modified, it could be a useful mechanism for encouraging employers to aggregate purchasing power to lower the cost of insurance benefits.

(E) EXPAND CHIP HIGH RISK POOL FOR PERSONS WITH PREEXISTING CONDITIONS

The State's high risk pool that offers comprehensive health insurance benefits to individuals with pre-existing health problems should be expanded to provide comprehensive coverage **and vouchers** to persons rejected from coverage due to preexisting medical conditions. These vouchers could be provided on a sliding scale basis tied to the individual's income and other resources. Further research is needed to ascertain the number of uninsured persons with pre-existing conditions. It is assumed that any vouchers provided to this population would be costly, but necessary to enable these individuals to obtain coverage.

The premiums in this current pool are set by law and rule and are approximately 135 percent of the average market rate. Seven states have started low income premium subsidy programs for these risk pools – Wisconsin, Connecticut, New Mexico, Oregon, Colorado, Washington and Montana. Montana was recently awarded a special federal pilot grant for $1.25 million to subsidize premiums for people with incomes less than 150% of poverty in the Montana Comprehensive Health Association. The premiums were reduced by 50% during the pre-existing condition waiting period and 40% afterwards. Under such an approach, Illinois would expand funding for low-income uninsurable individuals so that they could afford the higher cost of the State's high risk pool coverage and for the additional losses that would occur in the pool itself.

II. CHILDREN 0-18

ILLINOIS ALL KIDS PROGRAM

Provide Access to Coverage for up to 283,112 Uninsured Children

The *All Kids* program will offer Illinois' uninsured children 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 will pay monthly premiums for the coverage, but rates for middle income families will be significantly lower than they are in the private market. This program is scheduled to begin on July 1, 2006.

III. COLLEGE STUDENTS

Provide Access to Coverage for up to 72,000 uninsured students over age 18

(A) COLLEGES PROVIDE HEALTH COVERAGE

It is suggested that the State should consider requiring colleges and universities to include a minimum health benefit package as part of tuition and fees. By making it part of the tuition and fees, scholarships and college loans could be used to pay for the coverage. While there may be resistance to this proposal because of the dramatic increases in the cost of higher education, it is appropriate to require such coverage since it can be obtained for relatively low cost.

(B) EXPAND KID CARE FOR COLLEGE STUDENTS

It is suggested that the State expand Medicaid coverage for full-time college students (age 18 - 22) who have incomes at or below 200% of the federal poverty level. The Medicaid program allows states to provide coverage to persons age 18 to 22 who are enrolled as full-time students.

IV. UNEMPLOYED

Provide Access to Coverage for up to 73,569 Uninsured Individuals

(A) BRIDGE LOANS

It is proposed that bridge loans from the State be provided to help workers maintain their coverage when they become unemployed. This loan would have to be used to continue the individual's health coverage under COBRA or the State's Continuation Law. Individuals eligible for such loans would have the following characteristics:

- lost their access to employer-based health care coverage because of voluntary or involuntary job change; and
- had continuous creditable coverage for a specified period (for example, 12 months) of time before losing such access.

These individuals would qualify for a no-interest health care bridge loan from a state-based loan program for a specified period, such as 12 months. Recipients of unemployment insurance could receive the loan as part of their unemployment benefits. Loan amounts would be set at a substantial percentage of premiums. Individuals would begin to repay their loans within a specified number of months after beginning a new job**.**

(B) CONTINUATION COVERAGE EXTENSION

It is proposed that the Illinois Continuation Law be expanded to provide coverage for up to eighteen months after the date insurance stops, from the current nine month period. This change would result in the Illinois law mirroring the federal COBRA law.

The Illinois Continuation Law protects individuals who lose their group health insurance coverage with an employer group of any size due to termination of employment or reduction in hours. This protection is generally for small employer groups because COBRA only covers employers that hire 20 or more employees. Currently, continuation coverage must be provided for nine months after the date insurance stops because employment is terminated or hours are reduced. It can be terminated earlier under specified circumstances. Once continuation ends or during the continuation period, an individual and dependents may convert the coverage to an individual policy or enroll in the State's HIPAA CHIP plan if there is a precluded medical condition. The law does not apply to individuals covered by Medicare or any other insurance plan.

The premium for Illinois continuation coverage may not exceed that of the group rate and an individual is responsible for paying the entire premium for the coverage, including the portion which was formerly paid by the employer. Benefits for hospital, surgical or major medical are the same as they were under the individual's previous group coverage. However, dental, vision care, prescription drug benefits, disability income, specified disease benefits and supplementary benefits are not required and may no longer be available under the continuation coverage.

INFORMATION REPORTING & PUBLIC EDUCATION

The development of this proposal was especially challenging due to a lack of sufficient data and information related to health care coverage. To assist policy makers in the future in making informed judgments on this topic, it is suggested that individuals and employers should be responsible for reporting their coverage or coverage options, so the State can evaluate changes in health care coverage. Specifically, the state should: (1) require individuals on their state tax return to report their individual/family health insurance coverage status; and (2) require employers to report to the state coverage information with respect to insurance plan or plans available, the take-up rate of the plan(s), as well generally report the category of benefits offered.

In addition, individuals and families who do not obtain health insurance at the place of work or do not have Internet access to health plans often do not know how or where to secure affordable coverage. The State should assist in educating the public by making information available in an easy and accessible way through agencies or local providers. In addition, there must be intensified efforts to enroll adults and children who are eligible for Medicaid, SCHIP and other state programs.

CONCLUSION

The Illinois Hospital Association (IHA) believes that this proposal is a thoughtful plan for providing access to health insurance for Illinois' uninsured population. While this proposal does not address every subject specified under the Health Care Justice Act, IHA believes that this plan sets forth a practical and necessary first step in achieving universal coverage.

The plan:

- Focuses on overcoming the single most important barrier that prevents individuals from obtaining health insurance – cost.

- Is population based, recommending strategies that are targeted at specific segments of the 1.8 million uninsured Illinoisans.

- Builds on existing private and public sector insurance programs in order to make coverage more affordable for employers and individuals, without imposing employer or individual mandates.

By employing the options described in this plan, the State of Illinois would make health insurance more affordable and available to uninsured Illinoisans. Although there is no guarantee that all uninsured persons would actually take advantage of these options, it is clear that the plan would significantly increase access to affordable health insurance and be a significant first step toward reducing the number of uninsured individuals.

As the value of coverage becomes apparent, more employers and individuals will choose to participate, leading to virtual universal coverage through voluntary participation and, if necessary, setting the stage for a mandated approach in the future.

On behalf of its 200 hospital members, and the communities they serve, the IHA urges the Adequate Health Care Task Force to select the IHA proposal for further review.

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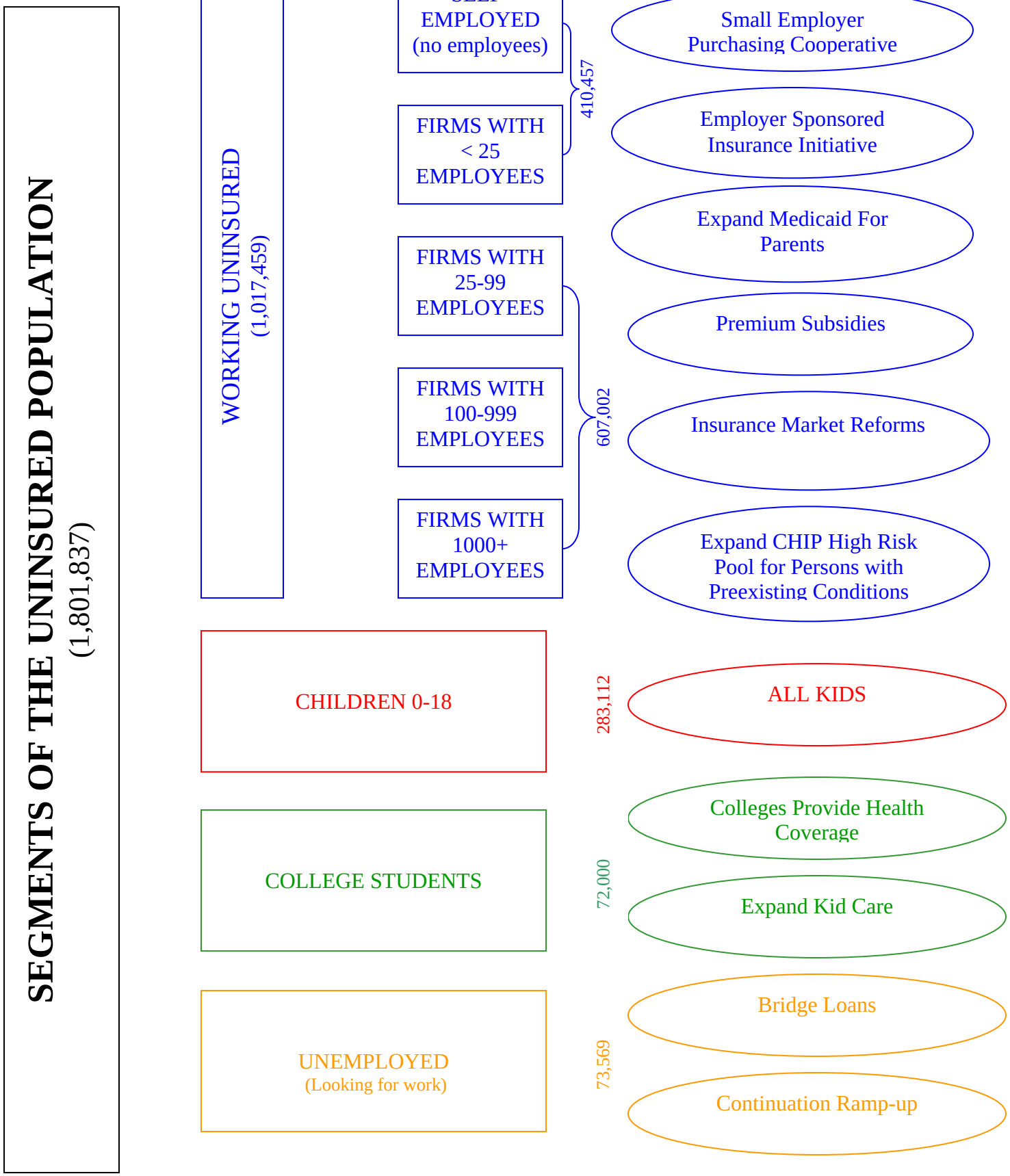

NOTE: College students represent 72,000 of 427,697 “non-workers.” Non-workers consist of dependents, college students, ill & disabled, retired and other individuals. Some of the categories described herein are addressed in other circles.