AmeriCare-Choice

Setting a Course Toward Universal Health Care
Bobby Peterson, ABC for Health, Inc.
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# AmeriCare-Choice

## Table of Contents

*About ABC for Health*  
*Acknowledgments*  
*Executive Summary*  

I. Structure  
II. Eligibility  
III. Benefits  
IV. Administration  
V. Appeals Process  
VI. The Office of Health Care Outreach and Advocacy  
VII. Financing  
VIII. Implementation  
IX. Legislative Imperatives  
X. Stakeholders—Roles and Reactions  

AmeriCare-Choice and Washington: A Comparison to President Obama’s Reforms  

Conclusion  

*Appendix I*  
*Appendix II*  

*Endnotes*
About ABC for Health

ABC for Health, Inc. is a Wisconsin-based nonprofit public interest law firm dedicated to linking children and families, particularly those with special health care needs, to health care benefits and services.

Our Mission
ABC for Health, Inc.’s mission is provide information, advocacy tools, legal services, and expert support needed to obtain, maintain, and finance health care coverage and services.

Our Vision
ABC for Health, Inc., a nonprofit, public interest law firm, will develop a nationally recognized, integrated model of Health Benefits Counseling, legal services, and policy advocacy that promotes a universal system of health care coverage and access for all people. We will develop multi-purpose education strategies to inform customers, providers, and the broader community of health care coverage options while also advocating directly for individuals disenfranchised from health care coverage and services. ABC for Health, Inc. will also serve as a catalyst in the development of local HealthWatch Coalitions as well as other partnerships and strategic alliances to influence public policy and opinion while also working to maximize all available health care coverage options for all people.

Our Experience:
For the past fifteen years, ABC for Health has provided services to families statewide. The experience and expertise gained from these daily interactions with individuals and one-on-one counseling with patients in a hospital setting serves as the foundation for much of ABC for Health’s proposal.

About the Author:
Robert “Bobby” Peterson, Jr. is a 1987 graduate of the University of Wisconsin Law School. Born in Milwaukee and raised in Butler, Wisconsin, Bobby is the founder and Executive Director of ABC for Health, Inc., a nonprofit, public interest law firm in Madison, Wisconsin dedicated to helping individuals connect to health care coverage and services. Bobby is a national consultant on issues pertaining to financing health care coverage and services and participates in policy discussions at the state and national level, serving on numerous boards and advisory committees regarding the health care system, particularly the expansion of health care coverage programs.
Acknowledgments:

How can I possibly thank the thousands of contributors to the AmeriCare-Choice Plan? It won’t be easy, but here goes! ABC for Health, Inc. developed the AmeriCare-Choice Plan over a series of years with contributions from staff, students, and clients of our firm. Therefore, the plan includes essential “ground-level” perspectives often overlooked in many health reform proposals. ABC for Health originally developed the 2003 Pathway Plan with then-student Atty. Margret Hillman playing an instrumental role in drafting. In 2009, we revisited the proposal and updated significant sections to reflect today’s realities. ABC for Health Attorneys Erin and Brynne McBride made significant contributions to this version including edits and graphic design elements. In addition, student Marysa LaRowe provided research assistance and fact checking for the AmeriCare-Choice plan.

*Thank you to all who play such a vital roll in advocating for a right to health care for all Americans!*  

Respectfully,

*Bobby Peterson*
Executive Summary

As the global economic downturn continues, the crisis in our nation’s health care system worsens. Costs rise, reform stalls, and our country’s fragmented healthcare system currently leaves over 50 million citizens uninsured. The changes various interest groups have proposed to correct our broken system lack strong bi-partisan support: some leaders call for either an all-public, single-payer system, or an insurance industry-driven private market system. Both options will only further the status quo and lead to a stalemate—a victory for some but not all of the public.

We need a program that offers an alternative course toward universal health coverage; one that forges a partnership between public strength and protection, and private sector innovations and choice. We need a program that follows a philosophy of “progressive incrementalism,” with significant and meaningful changes that preserve consumer choice, expand coverage, reduce costs, and avoid the most pernicious and destructive political battles. By incorporating increased risk-pooling, public-private partnerships, administrative savings, and crucial advocacy and outreach services, our proposed program merges interests and offers incentives to all sides of the health reform debate. The proposed program seeks to reduce wasteful spending and offer comprehensive coverage to all Americans. The new program will be called *AmeriCare-Choice*.

The benefits program uses the existing Medicaid architecture as its foundation, then expands on its application through buy-in programs and employer incentives to cover more individuals. Incorporating a wide range of individuals spreads out the risk, increases purchasing power and allows for a more comprehensive benefits package. This group purchasing power is one of the most important leverage points for controlling accelerating costs.

Moreover, a streamlined administration system avoids the red tape and needless administrative costs in the current system, where overburdened health care providers sort through hundreds of different health plans in each state; some are governed by state law, others only by federal law, and others by both. In 2003, dollar amounts ranging from 16.7% to 30% of private health care dollars were spent on administrative costs.

**By the numbers:**

- In 2005, the average national Medicaid payment rate per member per month (pmpm) to contracted health plans was $175.16 for non-elderly, non-disabled adults and $134.75 for children.
- In 2009, the average monthly premium for an individual (employee plus employer contribution) in the Federal Employees Health Benefits Program (FEHBP) is $428.70.
In summary, we propose the following:

- Develop a comprehensive health plan built upon the foundation of the Medicaid program that will provide universal coverage within three years of passage.
  
  The public/private partnership plan will be financed through a combination of government, employer and individual contributions.

- Expand Medicaid eligibility to 300% of the Federal Poverty Level (FPL)—approximately $66,150 for a family of four.

- Create a “buy-in” component that allows private employers, self-employed individuals, and individuals with disabilities who earn over 300% FPL to purchase coverage with a low premium payment.
  
  Private employer dollars can be used to secure additional federal matching funds. The benefits of public employees at the local, school-district, county, and state levels would be handled through the buy-in program, administered through the existing Medicaid/SCHIP administrative structure.

- Create the Office of Health Care Advocacy and Outreach.
  
  This office would contract for, or reimburse Health Benefits Counselors to help consumers identify and obtain coverage and Health System Navigators to assist those with complex medical needs in managing care options. AmeriCare-Choice maintains and expands the core Medicaid hearings and appeals system, while community-based HealthWatch Coalitions comprised of local advocates, providers, social workers, and citizens assist the national oversight efforts by tracking local, regional, and statewide issues and trends.

- Use the Medicaid administrative system already in place to create AmeriCare-Choice. This will eliminate the need for enormous front-end costs and political battles associated with the creation of new benefits and billing structures.

- Continue current disability and senior based Medicaid/Medicare programs.

- Avoid an employer mandate that could potentially intimidate and mobilize small business and others against the plan. Lower costs and more comprehensive benefits will provide an incentive for employers to join the plan.

- Allow states to create their own plans following benefits standards. Larger employers could opt for the state or federal AmeriCare-Choice plan.
• Create a massive bargaining advantage for the states. Private health insurance companies will still bid for business with the states, but larger risk pools will give states greater leverage and purchasing power. Underwriting for risk groups created by employer plans would be part of the contract worked out with the health plan.

• Promote the development of electronic medical records and tools designed to improve efficiency. Electronic medical records will streamline the health care industry, improving efficiency and lowering overall health care costs. Innovative tools include electronic medical records and electronic coverage records to better administer the various health care coverage programs for families.
AmeriCare-Choice

I. Structure

AmeriCare-Choice retains and expands the existing Medicaid structure to create an efficient universal coverage program. Some commentators have justly termed Medicaid’s existing comprehensive benefits structure “Cadillac coverage” in its offering of preventive medicine, primary care, and access to specialists and prescription drugs. Medicaid and SCHIP rely on a public/private-sector partnership that delivers affordable, comprehensive health care to 59 million people in America. The AmeriCare-Choice program will work with this existing benefits structure to avoid the enormous amount of time, capital, and political resources devoted to bickering over a new benefit plan. Moreover, Medicaid has an existing administrative structure and strong consumer and due process protections. The Medicaid program has evolved through pitched political fights since its formation in 1965. There is no justification for spending billions to “reinvent the wheel.” Other reforms that propose to start a health plan “from scratch” will face political battles and debates over every provision, benefit, and administrative role. Retaining and retooling Medicaid to create AmeriCare-Choice is an efficient way to implement health care reform that allows for our goal of achieving universal coverage.

To drive reforms, the AmeriCare-Choice proposal creates larger risk pools based on the Medicaid system at the federal and state/regional level. This building from the base of Medicaid will also significantly increase purchasing power. Further, as seen with the current Medicaid architecture, the public-private partnership costs less to administer than private plans and is, in many cases, less expensive on a per member per month (pmpm) basis than most private health plans. Public programs, including Medicaid, spent 5.7% of their budget on administrative costs in 2007, while the private health industry spent 16.7% to 30.0% on administration.

The Federal Pool

The federal AmeriCare-Choice pool will include civilian, federal employees, members of the military, Veterans, Native Americans, and multi-state corporations seeking to buy coverage for their employees. The federal pool will follow the same benefits schedule and administrative structure as the Medicaid program. It will draw its enrollee base from those already insured under federally run programs and will operate and negotiate on behalf of those enrollees and employers operating in more than one state.
State/Regional Pools

The state AmeriCare-Choice pools will build from a base of current state employees and Medicaid beneficiaries and branch out to state-based employers, self-employed workers, and individual consumers. States will negotiate and oversee the plans for these pools.

AmeriCare-Choice will continue to be a partnership between the federal government and the states. States will retain certain flexibility over how to run their program, but will maintain minimum standards for benefits and coverage and will continue to receive federal matching funds. In addition, because program administration will be the responsibility of private health insurance companies, AmeriCare-Choice will allow for an even stronger partnership between the states and insurance companies.

II. Eligibility

Families and individuals with an income at or below 300% FPL will be eligible for the state subsidized portion of AmeriCare-Choice. When determining income, states should review the applicant’s gross income, disregarding the first $50,000 of depreciation for all self-employed persons and small businesses. States will have the freedom to institute other income disregards.

All children and pregnant women at or below 300% FPL will be presumptively eligible for the program. AmeriCare Choice will eliminate asset tests, as they discourage savings and create needless red tape for enrollees. States will be required to offer twelve months of continuous eligibility so that fluctuations in family income do not result in dropped coverage. Parents can maintain adult dependent children on their plan as long as the IRS considers them a dependent for tax purposes. This will help to reduce the large number of 18 to 25 year-olds who are currently uninsured.

Individuals, families, or self employed persons over 300% FPL will have the option to buy-in to the program by paying premiums. Consumers will also have the option to buy-in to AmeriCare-Choice during open enrollment periods, or anytime there is a change in eligibility due to “no fault of the consumer,” such as the birth of a child, the death of a spouse, the loss of a job, or school graduation.

Adults at 151%-300% FPL and children 201%-300% will have some cost-sharing in the form of low premiums and nominal co-payments for services. Enrollees above 300% FPL will pay premiums to buy-in. (See chart below).
Cost Sharing under AmeriCare-Choice

<table>
<thead>
<tr>
<th>Income</th>
<th>Children</th>
<th>Adults</th>
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<tbody>
<tr>
<td>0-150% FPL</td>
<td>Medicaid, no cost-sharing</td>
<td>Medicaid, no cost-sharing</td>
</tr>
<tr>
<td>151-200% FPL</td>
<td>Medicaid, no cost-sharing</td>
<td>Medicaid, premiums of 3% income, nominal co-payments</td>
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<tr>
<td>201-300% FPL</td>
<td>Medicaid, premiums of 3% income, nominal co-payments</td>
<td>Medicaid, premiums of 3% income, nominal co-payments</td>
</tr>
<tr>
<td>Over 300% FPL</td>
<td>Medicaid buy-in</td>
<td>Medicaid buy-in</td>
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</table>

Citizen Status

AmeriCare-Choice will allow anyone to buy in to the program, regardless of immigration status. For the non-citizen population at or below 300% FPL, the plan will only provide coverage for emergency care and services for pregnant women. Non-citizen individuals, families, or self employed persons over 300% FPL will have the option to buy-in to the program by paying premiums.

Deterring Adverse Selection

The program will institute a waiting period for enrollees who voluntarily drop their private coverage. Additionally, a restrictive re-enrollment penalty will deter people from enrolling only when they anticipate medical costs. Consistent with Medicaid rules, enrollees at or below 300% FPL will not face pre-existing condition exclusions. To combat adverse selection, individuals enrolled through the buy-in component would be subject to a three-month waiting period. All plans will follow Health Insurance Portability and Accountability Act (HIPAA) requirements.

III. Benefits

At a minimum, states will be required to maintain their existing benefits packages for the Medicaid-eligible population in AmeriCare-Choice. Federal regulations currently require states to cover inpatient and outpatient hospital services; physician, midwife and certified nurse practitioner services; laboratory and imaging; nursing home and home health care; early and periodic screening, diagnosis and treatment (EPSDT) for children under age 21; family planning; mental health and substance abuse treatment; and care received at rural health clinics or federally qualified health centers. Children are eligible for all medically necessary services. The Medicaid model includes equal physical and mental health benefits. AmeriCare-Choice will be consistent with the 2008 Mental Health Parity Act legislation that applies to large private plans.
States also have the authority at present to cover additional services and receive federal matching funds, with the most common services including prescription drugs, dental services and hearing aids. While states will have to provide for necessary prescription drugs, they will have the latitude to dictate which structure they prefer for the provision of those drugs. For instance, several states are currently joining with neighboring states to form purchasing pools for the purpose of negotiating lower drug prices with pharmaceutical companies. Practices like these are permissible, as is the development of formularies, so long as there is a reasonable number of medications available to consumers.

The program will mandate that all children at or below 300% FPL receive the full federal Medicaid package with AmeriCare-Choice, rather than a reduced SCHIP benefit package. Adults may receive a benefits package that is similar to the current SCHIP package; i.e., the Blue Cross-Blue Shield option under the Federal Employee Health Benefits Plan, or the HMO coverage with the largest enrollment in the state. States will continue to comply with any relevant federal statutes pertaining to benefits.

AmeriCare-Choice coverage for buy-in enrollees above 300% FPL will be actuarially equivalent to the benefits mandated under SCHIP. However, states will have more flexibility to negotiate with insurance companies when determining the benefits packages for the buy-in option. Presumably, the insurance companies that contract with the state will offer a range of benefit plans so that consumers will retain the choice that they generally have in the current market. Private insurance companies may offer benefit packages that are more extensive than the minimum benefit package for a slightly higher price, but all plans must meet the minimum benefit requirements. Further, AmeriCare-Choice will allow states to capitate monthly premiums.

Finally, AmeriCare-Choice will require that all plans make information available online, including cost information, appeals policies, physician networks, and other relevant information for consumers as determined by the state.

**AmeriCare-Choice Benefits Package**

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Dental services
- Family planning services and supplies
- Laboratory and imaging
- Mental health and substance abuse treatment
- Occupational, physical, and speech therapies
- Early and periodic screening diagnosis and treatment (EPSDT)
- Prescription medications
IV. Administration

AmeriCare-Choice will operate under a partnership between state and private administration, based on an expansion of the Medicaid Managed Care model. State governments, private insurance companies, and employers will all share the significant role of administering and implementing care.

Federal and State Government

The program will promote state flexibility in administration and regulation of their plans. The federal government will continue to work with the states and approve state plans to ensure compliance with minimum standards, but states will be at liberty to customize their plans to accommodate the needs and preferences of their residents. States will receive matching funds from the federal government, rather than a block grant or a capped allotment, as in SCHIP. States will also have wide flexibility to perform outreach, education, enrollment, and administrative duties. The program will include incentives for states to contract out some of these services to local public health departments and local nonprofit organizations. Some may wish to create a new agency to administer the program, while others may choose to maintain their current Medicaid agency.

Medicaid managed care constitutes over 65% of all current Medicaid beneficiaries. Following this model, states under the AmeriCare-Choice program will interact with private insurance companies to administer coverage to thousands of consumers enrolled in contracted HMOs. States will set capitation rates and minimum benefits packages, but private plans will still compete in the market and consumers will retain personal choice. States will also have the option to contract with health plans to provide services through Preferred Provider Organizations (PPOs) or using a point of service (POS) model if they can show these options to be cost-effective. States may also provide fee-for-service options in limited circumstances or for special populations, such as people with disabilities or children with special health care needs.

The program will require states to hire an independent enrollment broker or house enrollment functions within the Office of Health Care Advocacy and Outreach (see below) to prevent the undue influence of consumer plan selection. The broker can be an employee of the state government or an independent agent.

Private Insurance Companies

Most states administer their Medicaid programs through contracts with private insurance companies. As previously stated, states will retain the flexibility of these public-private partnerships under AmeriCare-Choice. The program will minimize health plans’ administrative costs by permitting minimal variation in plan benefits and cost-sharing provisions; administrative costs will be further reduced because the health plans will interact with just one entity.
Generally, state-managed care plans fall into one of two categories: Primary Care Case Management (PCCM) programs and capitated Health Maintenance Organizations (HMO). In general PCCMs pay primary care physicians a fixed fee in addition to regular fee-for-service payments for care, while the HMOs receive a fixed dollar amount per member per month for a specified benefit package. States also use three approaches to establish rates. About half of the states use some form of administrative pricing, in which states name a rate and plans decide whether or not to participate. Several states negotiate with plans individually, and the rest use some form of competitive bidding. As part of the new benefits program, states will continue to determine how to contract with the insurance companies, but may want to set up the structure differently for the population at or below 300% FPL than for the buy-in population because of the different benefits requirements and cost-sharing limitations. Plans will likely decide to offer a variety of benefit packages with different cost-sharing provisions to remain competitive among consumers. Consumers can choose a coverage option that makes the most sense for their health care needs.

**Multi-State Employers and Federal Employees**

The AmeriCare-Choice program will integrate large multi-state employers into an overarching AmeriCare-Choice federal plan. Currently, employers operating in several states typically opt to self-insure and fall under the ERISA regulations, so that they do not need to follow state mandates. The program recognizes the challenges for multi-state employers and offers AmeriCare-Choice National. This plan will include current Medicaid beneficiaries and will expand to include civilian employees, the military, veterans, and tribal members. The CMS, another agency at the Department of Health and Human Services (HHS), or the Office of Personnel Management (OPM) will administer this program.

The administering agency would first determine how health plans would bid for business, and then allow private companies to buy-in to the plans. Of course, employers could decide to buy in to plans at the state level as well, but may see cost savings by joining the federal plan.

**V. Appeals Process**

Medicaid recipients are entitled to a due process hearing if the state or health plan suspends, terminates, or reduces services, or denies a prior authorization. AmeriCare-Choice will adopt and maintain the Medicaid appeals and hearing process for all enrollees. Therefore, enrollees have a right to a hearing before the state agency, generally before an administrative law judge, with the following additional rights:
• The hearing must meet due process standards. The individual must request a hearing within a reasonable time, no more than 90 days after receiving notice of the action.

• The state must notify the beneficiary at least 10 days before a scheduled hearing. A beneficiary will continue to receive services until the administrative decision is made only when hearing request occurs within 10 days of the effective date of the denial.

• The due process hearing grants a beneficiary the right to review all relevant documents and records, to call witnesses, to establish all pertinent facts and circumstances, to present an argument without undue interference, and to question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

• The agency must provide the beneficiary written notice of the outcome of the case, as well as any available judicial review options.

• Contracted health plans must maintain a grievance process, an appeal process, and access to the state’s fair hearing system. Enrollment in a private health plan leaves the beneficiary’s rights to a fair hearing untouched.

AmeriCare-Choice maintains the Medicaid Due Process rights and makes the fair hearing process mandatory for any enrollee who wishes to address a grievance. Recipients will have the support of advocacy services for claim denials and benefit terminations or reductions (see below). Local non-profits or public health entities will provide advocacy services for recipients at a monthly capitation rate based on population-based formulas. These services will include advising and educating consumers on their rights and assisting in the appeals process.

### AmeriCare-Choice Fair Hearing

<table>
<thead>
<tr>
<th>All beneficiaries are entitled to a fair hearing if:</th>
<th>Rights of beneficiaries:</th>
</tr>
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<tbody>
<tr>
<td>• An Application is denied</td>
<td>• Due process rights are guaranteed</td>
</tr>
<tr>
<td>• A Prior authorization is denied</td>
<td>• Decision within 90 days of request</td>
</tr>
<tr>
<td>• Services are denied, reduced, or terminated</td>
<td>• Decision can be appealed to a state court</td>
</tr>
<tr>
<td></td>
<td>• Services continue until the decision is made</td>
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</tbody>
</table>
VI. The Office of Health Care Advocacy and Outreach

Regardless of the direction of health reforms, consumers will per usual face a bewildering range of choices and obstacles to receiving appropriate health care and connecting to the correct coverage option. The AmeriCare-Choice program creates the Office of Health Care Advocacy and Outreach (“The Office”) to provide or contract for consumer counseling and protection services for plan enrollees and prospective enrollees. The Office will be responsible for Outreach and Enrollment services as well as consumer advocacy. The Office will employ Health Benefits Counselors, to aid consumers in evaluating affordable coverage options and Health Care Navigators, to help consumers locate and access affordable care. The Office will support community-centered HealthWatch Committees, to offer local insight to the oversight and reform process.

Roles of the Office

Outreach and Education

The Office will serve as an education and outreach center, targeting at-risk or underserved populations and making plan information available to the public to aid in consumer decision-making and will serve as a resource for all public information available on health plans serving the area. The Office will maintain a database of health plan information and local health care resources and make this information available to consumers.

The Office will also document the concerns, inquiries, and problems cited by consumers across the state. Then, as a counseling and advocacy service, the Office would use this knowledge to best inform individual enrollees on how “make the plans work”—thereby increasing consumer satisfaction and effectuating a more democratic administration of health care.

Enrollment Initiative

The Office will also be responsible for procuring enrollment. This effort will help ensure the goal of effective and efficient universal coverage. Enrollment efforts, in tandem with outreach and education, will quell misconceptions and inform consumers about the plan. Additionally, in order to fight adverse selection, when each component of the program begins enrollment, states may provide incentives such as 50% reductions in co-payments for one year to people who enroll within the first six months. Medicare currently has penalties for seniors who do not enroll when they turn 65, as a similar effort to avoid adverse selection.
Specialists and Groups in AmeriCare-Choice

Health Benefits Counselors—Accessing Coverage

Health Benefits Counselors (HBC) help individuals and families find and maintain affordable health care coverage. HBCs inform clients of their options, offer help with filing applications or appeals, counsel clients on consumer rights and grievance procedures and, when appropriate, refer clients for legal intervention. Through their work, they document patterns of problems and coverage barriers. Legal staff will support the work of HBCs by providing training and consultation to counselors and pursuing legal action on behalf of individuals and families.

Within a community, HBC services reduce stress for families, create better-informed consumer choices, and call greater attention to the health and coverage needs of special populations.

Legal Services

The link to legal services must be affordable for families. As a part of AmeriCare-Choice, The Office will provide legal services to:

- Review and/or challenge health insurance plan disputes and denials of coverage based on preexisting condition clauses, medical necessity, and usual and customary costs,
- Evaluate eligibility denials for services under childhood disability programs such as Supplemental Security Income (SSI)
- Provide consultation in person or via telephone (fact-finding and gathering financial, medical or insurance information or documents)
- Negotiate with insurance companies, collection agencies and health care providers
- File complaints with the respective health plans or the Office and monitor responses to ensure proper redress for clients
- Provide representation at administrative due process hearings, or in state and federal court
- Direct referrals to the private bar, pro bono attorneys, and other agencies
- Review health insurance marketing

The involvement of lawyers in a public health program is highly effective in securing access to health care for families. Lawmakers in Wisconsin first developed this time-tested model for seniors in the 1970s, and the state now provides services in every
ABC for Health developed a program of family Health Benefits Counselors for individuals under age 60, serving people across Wisconsin for fifteen years.

Legal backup and training from attorneys give HBCs increased leverage and credibility when negotiating with recalcitrant third-party payers. Moreover, since the issues surrounding eligibility for government programs and the interpretation of insurance contracts are ultimately legal in nature, the capacity of HBCs to refer for legal review and or intervention is essential.

Health Care Navigators—Accessing Care

For some, the health care system can be particularly difficult to navigate, especially for individuals with special health care needs, language barriers or lower incomes. In any given health plan, 15% of enrollees account for 75% to 80% of the costs. Health Care Navigators (HCN) will target these few “high risk” enrollees that contribute to the majority of the costs by coordinating care for individuals with multiple health care needs. They will also help individuals with barriers to accessing care because of disability, language barriers, literacy or other issues navigate health care system efficiently.

All AmeriCare-Choice participants benefitting from HCN services will receive a comprehensive health status assessment and case monitoring services. The HCN’s tasks might include making appointments, providing for translation services, accompanying the client to appointments, working with the client to follow the provider’s recommendations, documenting progress, and educating the client about efficient use of the health care system. An essential component of the HCN’s role will be development and maintenance of the client’s self-sufficiency.

The program serves a preventative function to improve clients’ health and reduce repeated emergency room visits and hospital charity care spending. Participants would receive waivers on co-payments and deductibles for receiving recommended treatments. Participation would be voluntary. States would have flexibility to set standards for participation in this program, since the goal is to focus on the most expensive consumers. States can determine what criteria consumers need to meet in order to receive these services. The Office will work with states to promote the program and ensure that targeted populations know that these services are available.

Navigators will work in state or local public health offices or within the contracted private plans, under state oversight. Health Care Navigators housed in health plans will be responsible for referring plan members to the state’s Health Benefits Counselors if there are any denials of service or other similar issues of concern to the member. If the state receives too many complaints about a health plan’s Health Care Navigator, the state can impose fines. Health Care Navigators will be located across the state, since a crucial function will be to point consumers to local resources.
Community Oversight

HealthWatch Committees—Education and Accountability

HealthWatch Wisconsin (HWW), a project of ABC for Health, Inc. since 2008, has already grown to a statewide, member-based organization that includes seven local community coalitions and nearly 300 individual HWW coalition members. Coalitions, made up of local hospitals, health departments, advocates, social workers, and consumers, support and fine-tune the variety of issues raised at a community level. The greatest strength of these coalitions is their diversity of voices and the ability of group members to identify problems in their various roles and day-to-day interactions with patients and families. Additionally, these committees provide the necessary oversight and systems “reality check,” ensuring a degree of accountability from the ground up.

HWW coalitions are a vital part of maintaining a responsive system of universal health coverage. The coalitions zero in on public policy concerns and work to amplify these issues to policymakers. Community collaborations and training initiatives help inform the public and policymakers about health and coverage issues.

HealthWatch Coalitions work to:

- Create a local forum for networking to resolve local service issues and problems
- Identify systemic issues for policy change
- Provide community education events and resources

AmeriCare-Choice participants will benefit as HWW committees translate daily enrollee issues and problems into real solutions. The committees will educate consumers, advocates, and providers; facilitate communication among groups affected by the health care programs; identify areas of concern regarding access to health care coverage and services; participate in problem-solving strategies; and offer policy changes to make the health care system more responsive to the needs of families.

The structure of the HWW system benefits from broad government oversight informed by grass-roots, localized watchdog groups. A national HealthWatch Committee will operate out of the Office of Advocacy and Outreach. Each state will form a committee, and from there, assist in the formation of local community-based coalitions. Local committees may become part of existing local health department groups, or convene meetings independently. HWW committees in local communities will help to identify at-risk populations and high-priority issues and areas for reform.
Funding the Office

A combination of government, private, and consumer contributions will provide funding for the Office. Enhanced federal matching funds will support initial Outreach activities. Assessments on contracted health plans will help support state functions. Fees will be lower for plans that choose to maintain Health Benefits Counselors and Health Care Navigators in-house. Individuals and employers will pay an increase by $1 PMPM in capitation rates. Finally, the Office will levy fines against poorly performing health plans. The Office will keep fines and forfeitures to support office functions.

Funding for the Office of Health Care Advocacy and Outreach

| • 90/10 match from the federal government for outreach | • $1 addition to monthly capitation rate |
| • Sliding scale fees for benefits counseling | • Fees assessed on health plans |
| | • Fines and forfeitures on health plans for poor performance |

VII. Financing

Mutual responsibility and accountability among key stakeholders are hallmarks of the financing mechanisms that will support AmeriCare-Choice. The federal and state governments, contracted health plans, employers and consumers will all share responsibility for the costs of the program. To control costs, all players will be held responsible for minimizing spending while still promoting high quality and accessible health care services.

Finance Roles

Federal Government

In general, financing for AmeriCare-Choice will follow the current Medicaid model, where states receive federal matching dollars for most Medicaid expenditures. In addition, states will receive:

• Federal matching funds for the premiums and co-pays contributed by individuals at or below 300% FPL;

• “Enhanced” SCHIP matching rate for all covered children at or below 300% FPL, rather than the current mixture of regular Federal Medical Assistance Participation (FMAP) and enhanced FMAP depending on when expansions took place; and

• “Regular” FMAP for all covered adults at or below 300% FPL.
The federal government calculates the FMAP rates based on the average income per person in each state and in the nation as a whole and recalculates the rates every fiscal year. The regular FMAP for fiscal year 2009 ranges from 50% in 16 states including California and New York to over 75% in Mississippi, with an average rate of 56%. The enhanced FMAP for fiscal year 2009 ranges from 65% in 13 states to 83% in Mississippi, with an average rate of 72%. Under the American Recovery and Reinvestment act of 2009, FMAP rates will increase by 6.2% for the period between Oct. 1, 2008 and Dec. 31, 2010, with additional increases for states with high rates of unemployment. (Please see Appendix 1For a complete list of FMAP rates and additional grant allocations.)

In order to encourage outreach, particularly at the beginning of implementation, the states will receive a 90% match on all outreach, advocacy and education expenditures.

State Governments

The states will share responsibility for financing beneficiaries with household incomes under 300% FPL. This funding will be allocated through general state revenues, a tax on contracted health plans or any other funding mechanism the states deem appropriate.

Premiums

States will have flexibility to set premiums for individuals and businesses using the buy-in feature of the plans. States may negotiate with plans as to any cost sharing, but must offer a plan with low deductibles and co-payments. With consent from the state, plans can offer more extensive benefits packages than the standardized minimum package. However plans must also offer an option with the minimum benefits package. The state must budget part of the capitation rate for The Office of Health Care Advocacy and Outreach.

Families will have an option to purchase family coverage. The state will develop one rate for individuals and a separate rate for families. The family rate will be approximately 2.5 times the individual rate, depending on state demographics. Some state employee health plans, like Connecticut’s, also have a third rate for couples with no children. States may choose to negotiate rates for these childless couples.

Employers

Employers can choose to buy-in to any of the state-approved programs and contribute part of their employees’ premium costs through payroll deductions. Employers will receive a tax credit of 60% of the amount spent on these premiums. If employers do not pay for a part of the monthly premiums, they must let employees set up pre-tax medical spending accounts, so that the employees can pay the premiums with pre-tax dollars.
Consumers

Consumers contribute to the economics of the plan through cost-sharing and buy-in premiums. Reasonable cost sharing measures contribute money to the state and help to mitigate inappropriate use of the health care system.

- No cost-sharing for children at or below 200% FPL, adults at or below 100% FPL or Native American and Alaskan Natives at or below 300% FPL.
- Income-based cost-sharing for beneficiaries under 300% FPL.
- Nominal co-payments and premiums of 3% of the monthly household income for children 201%-300% FPL and adults 101%-300% FPL.
- Total cost-sharing will not exceed 5% of income each year. Total annual cost-sharing will not exceed 7% of total family income for families at or below 300% FPL with multiple members enrolled in AmeriCare-Choice.

Cost-Sharing

<table>
<thead>
<tr>
<th>Income</th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-150% FPL</td>
<td>Medicaid, no cost-sharing</td>
<td>Medicaid, no cost-sharing</td>
</tr>
<tr>
<td>151-200% FPL</td>
<td>Medicaid, no cost-sharing</td>
<td>Medicaid, premiums of 3% income, nominal co-payments</td>
</tr>
<tr>
<td>201-300% FPL</td>
<td>Medicaid, premiums of 3% income, nominal co-payments</td>
<td>Medicaid, premiums of 3% income, nominal co-payments</td>
</tr>
<tr>
<td>Over 300% FPL</td>
<td>Medicaid buy-in</td>
<td>Medicaid buy-in</td>
</tr>
</tbody>
</table>

Individual consumers above 300% FPL may use pre-tax dollars to buy-in to the program and pay the state-negotiated monthly premiums, co-pays and deductibles to their contracted health plan. Consumers enrolled through their employers will pay whatever is left of the monthly premium after the employer’s contribution, along with any co-payments and deductibles. Individuals and self-employed workers may choose to exercise a buy-in option.

Consumers over 300% FPL who seek a fair hearing with the assistance of a Health Benefits Counselor must pay a nominal fee on a sliding scale basis. These funds will support the Office of Advocacy and Outreach. The contribution will start at $5 for those just over 300% FPL and will not exceed $25 for the highest incomes.

Reinsurance

The federal government will develop a reinsurance plan. If health plan expenditures exceed a predetermined amount because of natural disaster, disease outbreak, or other uncontrollable conditions, a federal reinsurance mechanism will pay all costs above the
predetermined amount. Additionally, if an individual patient costs a health plan more than a set amount, a reinsurance mechanism will be in place to cover the cost of that individual’s care. These measures limit the risk the contracted health plans face. State governments will negotiate these maximum spending amounts, with the guidance of the federal government.

**Savings**

The program will achieve considerable savings through administrative streamlining. Contracted health plans benefit from a simplified administration as one entity—the state—will set contract terms versus hundreds of employers which requires vast redundancy and paperwork. States will offer fewer but comprehensive plans, rather than the hundreds of variations operating in each state now. Federal and state government has shown that administering health care does not have to be expensive; in 2007, administrative costs were as low as 5.0% of Medicare spending and 7.7% of Medicaid spending.\(^3^3\)

Large purchasing power will secure savings for AmeriCare-Choice due to the size of the risk pool. Reasonable rates for services and prescription will also result from less financial risk due to the large pools. The contracted health plans, therefore, will have incentive to offer more comprehensive benefits and engage in educational activities and wellness initiatives to prevent clients’ needs for expensive medical services.

AmeriCare-Choice will result in increased coverage and lower uncompensated care costs for the uninsured. These savings will help to fund AmeriCare-Choice. In 2008, health care providers spent an estimated $54.3 billion on uncompensated care with the great majority of that, $39.2 billion, offset by federal, state and local government payments.\(^3^4\)

**Efficiencies**

AmeriCare-Choice will emphasize the adoption of electronic medical records and other tools to promote the efficient delivery and administration of health care programs and services. Electronic medical records are an important tool\(^3^5\) to help streamline the health care industry, improving efficiency and lowering overall health care costs. The American Recovery and Reinvestment Act of 2009 provides an estimated $17.2 billion in Medicare and Medicaid incentive payments for hospitals and other eligible professionals who engage in the meaningful use of electronic health record (HER) technology.\(^3^6\) The HITECH Act contained in the Obama administration’s federal stimulus package demands the much wider use of information technology across health care providers in a short period of time. Understanding the practical aspects of implementing secure, interoperable, real-time EHRs has become critical.

ABC for Health has been very involved in developing new and innovative software programs to help individuals and families connect with the health care and coverage services they need. The software application, “My Coverage Plan”\(^3^7\) is an electronic
medical record that helps families identify needed health care coverage and create a personal health care planning document. The software generates an electronic, online record that organizes the public or private benefits coverage a family has had in the past, and outlines coverage opportunities for the future. The record is especially helpful for families with special needs, life transitions and complicated coverage scenarios.

Innovative tools such as electronic medical records and electronic coverage records are extremely important in helping to better administer the various health care coverage programs for families. For care providers, promotion of these tools can increase patient understanding and satisfaction, improve staff-patient morale, and increase third-party reimbursements to the hospital. Not only can AmeriCare-Choice help families maximize coverage opportunities, it ensures insurance providers are accountable for the care and coverage they should rightfully be providing.

**VIII. Implementation**

We propose phasing in the AmeriCare-Choice program over a period of three years, starting with the most vulnerable populations and public employees, and then moving to businesses or higher-income populations. We anticipate inherent delays as state legislatures will need to pass legislation to enact this new program and then set up the management process. *(See below, VIII. Legislative Imperatives.)*

**Phase 1**

- States expand Medicaid coverage to everyone at or below 300% FPL.
- States switch their state employee health benefits programs over to a state AmeriCare-Choice plan to begin to establish a larger regional pool.
- Civilian federal employees switch into a federal AmeriCare-Choice plan.

**Phase 2**

- States implement the buy-in component for businesses and individuals over 300% FPL. Waiting periods apply to individuals who already have access to health coverage.
- The federal government allows multi-state corporations to buy-in to the federal AmeriCare-Choice plan.
- Employers receive a 60% tax credit for contributions toward their employees’ health benefits. Unlike other proposals, AmeriCare-Choice does not mandate employers to buy-in to the plan. We expect that lower costs and better benefits will draw many employers to AmeriCare-Choice.
• The private market competes with the program as it develops. Health plans compete for business with states and the Federal government. Large-scale pooling creates purchasing leverage for the government and keeps costs low.

Phase 3

• The military, veterans and tribal members are phased in over a period of three years. Separate health facilities on bases, reservations and Veterans’ Administration hospitals will physically remain where they are, but funding will ultimately come from AmeriCare-Choice.

• Once 4/5 of a state’s population is enrolled, enrollment becomes mandatory.

• Once 30 of 50 states have made enrollment mandatory, the federal government requires all employers to offer insurance through either a state or federal plan.

• Multi state purchasing pools will be permitted.

AmeriCare-Choice will develop through the buy-in by business or through Medicaid expansions. Our plan predicts a critical mass of people and business enrollment will create a snowball effect for the program. Enrollees will gravitate to the program, incentivized by lower cost comprehensive and quality care. States will have some discretion about exercising mandatory enrollment options based on how quickly residents and businesses join AmeriCare-Choice. However states will be required to mandate coverage within seven years from the initial passage of AmeriCare-Choice. Limited extensions could support states that had difficulty enrolling eligible individuals, the program will not be mandatory until a critical mass of people are enrolled and recognize the cost savings and benefits.

States will receive monetary incentives from the federal government if they meet the goals set up in this timeline. For instance, they could receive bonuses if they have:

• 90% of children at or below 300% FPL enrolled within one years, or

• 90% of adults at or below 300% FPL enrolled within two years or

• 95% or all residents of the state enrolled within three years.

IX. Legislative Imperatives

Federal Legislation

The program requires federal legislation to create AmeriCare-Choice through modification of the Social Security Act. New levels of eligibility are required so that states receive matching funds for all persons covered who are under 300% FPL and
receive the enhanced matching rate for all children below 300% FPL. Legislation will also be necessary to authorize states to set up the buy-in program and to allow large employers to buy-in to the federal program. The creation of the Office of Advocacy and Outreach will also require legislation action.

State Legislation

AmeriCare-Choice at the state level will build on existing Medicaid programs. Features like the buy-in program as well as the flexibility to enact new legislation appropriate for the state’s population will require state legislative changes. State AmeriCare-Choice programs will require an expansion of their existing Medicaid administrative structure to deal with more beneficiaries. States will be required to merge the existing SCHIP program and the new buy-in component into the AmeriCare-Choice program.

Similarities to the Medicaid Buy-In Program: Ticket-to-Work

Congress passed the Ticket-to-Work and Work Incentives Improvement Act of 1999 in an effort to encourage people with disabilities to participate in the work force without fear of losing their Medicaid benefits. The Act gave states the option to raise their Medicaid income and asset limits for individuals with disabilities who were employed. States are permitted to require individuals with disabilities who work to buy-in to Medicaid by sharing in the costs of their coverage. According to the Social Security Administration, all fifty states currently participate in this program. The states have wide latitude in assessing cost sharing and in raising asset and income limits, and have had varying success in enrolling individuals with disabilities who work.

The Medicaid buy-in serves as a model for states that are looking at supporting coverage for populations with incomes higher than their traditional Medicaid income eligibility levels. Every state (with the exception of Wyoming) that has implemented this program has raised income eligibility levels to 200% FPL or greater, with Minnesota imposing no income limit.

A few lessons can be learned from initial evaluations of the implementation of this program and applied to AmeriCare-Choice.40

- Stakeholder involvement in program design is crucial;
- The program should be linked to other community supports for populations with barriers to care;
- Premium payments and private insurance offsets have been lower than expected;
- Actual enrollment has exceeded projections in two states, been lower than projections in one state and matched projections in five states.
X. Stakeholders—Roles and Expected Reactions

We believe the various stakeholders in the current health care system will have a reaction to the part and parcel of AmeriCare-Choice, but we anticipate that the response will generally be positive. The following presents in detail the expected reactions of these different groups, as well as their roles and incentives under the program.

Federal Government

The federal government will find AmeriCare-Choice attractive due to the comprehensive coverage for all people and the long term savings and deficit reduction.

State Governments

Most state governments will support the AmeriCare-Choice program. States will receive more in matching funds for children at or below 300% FPL. AmeriCare-Choice will provide for additional funding for states in the first two to three years of implementation to assist with the upfront costs of reorganizing the agency that administers Medicaid and adding employees to administer the buy-in program. Uncompensated care costs will be nearly eliminated under this plan, freeing up more resources to pay for the program.

States will have an important role in negotiation and oversight of health plans to ensure plans provide adequate benefits and meet cost-sharing limits, and claims processing efficiency.

Insurance Companies

AmeriCare-Choice will preserve a roll for the health insurance industry. Some competing proposals to AmeriCare-Choice suggest eliminating the private insurance market entirely. Under our system, the insurance companies remain in business, and save money by contracting with one entity instead of hundreds of employers. AmeriCare-Choice will allow for massive administrative savings by simplifying administration.

Employers

Employers, particularly those who are not currently self-insured, will be supportive of the program. They will spend fewer resources on health care for their employees, and in most cases, will provide more comprehensive benefits than they are currently. Health care costs have become a major part of most company budgets and have a severe impact on the business’s bottom line. Further, these costs have become the biggest sticking point in
union contract negotiations. AmeriCare-Choice will increase profits and enable employers to pass some of the savings on to employees through wage increases.

AmeriCare-Choice will provide incentives to employers for providing health insurance to their employees through refundable tax credits for 60% of the costs, a larger tax advantage than they currently receive.

Employers will not play as large of a role in selecting which health insurance plans their employees may choose because the employees will be able to choose any of the plans that the state has designated. This will reduce paperwork and time for the employer because all contributions will go to a single entity. Employers will also benefit from having happier, healthier workers.

Small businesses will be very supportive of this plan because it will allow them to provide health insurance for their employees at a rate they can afford. Currently, many small business owners cannot provide insurance for their employees as the small risk pool makes the small group market prohibitively expensive.

Large, multi-state employers that currently self-insure will also be satisfied with the program as they will have the option to either buy in through the states in which they operate or buy in to the federal plan. Due to the nature of self-insuring, however, and since these employers are exempt from state regulations, most of the employers currently do not pay very much to insure their employees. This plan may represent a cost increase to those employers and they will be the most resistant to the plan. Over time, as more, smaller employers buy-in, the large employers will see increased incentives in reduced costs arising from the large risk pools.

**Providers**

Providers will support AmeriCare-Choice. Under the program, providers will receive adequate reimbursement and reimbursement rates will increase well above current Medicaid rates to ensure maximum provider participation. In particular, woefully underpaid specialists like dentists and mental health professionals will see payments increase. AmeriCare-Choice will reduce uncompensated care costs for providers. Hence they will have fewer problems with bad debts and collecting on unpaid bills.

Further, the role of the provider will not change significantly. Patients will have more access to preventive care, so primary care doctors may see more patients for prevention than for acute incidents. Specialists should not be concerned with AmeriCare-Choice benefits, since there will be fewer roadblocks for referring patients.
Pharmaceutical Companies

Pharmaceutical companies will most likely resist the implications of the AmeriCare-Choice program because of the purchasing power that states will have. Depending on how states structure their prescription drug benefit, they may be able to drive down prices and threaten pharmaceutical company profits. On the other hand, states may decide to let the individual contracted health plans negotiate prices, which would provide pharmaceutical companies with greater leverage and create support for the plan.

Consumers

We firmly believe that the vast majority of consumers will support the proposed program. Consumers will have more choices about the health plan they can participate in—they will be able to choose the plan that provides the most care for the cost. They will also retain control over which doctors they see, a major complaint with many universal health care plans. Many consumers who currently have health insurance want the uninsured to be covered, but they do not want to give up the benefits they have. AmeriCare-Choice will be built to encourage consumers to be personally responsible and accountable for their health and the care they receive. (The health care system will not be effective if emergency rooms continue to be used for primary care or to receive a prescription. The uninsured will obtain coverage but will retain the element of choice that only the currently insured have. Additionally, underinsured Americans—those who have coverage but not the benefits they need—will support the program because of the more comprehensive benefits plan.

Consumers with Disabilities and Special Health Care Needs

A large percentage of individuals with disabilities are enrolled in Medicaid. Because of their familiarity with the current system, they are likely to be supportive of AmeriCare-Choice. A major concern for this group of consumers is their access to the specialists they need to see for treatment of their conditions. The assistance of Health Care Navigators and Health Benefits Counselors will help these individuals to access care. Additionally, states will have the flexibility to designate fee-for-service care for some beneficiaries whose needs are not amenable to managed care.
AmeriCare-Choice and Washington: A Comparison to President Obama’s Reforms

President Barack Obama has made health care a strong priority in the first months of his presidency, stressing the importance of reducing health care costs to the welfare of the nation and the recovery of the lagging economy. His administration has outlined key areas for reform and vowed to allocate $634 billion as a “down payment” over the next ten years. His proposals include a new public plan based on the benefits offered to members of Congress, and aid to businesses to help cover employees, as well as incentives to lower the costs of prescription drugs. All of these concepts echo the vision of the AmeriCare-Choice program, with its emphasis on working from an established public system while retaining the innovation and vitality of the private market. However, while Obama’s model maintains a system of spread-out risk “puddles” and new requirements and rules for both businesses and consumers, AmeriCare-Choice embraces the President’s goals while expanding purchasing power and offering specific resources and solutions for people on all levels of the health care system.

<table>
<thead>
<tr>
<th>Obama’s Proposals</th>
<th>AmeriCare-Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a National Health Insurance Exchange with a range of private insurance options as well as a new public plan based on benefits available to members of Congress that will allow individuals and small businesses to buy affordable health coverage.</td>
<td>Create a public-private partnership that vastly expands risk pools and purchasing power that would allow individuals and businesses to buy-in to a benefit plan. Include a localized consumer protection and advocacy system that helps residents find, maintain, navigate, and improve coverage and care.</td>
</tr>
<tr>
<td>Allow people to maintain their current health insurance plan.</td>
<td>Cover those without insurance first. Make the plan optional, with incentives for consumers over existing coverage.</td>
</tr>
<tr>
<td>Provide tax credits to small business and individuals paying insurance premiums to reduce costs of coverage.</td>
<td>Combine established government purchasing power with private sector plans to spread risk and lower administrative costs, resulting in lower premiums and lower costs for businesses.</td>
</tr>
<tr>
<td>Cover a portion of catastrophic illness costs for small businesses to keep premiums down</td>
<td>Expand the size of the purchasing pool so risk is spread between more people and major illness costs do not jeopardize coverage.</td>
</tr>
<tr>
<td>Require coverage of preventative care, cancer screenings, and pre-existing conditions.</td>
<td>No pre-existing condition exclusions and includes preventative care, long-term care and mental health parity.</td>
</tr>
<tr>
<td>Establish checks to keep malpractice insurance costs down and to protect consumers from “noncompetitive” activity that drives up private plan costs.</td>
<td>Establish a system of HealthWatch committees to lend a local component to national oversight. In addition, establish Health Benefits Counselors and Health System Navigators to lead consumers through locating services and addressing grievances.</td>
</tr>
</tbody>
</table>
Conclusion

The proposed AmeriCare-Choice program offers the promise of a universal system of coverage built upon a public-private partnership that spreads risk, increases purchasing leverage, and maintains consumer choice. Of course, some health care profiteers will cry foul as they see the profits secured through waste and redundant systems of administration disappear. An influx of public and private sector employees will strengthen the program, helping to build delivery capacity. Administrative cost savings will raise payment rates for underfunded Medicaid-covered services like dental care, mental health, and home care services. AmeriCare Choice’s counseling and advocacy feature is a proven and effective method to help families’ secure Medicaid eligibility in both the public health and private medical settings. If a new system of universal health care coverage does not include a system of family support and advocacy, our current predicament will continue: millions of Americans will continue to go without either coverage or care.

The big bang theory of health care reform is simply too ambitious for the public’s appetite and too big a target for the scare mongers, à la “Harry and Louise.” Progressive Incrementalism, the philosophical underpinning of this proposed program, is our best hope for achieving universal coverage. Our marvelously advanced health care system offers little if those who need it most are unable to access it. AmeriCare-Choice offers a way to secure the coverage and care all Americans need and deserve.
## Appendix 1: Federal Medical Assistance Participation FY 2009

<table>
<thead>
<tr>
<th>State</th>
<th>Regular FMAP</th>
<th>Expanded FMAP</th>
<th>State</th>
<th>Regular FMAP</th>
<th>Expanded FMAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>67.98</td>
<td>77.59</td>
<td>Montana</td>
<td>68.04</td>
<td>77.63</td>
</tr>
<tr>
<td>Alaska</td>
<td>50.53</td>
<td>65.37</td>
<td>Nebraska</td>
<td>59.54</td>
<td>71.68</td>
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<tr>
<td>Arizona</td>
<td>65.77</td>
<td>76.04</td>
<td>Nevada</td>
<td>50</td>
<td>65</td>
</tr>
<tr>
<td>Arkansas</td>
<td>72.81</td>
<td>80.97</td>
<td>New Hampshire</td>
<td>50</td>
<td>65</td>
</tr>
<tr>
<td>California</td>
<td>50</td>
<td>65</td>
<td>New Jersey</td>
<td>50</td>
<td>65</td>
</tr>
<tr>
<td>Colorado</td>
<td>50</td>
<td>65</td>
<td>New Mexico</td>
<td>70.88</td>
<td>79.62</td>
</tr>
<tr>
<td>Connecticut</td>
<td>50</td>
<td>65</td>
<td>New York</td>
<td>50</td>
<td>65</td>
</tr>
<tr>
<td>Delaware</td>
<td>50</td>
<td>65</td>
<td>North Carolina</td>
<td>64.6</td>
<td>75.22</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>70</td>
<td>79</td>
<td>North Dakota</td>
<td>63.15</td>
<td>74.21</td>
</tr>
<tr>
<td>Florida</td>
<td>55.4</td>
<td>68.78</td>
<td>Ohio</td>
<td>62.14</td>
<td>73.5</td>
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<tr>
<td>Georgia</td>
<td>64.49</td>
<td>75.14</td>
<td>Oklahoma</td>
<td>65.9</td>
<td>76.13</td>
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<td>Hawaii</td>
<td>55.11</td>
<td>68.58</td>
<td>Oregon</td>
<td>62.45</td>
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<td>Rhode Island</td>
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<td>Indiana</td>
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<td>South Carolina</td>
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<td>79.05</td>
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<td>72.06</td>
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<td>Kentucky</td>
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<td>Wisconsin</td>
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<td>75.84</td>
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<td>Washington</td>
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<td>65</td>
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<tr>
<td>Missouri</td>
<td>63.19</td>
<td>74.23</td>
<td><strong>Average</strong></td>
<td>60.165</td>
<td>72.11576923</td>
</tr>
</tbody>
</table>
Appendix 2: Additional Federal Allocations to States for Medicaid Costs under the American Recovery and Reinvestment Act of 2009 (in millions)


The Kaiser Commission on Medicaid and the Uninsured. March 2009

<table>
<thead>
<tr>
<th>State</th>
<th>Pre-ARRA FMAP FY 2009</th>
<th>Actual Grant Allocations (2 Quarters)</th>
<th>Estimated Total (9 Quarters)</th>
</tr>
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<tbody>
<tr>
<td>United States</td>
<td>56.7%†</td>
<td>$15,246.8</td>
<td>$87,144</td>
</tr>
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<td>67.98%</td>
<td>$169.8</td>
<td>$850</td>
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<td>50.53%</td>
<td>$41.6</td>
<td>$220</td>
</tr>
<tr>
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<td>65.77%</td>
<td>$351.5</td>
<td>$1,980</td>
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<tr>
<td>Arkansas</td>
<td>72.81%</td>
<td>$109.9</td>
<td>$730</td>
</tr>
<tr>
<td>California</td>
<td>50.00%</td>
<td>$1,991.9</td>
<td>$11,230</td>
</tr>
<tr>
<td>Colorado</td>
<td>50.00%</td>
<td>$140.9</td>
<td>$880</td>
</tr>
<tr>
<td>Connecticut</td>
<td>50.00%</td>
<td>$274.6</td>
<td>$1,320</td>
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<td>Delaware</td>
<td>50.00%</td>
<td>$60.7</td>
<td>$320</td>
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<td>70.00%</td>
<td>$58.9</td>
<td>$300</td>
</tr>
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<td>55.40%</td>
<td>$817.0</td>
<td>$4,390</td>
</tr>
<tr>
<td>Georgia</td>
<td>64.49%</td>
<td>$339.6</td>
<td>$1,730</td>
</tr>
<tr>
<td>Hawaii</td>
<td>55.11%</td>
<td>$70.6</td>
<td>$360</td>
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<tr>
<td>Idaho</td>
<td>69.77%</td>
<td>$53.4</td>
<td>$300</td>
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<tr>
<td>Illinois</td>
<td>50.32%</td>
<td>$470.9</td>
<td>$2,900</td>
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<tr>
<td>Indiana</td>
<td>64.26%</td>
<td>$247.2</td>
<td>$1,440</td>
</tr>
<tr>
<td>Iowa</td>
<td>62.62%</td>
<td>$89.1</td>
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<td>Kansas</td>
<td>60.08%</td>
<td>$71.6</td>
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<tr>
<td>Kentucky</td>
<td>70.13%</td>
<td>$205.3</td>
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</tr>
<tr>
<td>Louisiana</td>
<td>71.31%</td>
<td>$230.0</td>
<td>$1,660</td>
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<tr>
<td>Maine</td>
<td>64.41%</td>
<td>$94.5</td>
<td>$470</td>
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<tr>
<td>Maryland</td>
<td>50.00%</td>
<td>$275.5</td>
<td>$1,630</td>
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<tr>
<td>Massachusetts</td>
<td>50.00%</td>
<td>$594.3</td>
<td>$3,090</td>
</tr>
<tr>
<td>Michigan</td>
<td>60.27%</td>
<td>$464.4</td>
<td>$2,270</td>
</tr>
<tr>
<td>Minnesota</td>
<td>50.00%</td>
<td>$356.2</td>
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</tr>
<tr>
<td>Mississippi</td>
<td>75.84%</td>
<td>$137.1</td>
<td>$790</td>
</tr>
<tr>
<td>Missouri</td>
<td>63.19%</td>
<td>$270.5</td>
<td>$1,600</td>
</tr>
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<table>
<thead>
<tr>
<th>State</th>
<th>Pre-ARRA FMAP FY 2009</th>
<th>Actual Grant Allocations (2 Quarters)</th>
<th>Estimated Total (9 Quarters)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montana</td>
<td>68.04%</td>
<td>$34.2</td>
<td>$180</td>
</tr>
<tr>
<td>Nebraska</td>
<td>59.54%</td>
<td>$47.8</td>
<td>$310</td>
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<tr>
<td>Nevada</td>
<td>50.00%</td>
<td>$90.3</td>
<td>$450</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>50.00%</td>
<td>$31.5</td>
<td>$250</td>
</tr>
<tr>
<td>New Jersey</td>
<td>50.00%</td>
<td>$362.2</td>
<td>$2,220</td>
</tr>
<tr>
<td>New Mexico</td>
<td>70.88%</td>
<td>$95.2</td>
<td>$630</td>
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<tr>
<td>New York</td>
<td>50.00%</td>
<td>2,070.8</td>
<td>$12,650</td>
</tr>
<tr>
<td>North Carolina</td>
<td>66.40%</td>
<td>$439.6</td>
<td>$2,350</td>
</tr>
<tr>
<td>North Dakota</td>
<td>63.15%</td>
<td>$18.8</td>
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<td>Ohio</td>
<td>62.14%</td>
<td>$500.2</td>
<td>$3,010</td>
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<tr>
<td>Oklahoma</td>
<td>65.90%</td>
<td>$174.8</td>
<td>$960</td>
</tr>
<tr>
<td>Oregon</td>
<td>62.45%</td>
<td>$155.8</td>
<td>$830</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>54.52%</td>
<td>$680.3</td>
<td>$4,070</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>52.59%</td>
<td>$93.5</td>
<td>$470</td>
</tr>
<tr>
<td>South Carolina*</td>
<td>70.07%</td>
<td>$173.0</td>
<td>$860</td>
</tr>
<tr>
<td>South Dakota</td>
<td>62.55%</td>
<td>$20.5</td>
<td>$120</td>
</tr>
<tr>
<td>Tennessee</td>
<td>64.28%</td>
<td>$331.3</td>
<td>$1,620</td>
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<td>Texas</td>
<td>59.44%</td>
<td>$952.2</td>
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</tr>
<tr>
<td>Utah</td>
<td>70.71%</td>
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<td>Vermont</td>
<td>59.45%</td>
<td>$45.5</td>
<td>$280</td>
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<td>Virginia</td>
<td>50.00%</td>
<td>$252.7</td>
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<td>Washington</td>
<td>50.94%</td>
<td>$339.3</td>
<td>$2,060</td>
</tr>
<tr>
<td>West Virginia</td>
<td>73.73%</td>
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<td>Wisconsin</td>
<td>59.38%</td>
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<tr>
<td>Wyoming</td>
<td>50.00%</td>
<td>$15.9</td>
<td>$110</td>
</tr>
</tbody>
</table>

* Section 5001(f) of ARRA provides a set of special rules regarding States maintaining their eligibility requirements (MOE) in order to qualify for the increased FMAP for Medicaid and, based on preliminary analysis, Title IV-E; it also provides States which fail to satisfy the MOE an opportunity to reinstate their eligibility standards, methodologies, and procedures by July 1, 2009 and become eligible, should they wish to do so, for the increased FMAP. As of February 23, 2009, CMS had clearly determined South Carolina failed to qualify for the increased FMAP at this time.

Note: U.S. Total includes Guam, Puerto Rico, Virgin Islands, American Samoa, and Northern Mariana Islands.

Source: Allocations for First 2 Quarters are from the US Department of Health and Human Services, available at http://www.hhs.gov/recovery/statefunds.html. Access February 23, 2009. Estimates for full 9 Quarters were prepared by the Government Accountability Office, February 11, 2009. For the U.S. Senate Committee on Finance. Territory estimates for the full 9 quarters are from the Center on Budget and Policy Priorities, "Temporary Increase in State FMAP," available at http://www.cbpp.org/1-22-09bud-fmap.pdf. Accessed February 23, 2009.† Prior to the ARRA, the Federal share of Medicaid spending ranged from a floor of 50% to a high of 75.67% in Mississippi. The U.S. value shown here is the weighted average of all states and DC based on the federal share of Medicaid spending in FY 2006 as reported on CMS.
Endnotes

1 Kaiser Foundation, Policy Brief. Low-Income Adults Under Age 65—Many are Poor, Sick, and Uninsured. Available at: http://www.kff.org/healthreform/upload/7914_ES.pdf. See also, Families USA and The Lewin Group. Americans at Risk: One in Three Uninsured. This analysis found that 86.7 million people—one out of every three Americans under the age of 65—was uninsured for some period of time during 2007 and 2008. Available at: http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf (2009).

2 The Americare-Choice proposal shares a similar name to Representative Pete Stark (D-CA)’s Americare proposal to expand Medicare to all. The proposed “Americare-Choice” proposal differs in significant ways. The AmeriCare-Choice plan builds off the Medicaid program, which is designed to serve families and children with diverse needs. It also offers consumers combined pooling through a managed care system, which offers purchasing power and individual choice, along with individual advocacy assistance. Certain elements of the Medicaid program for low-income people with disabilities will be preserved including long term care and waiver programs. See H.R. 193: America Health Act of 2009, available at: http://www.opencongress.org/bill/111-h193/show (June 2009).


6 The AmeriCare-Choice program is not focused on changing Medicare, as that benefits program currently provides near universal coverage to individuals over age 65.


11 On October 3, 2008, the President signed the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

12 “Medicaid Managed Care Penetration Rates and Expansion Enrollment by State.” Centers for Medicare and Medicaid Services. (December 2006). Available at: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/05_MdManCrPenRateandExpEnrll.asp.

13 Id., p 2.

14 Id., pp. 7-8.


16 Fair hearing decisions can be appealed to a state court. 42 C.F.R. §431.205.

17 Id.

18 42 C.F.R. §431.221.

19 42 C.F.R. §431.211.

20 42 C.F.R. §431.230.


22 42 C.F.R. §431.245.

23 42 C.F.R. §438.402.


25 Information on Wisconsin’s Aging and Disability Resource Centers (ADRCs) is available at: http://dhs.wisconsin.gov/LTCare/Generalinfo/RCs.htm. See also, www.aoa.dhhs.gov. Since 1965, the Older Americans Act (the Act) has contributed greatly to programs for people 60 years and older. State Agencies on Aging receive Title III funds, which are made available to the States on a formula basis upon approval of State Plans by the AOA Regional Offices. States then allocate funds to the Area Agencies on Aging, based on approved Area Plans. The Older Americans Act supports the elderly nutrition program and meals-on-wheels, the county and area offices on aging, and the benefit specialists.
Many of the ideas in this section were developed in conjunction with the Health Council Management Team in Dane County, Wisconsin and James Wrich & Associates.


See http://www.healthwatchwisconsin.org for more information on HealthWatch Wisconsin projects, trainings, e-newsletter updates and publications.


Id.


FEHB members currently pay about two and one half times as much for family coverage as opposed to single coverage. Calculations based off fiscal year 2004 rates found at www.opm.gov.

HHS FY 2004 Budget in Brief p 51, 57.


Software Development and IT Governance Expenditures 2008 Study, (May 2008). According to the Gantry Group, providers will broaden the adoption and deployment of technology across all major clinical tool categories. The report notes that providers are making significant investments in clinical technology, with nearly half allocating 40 percent or more of their current technology budget to such solutions. On average, Digital Medical Imaging and EMR/EHR together command 64 percent of providers' clinical technology budgets; approximately 75 percent of providers plan to increase their commitment to vendors' clinical solutions rather than developing custom solutions in-house.


See http://www.ssa.gov


The argument is largely centered on profits: 2007 profits of top insurance companies by Fortune 500 rank: United Health $4.6 billion; WellPoint $3.3 billion; Aetna $1.8 billion; Humana $834 million; Cigna $1.1 billion; HealthNet $194 million; Coventry Health Care $626 million. Combined net income of $11.4 billion, Fortune May 5, 2008, Available at: www.hoovers.com;

Federal Register: November 28, 2007 (Volume 72, Number 228).