



Covering Ohio's Uninsured: The SCI Team's Final Report to Governor Ted Strickland

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(July 2008)



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Letter of Transmittal

To : Governor Ted Strickland

In September of 2007, you appointed the State Coverage Initiative (SCI) team to participate in a Robert Wood Johnson Foundation (RWJF) program to help states develop strategies to cover the uninsured. The SCI team was charged with developing health care coverage reforms to: (1) reduce the total number of uninsured Ohioans by 500,000 by 2011 and (2) increase the number of small businesses that are able to offer health coverage to their workers.

Over the past year, the SCI team has worked diligently to uncover the facts about Ohio's uninsured residents, Ohio's health insurance programs and markets, and the gaps in the current system that cause many Ohioans to be uninsured. The SCI team has worked closely with the Healthcare Coverage Initiative Advisory Committee to develop a comprehensive set of recommendations to cover Ohio's uninsured residents. These recommendations are based on the best available information and the diverse views of those impacted by Ohio's health care and coverage systems.

The SCI team therefore submits the attached *Covering Ohio's Uninsured: The SCI Team's Final Report to Governor Ted Strickland*.

Sincerely,

Ohio's SCI Team

The Healthcare Coverage Initiative Participants

In August of 2007, Governor Strickland appointed the following individuals to the SCI team:

STATE COVERAGE INITIATIVE TEAM (SCI team)

Doug Anderson	Chief Policy Officer at the Ohio Department of Insurance
John Burant	Health Systems Division Director, SEIU, District 1199
Cindy Burnell	Director of the Office of Healthy Ohio, Ohio Department of Health
Bill Hayes	President of the Health Policy Institute of Ohio
Janetta King	Policy Director for Governor Ted Strickland
Tom Niehaus	State Senator (R) from the 14th Senate District
Col Owens	Senior Attorney, Legal Aid Society of Southwest Ohio
Jim Raussen	State Representative (R) from the 28th House District
Shirley Smith	State Senator (D) from the 21st Senate District
Richard Stoff	President, Ohio Business Roundtable
Cristal Thomas	Executive Director, Executive Medicaid Management Administration
Sandra Williams	State Representative (D) from the 11th House District

In August of 2007, Governor Strickland appointed the following individuals to the Healthcare Coverage Initiative Advisory Committee. The Advisory Committee also included all members of the SCI team.

ADVISORY COMMITTEE

Doug Anderson	Chief Policy Officer, Ohio Department of Insurance
Jeff Biehl	Executive Director, Access HealthColumbus
Ernie Boyd	Executive Director, Ohio Pharmacists Association
Cheryl Boyce	Executive Director, Ohio Commission on Minority Health
Ron Bridges	Government Affairs Representative, AARP Ohio
Jon Burant	Health Systems Division Director, SEIU, District 1199
Cynthia Burnell	Director of the Office of Healthy Ohio, Ohio Department of Health
Jim Castle	President & CEO, Ohio Hospital Association
Angela Cornelius	Director of the Ohio Department of Alcohol and Drug Addition Services
George Dunigan	Director of Government Affairs, OU College of Osteopathic Medicine
Rob Edmund	Director of Policy and External Relations, Ohio Business Roundtable
Nancy Enright	Industry Research Analyst, SEIU, District 1199
Ted Fisher	Partner, Porter Wright Morris & Arthur
William Fitzgibbon	CWS Governmental Relations, Ltd.

Marjorie Frazier	Executive Director, Ohio Association of Free Clinics
Shawn Frick	Executive Director, Ohio Association of Community Health Centers
Jerry Friedman	Policy Advisor and Director of Government Relations, The Ohio State University
Roger Geiger	Vice President, NFIB/OH Executive Director, National Federation of Independent Business
Amy Goldstein	Director of Government Relations and Legal Counsel, The Free Medical Clinic of Greater Cleveland
Robin Harris	Health & Human Services Policy Executive Assistant, Governor's Office
Bill Hayes	President, Health Policy Institute of Ohio
Mary Jo Hudson	Director, Ohio Department of Insurance
Brian F. Keaton	President, American College of Emergency Physicians
Janetta King	Policy Director for Governor Ted Strickland
Nick Lashutka	President, Ohio Children's Hospital Association
Cathy Levine	Executive Director, Universal Health Care Action Network of Ohio
Teresa Long	Health Commissioner, Columbus Department of Health
Jen Lynch	Agriculture, Environment, Commerce and Insurance Policy Executive Assistant, Governor's Office
Heath MacAlpine	Assistant Director, Montgomery County Department of JFS
Kelly McGivern	President & CEO, Ohio Association of Health Plans
Fred McGraw	Director, Education and Research Dept., OAPSE
Steve Millard	Executive Director, Council of Smaller Enterprises
Brent Mulgrew	Executive Director, Ohio State Medical Association
Tom Niehaus	State Senator (R) from the 14th Senate District
Col Owens	Senior Attorney, Legal Aid Society of Southwest Ohio
Ty Pine	Legislative Director, NFIB-Ohio
Jim Raussen	State Representative (R) from the 28th House District
Carol Roe	Ohio Nurses Association
Amy Rohling McGee	Health & Human Services Policy Executive Assistant, Governor's Office
Shirley Smith	State Senator (D) from the 21st Senate District
Ken Statz	Ohio Association of Health Underwriters, Statz & Associates
Marianne Steger	Director of Health Care & Public Policy, AFSCME Ohio Council 8, AFL-CIO
Sandra Stephenson	Director, Ohio Department of Mental Health
Richard Stoff	President, Ohio Business Roundtable
Cristal Thomas	Executive Director, Executive Medicaid Management Administration
Dwight Tillery	President & CEO, Center For Closing The Health Gap In Greater Cincinnati
Sandra Williams	State Representative (D) from the 11th House District
Linda Woggon	Vice President, Governmental Affairs, Ohio Chamber of Commerce

Acknowledgments

The work of the State Coverage Initiative (SCI) team could not have been completed without the dedication, support and hard work of a number of organizations and individuals.

- Staff members from the Ohio Department of Insurance provided the administrative, technical and research support needed for the SCI team and Advisory Committee to complete its work. Special thanks must be given to Malika Bartlett, Suparna Bhaskaran, Kyrsten Chambers, Sarah Curtin, Marjorie Ellis, Alan Furan, Carly Glick, Ashley Pierce, Ron Pokorny, Adam Rossbach and Kevin Tyler and for their hard work and dedication to this project. They all did a great job keeping the SCI team and Advisory Committee informed, on track and equipped to complete their work.
- Dave Dillon at the firm of Lewis & Ellis did the analysis of Ohio's insurance markets and modeling of reform proposals developed by the SCI team and Advisory Committee. Dave's tireless efforts have helped the SCI team craft these recommendations based on the best available data and analysis. Dave made it a priority to attend meetings and answer countless questions and concerns raised during this process.
- We would like to thank Tim Sahr at the Health Policy Institute (HPIO) for his research assistance and HPIO for generously sharing their office space to host the SCI team meetings.
- Steve Wall, of the Ohio Department of Administrative Services, must also be given thanks for his help in structuring and facilitating the SCI team and Advisory Committee meetings. Steve's expertise helped keep the SCI team and Advisory Committee on track toward building consensus recommendations with widespread support.
- The staff at the Ohio Department of Job & Family Services did a wonderful job in hosting the Healthcare Coverage Advisory Committee meetings. A special thanks must be given to Mary Gerlach of the ODJFS Office of Ohio Health Plans.
- All the members of the Advisory Committee must be thanked for the countless hours they devoted to this process. Much was asked of the Advisory Committee in terms of their time and talents, and they responded by providing the SCI team with the information, insights and counsel that was necessary to understand Ohio's health care and coverage system and the challenges faced by Ohio's uninsured residents.
- We would like to thank Allard Dembe (Associate Professor, College of Public Health, Ohio State University), Barry Jamieson (Research Specialist, Center for HOPES, Ohio State University) and John McAlearney (Assistant Professor, Boonshoft School of Medicine, Wright State University) for their research report "Assessing the impact of SCI policy options on Ohio's economy, businesses, labor and uninsured."

A. Introduction

1.3 million Ohioans are uninsured. Most of them do not have access to affordable health insurance coverage. As a result, they do not get the care they need to maintain healthy and productive lives.

Governor Ted Strickland established the following goals for the State of Ohio:

1. Reduce the number of uninsured Ohioans to 500,000 by 2011; and
2. Increase the number of small businesses that are able to offer health coverage to their workers.

To accomplish these goals, the State of Ohio partnered with the Robert Wood Johnson Foundation (RWJF) Program and AcademyHealth through a program called the “State Coverage Initiative” (SCI). SCI is a program designed to help states develop and implement strategies to expand access to affordable health insurance coverage and thereby reduce the number of uninsured citizens. Ohio was one of several states selected to participate in the SCI and has worked over the past year with RWJF, AcademyHealth and their experts to develop comprehensive, effective strategies to cover Ohio’s uninsured residents.

As part of this initiative, Governor Strickland created a bipartisan team to work together in an open, inclusive and transparent process to develop strategies to cover Ohio’s uninsured residents. The SCI team is comprised of four members of Governor Strickland’s administration, four members of the Ohio General Assembly, and four key stakeholders. The SCI team was tasked with developing recommendations to achieve the Governor’s goals of covering Ohio’s uninsured residents.

To assist and guide the SCI team, the Governor also created a larger Healthcare Coverage Advisory Committee (the Advisory Committee). The Advisory Committee is comprised of forty-six leaders representing all segments of the Ohio health care community, including consumer advocates, doctors and nurses, hospitals, insurers, businesses, labor, free clinics and community health centers. The Advisory Committee was tasked with providing the SCI team with feedback throughout its decision making process.

This report contains the recommendations of the SCI team as to how Ohio should go about covering its uninsured residents. These recommendations achieve the goal of extending coverage to at least 500,000 of Ohio’s uninsured residents, helping small businesses offer coverage to their workers, and creating a system where all Ohioans can obtain affordable health insurance coverage.

B. Summary of the Problem

The SCI team and Advisory Committee worked to uncover the facts about Ohio's uninsured residents, current health coverage programs, and markets and opportunities to provide cost-effective, affordable coverage to Ohio's uninsured residents. Based on a review and analysis of the best available information (detailed in the body of this report) the following picture of Ohio emerged.

Who is uninsured in Ohio?

Ohio has about 11.2 million residents. Approximately 1.3 million Ohioans, or 12%, are uninsured.

Uninsured Ohioans are a diverse group, but they do have some common characteristics. For example, uninsured Ohioans generally have lower incomes. In fact, about 350,000 uninsured Ohioans live at or below 100% of the federal poverty level (FPL) and an additional 410,000 uninsured Ohioans live between 100% and 200% FPL.

Generally, uninsured Ohioans:

- live in households with a full-time worker;
- are working-age adults;
- are high school graduates;
- have been uninsured for more than one year; and
- live in urban areas.

Who among Ohio's uninsured are disproportionately impacted, and what are the consequences?

The available information shows that being uninsured disproportionately impacts certain populations, including:

- lower income Ohioans;
- racial minorities;
- Ohioans living in Appalachia.
- people in poorer health;
- young adults;
- older adults nearing the age of 65; and
- people who are independently employed or work at small businesses.

Having no insurance has negative consequences. As compared to insured residents, uninsured Ohioans:

- are in poorer health;
- receive less preventive and primary health care;
- receive less timely care;
- have worse health outcomes;
- have more medical debt;
- are less productive; and
- live shorter lives.

What will happen if Ohio does nothing to cover its uninsured residents?

If Ohio does not create new programs to cover its uninsured residents, the following will occur:

- an increasing number of Ohioans will be uninsured;
- fewer employers will offer coverage;
- coverage will become more expensive;
- people in poor health will continue to be rejected for individual coverage; and
- the cost of providing care to the uninsured will continued to be shifted to those with coverage.

What will happen if Ohio does create new programs to cover its uninsured residents?

If Ohio develops effective programs to cover its uninsured residents, such programs can:

- help prevent serious illness;
- increase the number of Ohioans with a usual source of care;
- stimulate economic growth and improve business productivity;
- reduce job-lock;
- reduce health care disparities;
- reduce medical debt and bankruptcies;
- reduce mortality and disability rates;
- improve quality of life;
- improve the quality of health care services for all; and
- potentially reduce cost shifting to government, employers and consumers by reducing uncompensated care.

Where are there opportunities to cover Ohio's uninsured residents?

There are significant opportunities for Ohio to cover its uninsured residents. They include:

- getting more people enrolled in Medicaid;
- making employer sponsored coverage more affordable;
- helping young adults get coverage;
- helping lower income Ohioans to purchase coverage;
- leveraging federal funding wherever possible; and
- making Ohio's individual market accessible to more Ohioans.

C. Principles

As a guide for developing the recommendations contained in this report, the SCI team identified the following principles that build upon the Governor's goals of covering more of Ohio's uninsured residents:

- All Ohioans, including people with lower incomes and serious health conditions, must have access to affordable health coverage.
- Everyone in Ohio must help to make health care affordable.
- We all must take personal responsibility for reducing health care costs, which includes taking action to keep ourselves healthy.
- Many Ohioans cannot achieve good health without a partnership of government, business and Ohio's health care community to equip people with the tools and services they need to stay healthy. This commitment includes a responsibility to provide everyone with the appropriate care at the right place and time.

- Health care coverage for Ohio’s uninsured residents must be aligned with prevention, primary care, continuity of care, positive outcomes and quality.
- Reforms must be financially viable, sustainable and have measurable impacts.
- In developing strategies to cover Ohio’s uninsured residents, Ohio should leverage funds currently available in the existing system, including federal and employer contributions to health care benefits.
- Reforms should be built on the strengths of Ohio’s existing public and private health care systems.
- The task of the SCI team – to improve access to health insurance coverage– cannot be considered alone. The SCI team’s recommendations are an important first step, but equally important is the focus on the cost and quality of Ohio’s health care system, and improving the health of Ohioans through population health strategies.

D. Summary of the SCI Team's Recommendations

To fully realize our vision for a healthy Ohio and comprehensively address the problems that uninsured Ohioans and small businesses face in obtaining coverage, bold action is needed. The SCI team is proposing a range of initiatives that involve numerous public and private partners.

In making these recommendations, the SCI team considered the fiscal challenges currently facing our State. While fiscal challenges should not be the only consideration in meeting the Governor’s objectives, cost is a factor in the timing of reform initiatives as well as program sustainability. As a result, the SCI team recognizes that it may be necessary for the Governor and General Assembly to adopt and implement some reforms over a period of years, in a step by step approach, that extends beyond 2011.

In making these recommendations, the SCI team has always worked toward consensus as much as possible, but as with any diverse stakeholder group, not every member of our team agrees with every recommendation, the precise timing of recommendations, or the order of implementation. Nonetheless, we have worked diligently and in good faith to identify what we collectively believe are the best short and long-term strategies for meeting the Governor’s goals of extending affordable coverage to all Ohioans. The SCI team’s recommendations are as follows:

1. Recommendations Focused on Employer Sponsored Coverage

1.1. Require Ohio employers to adopt Section 125 premium-only plans to allow employees at employers not currently offering coverage to purchase coverage using pre-tax dollars.

Ohio employers, by simply establishing Section 125 premium-only plans, can provide employees with a mechanism to purchase coverage using pre-tax dollars. For workers at moderate income levels, Section 125 plans can generate savings of between 21% and 34% off the cost of coverage.

1.2. Ohio should adopt a reinsurance program to fund coverage for uninsured individuals and uninsured workers at small businesses.

If Ohio were to adopt a state-sponsored reinsurance program, similar to the Healthy New York program, the cost of coverage could be reduced by about 25% for eligible small businesses and individuals.

1.3. Extend coverage to dependents up to the age of 29.

Young adults (ages 19 to 29) are one of the largest and fastest-growing segments of the U.S. population without health insurance. A simple, cost-effective way to get more young adults covered is to raise the dependent age within family policies.

1.4. Provide premium assistance to workers to help them take up employer-sponsored coverage.

Approximately 120,000 uninsured Ohioans are eligible for health insurance at work, but cannot afford to pay the premium. Premium assistance from the state will help more take up coverage.

2. Recommendations Focused on Covering Lower Income Ohioans

2.1. Enroll more uninsured Medicaid eligible Ohioans into Medicaid.

Currently, about 250,000 Ohioans are eligible for Medicaid but are not enrolled. Implementing strategies to enroll more lower-income and disabled Ohioans into Medicaid is cost-effective because the federal government currently pays 62% of the cost of coverage.

2.2. Expand Ohio's Medicaid eligibility to cover more of the uninsured population.

Lower income Ohioans need help to pay for coverage. Expanding Medicaid is a cost-effective solution because it takes advantage of federal matching funds.

2.3. Allow non-Medicaid eligible adults below 100% FPL without access to employer sponsored coverage to obtain coverage, with state subsidies, through Medicaid managed care or other similar organizations.

The SCI team knows that insuring Ohioans below 100% FPL is a priority. An effective solution is to enroll these Ohioans in cost-effective plans developed and offered by Medicaid managed care organizations.

3. Reforms focused on providing all Ohioans, including those who are older and/or unhealthy, with access to affordable health coverage.

Ohio must reform its individual health insurance market because it fails to serve many residents. People can be denied coverage, issued coverage that excludes pre-existing conditions permanently, or charged extremely high premium rates that most people cannot afford. To address these problems, the SCI team makes the following recommendations, which work in concert to provide Ohioans with access to affordable coverage regardless of age or health status.

3.1. Insurance companies in Ohio's individual market must offer coverage to all individuals and families that apply.

Ohio needs to move to a system requiring insurance companies to sell all products to each and every individual and family that applies for coverage regardless of age or health status - otherwise known as "Guaranteed Issue."

3.2. Ohioans who are able to purchase affordable coverage should be required to purchase at least a basic benefit plan.

An individual mandate for those who are able to buy affordable coverage recognizes that having continuous coverage throughout one's lifetime is the best way to fund health care expenses. It is important to understand, however, that an individual mandate can only be tolerated in a market that guarantees the issuance of coverage to everyone who applies, limits the rates charged to people who are older and/or in poor health, provides subsidies to lower income individuals, and exempts people who cannot find affordable coverage.

3.3. Ohio should adopt increasingly progressive and restrictive rating rules to be implemented over a period of time to reduce the variance in rates in the individual market to eventually reach a rating variance of 5 to 1.

Guaranteed issuance of coverage means very little if insurance is still unaffordable. The SCI team recommends that Ohio adopt progressively restrictive rating rules to be implemented over a period of time to reduce the variance in rates in the individual market.

3.4. The State of Ohio should provide low-income subsidies to help people afford coverage.

For the individual market to work for people at lower income levels they need to have subsidies to help them pay for coverage.

3.5. Ohio should adopt a number of other market reforms to make sure the market is running effectively and people are not being denied coverage or charged rates outside the bounds permitted by law.

Ohio should adopt a number of market reforms that would include: (1) limits on the ability of a carrier to exclude pre-existing health conditions, (2) measures to increase administrative efficiencies so that premiums pay for health care to the greatest extent possible, (3) better reporting of Ohioans who are insured and uninsured, and (4) data reporting and analysis to make sure markets and programs are running effectively.

4. Recommendations Related to Implementation of Coverage Reforms

4.1. The state should create a quasi-public/private organization – a connector – controlled by a board that would help to implement coverage expansion programs and assist Ohioans who want to enroll in available health plans.

A connector board should be formed and authorized by law to make critical decisions regarding implementation of coverage expansions. A connector board could also oversee activities to strategically match uninsured Ohioans with coverage. These activities could include marketing and outreach; providing information about plans and prices; determining eligibility for subsidies; and coordinating programs so that Ohio's uninsured experience "no wrong door" as they try to get coverage.

4.2. Benefit plans offered to uninsured Ohioans through coverage expansion programs should be affordable and must focus on prevention, primary care and chronic care management.

Health benefits should focus on care that has proven value, require that consumers use health care wisely, incentivize consumers to improve their own health, encourage consumers to establish a medical home, include health management components, and be affordable and portable.

5. Funding Recommendations

5.1. Programs to cover Ohio's uninsured residents must be as cost-effective as possible, to reduce the need for funding.

The SCI team has made every effort to recommend health coverage reforms that are the most cost-effective options available to provide affordable coverage to Ohio's uninsured residents.

5.2. In developing strategies to cover Ohio’s uninsured residents, Ohio should try to leverage existing funding wherever possible, including federal funding and employer contributions to health care.

It makes little sense to provide subsidies to lower income Ohioans using only state dollars when federal and employer dollars are available to cover the same populations. With Medicaid, the federal government currently pays 62% of the cost of coverage. Employers generally contribute more than 50% to the cost of worker coverage.

5.3. The state should look within its existing budget to pay for health coverage reforms.

The strongest possible effort should be made to fund any new reform strategies from reallocation of existing revenues as well as efforts to obtain cost savings within existing programs.

5.4. As for additional funding, health coverage reform proposals should be paid for with broad based funding.

If sufficient revenues to fund the SCI team’s proposals cannot be secured by re-prioritizing allocations within the current state budget, or by implementing cost saving strategies, the SCI team believes policy leaders should take a shared responsibility approach to funding. This shared responsibility principle is based on the recognition that all stakeholders in this process – insurers, providers, employers, citizens, and government – will benefit from adoption of the SCI team’s proposals.

6. Recommendations for Sustainable Programs

6.1. An Advisory Group should continue to meet and work on health care system reforms and population health proposals.

The Advisory Group has proven to be an excellent forum to discuss and develop health care reform proposals. The SCI team recommends an Advisory Group continue to meet and work on reforms that go beyond providing coverage to Ohio’s uninsured residents.

6.2. Ohio should support the development of provider networks in underserved areas of Ohio and, as part of that effort, increase support for community health centers, free clinics and other community-based providers.

Throughout Ohio, there are areas that do not have enough providers to treat patients. As a result, the state should develop strategies to attract and retain a diverse workforce of providers in medically underserved areas.

6.3. Ohio should support local programs that promote medical homes and provider networks focused on the coordination of preventive and primary care.

The SCI team supports the establishment of community-based collaboratives that can serve as pilots or demonstration projects to encourage medical homes that provide primary care, health promotion and care coordination to patients.

6.4. Ohio should continue to work toward the adoption of health information technology.

One important element to transform Ohio's health care system is the adoption of health information technology to facilitate the exchange of information between providers, participants and payers.

6.5. Ohio should adopt transparency/reporting requirements for hospitals and insurance companies to enable more informed decision-making by consumers and third-party payers.

To cover Ohio's uninsured residents effectively, there must be transparency and accountability. Health care providers and insurers must be open about prices, costs, revenues and finances for Ohio's health care system to run efficiently.

6.6. Ohio should continue to work on improving the health of its citizens through population-based and other strategies that promote wellness and prevent disease and injury.

Through initiatives, such as Healthy Ohio, the state should continue to pursue priorities such as the development of a comprehensive strategy to prevent and reduce obesity, especially among children, in schools, worksites, and communities.

6.7. The Governor and General Assembly should advocate for the federal government to become a partner with the State of Ohio to develop innovative and effective solutions for covering Ohio's uninsured residents.

Federal law and the federal government play a vital role in Ohio's health care and coverage systems. The Governor and the Ohio General Assembly should partner with the President and Congress to develop innovative solutions for providing affordable coverage to uninsured people.

D. Summary of the SCI Team's Recommendations

The following chart shows the estimated number of uninsured Ohioans who would gain coverage and the cost to the State of Ohio related to the SCI team's recommendations.

**Estimates For 2011 of the Number of Covered Lives and State Costs
Related to the SCI Team's Coverage Recommendations**

Reform Proposal	Impact Without An Individual Mandate (2011) (covered lives/state cost)	Impact With An Individual Mandate (2011) (covered lives/state cost)
1.1 Require employers to establish §125 Plans	37,000/\$5.7 million	55,000/\$8.5 million
1.2 Reinsurance for individuals and small businesses	181,000/\$157 million	293,500/\$229 million
1.3 Extend group coverage to dependents up to age 29	11,300/zero	17,000/zero
1.4 Premium assistance for low income workers	50,000/\$106 million	64,000/\$131 million
2.1 Enroll more Ohioans in Medicaid	75,000/\$96 million	150,000/\$192 million
2.2 Expand Ohio's Medicaid to 200% FPL for parents	135,000/\$168 million*	150,000/\$186 million*
2.3 Allow non-Medicaid eligible adults to enroll in Medicaid managed care plans	149,000/\$761 million	163,000/\$831 million
3.1-4 Reforms to the individual health insurance market		154,000/\$687 million

*These estimates only reflect currently uninsured Ohioans who would take up coverage. If crowd-out protections are not adopted to keep currently insured people from switching coverage, the numbers and cost will increase.

II. Background: Ohio's Current Situation, the Problem, and the Reason for Change

Ohio has 11.2 million residents. 1.3 million Ohioans are uninsured. This equals 12% of Ohio's population.

A. Who in Ohio is Uninsured?

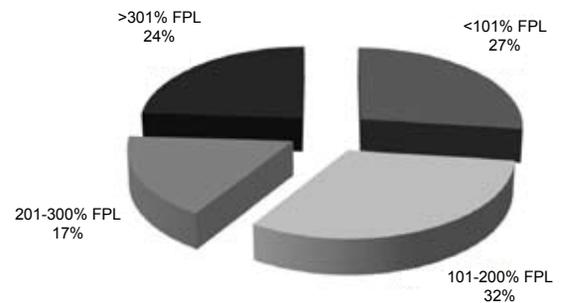
The SCI team and Advisory Group worked to uncover who is uninsured in Ohio and why. Based on a review and analysis of available information, the following picture of Ohio's uninsured residents emerged.

Most uninsured Ohioans are lower income.

59% of working age adult Ohioans (18-64) earn below 200% Federal Poverty Level (Chart 1). For 2008, 100% FPL for a single person is \$10,400, and 200% FPL is \$20,800.

Chart 1

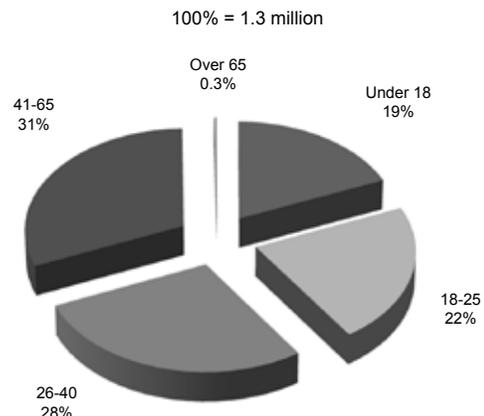
Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL) in Ohio (2004-2005)



Source: Urban Institute and Kaiser commission on Medicaid; Census Bureau's March 2005 and 2006 Current Population Survey; Health Policy Institute of Ohio, 2004 Ohio Family Health Survey.

Chart 2

Age Distribution of Ohio's Uninsured, 2005



Source: U.S. Census Bureau Current Population Survey, 2005.

Half of uninsured Ohioans are between the ages of 18 and 40.

Young adults are most likely to be uninsured. As they grow older, they generally take up coverage and, at age 65, most enroll in Medicare. The 41-65 age group is also significant because they often face loss of employment and health problems (Chart 2).

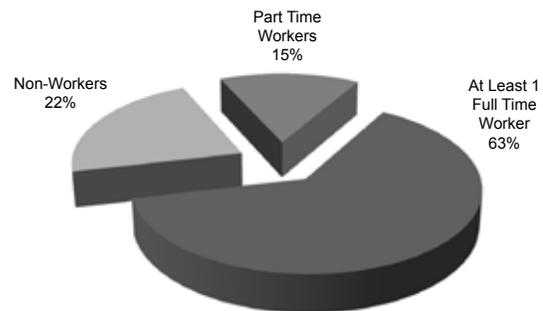
Chart 3

Most uninsured Ohioans are living in working households.

78% of uninsured Ohioans live in families with at least one full-time or part-time worker (Chart 3).

Distribution of the Nonelderly Uninsured by Family Work Status in Ohio (2004-2005)

100% = 1.3 million



Source: Urban Institute and Kaiser commission on Medicaid; Census Bureau's March 2005 and 2006 Current Population Survey; Health Policy Institute of Ohio, 2004 Ohio Family Health Survey.

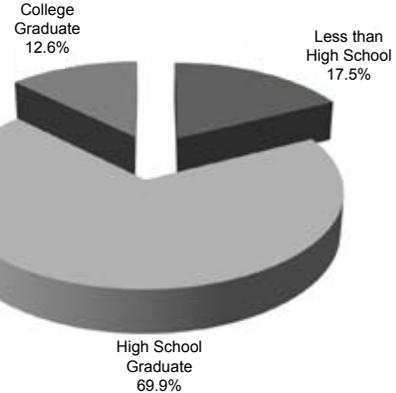
Chart 4

Most uninsured Ohioans are high school graduates.

82% of Ohio's uninsured residents have at least a high school diploma (Chart 4).

Percentages of Uninsured Ohioans Based Upon Education

100% = 1.3 million



Source: 2004 Ohio Family Health Survey.

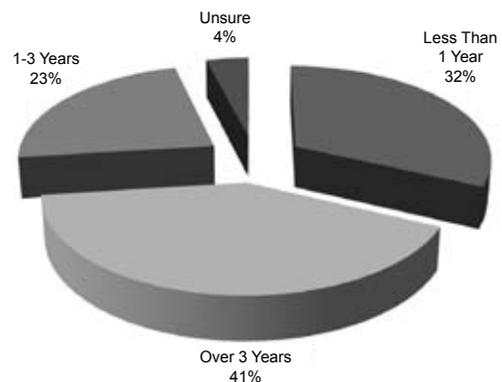
Chart 5

Most uninsured Ohioans have been uninsured for more than one year.

73% of uninsured Ohioans have been uninsured for one or more years (Chart 5).

Self-Reported Duration of Uninsurance Among the Working Class Age Adult Uninsured in Ohio, 2004

100% = 1.3 million



Source: Health Policy Institute of Ohio, Ohio Family Health Survey, 2004; U.S. Census Bureau Current Population Survey, 2005; Urban Institute of 2002-2004. MEPS data reweighted to represent Ohio population.

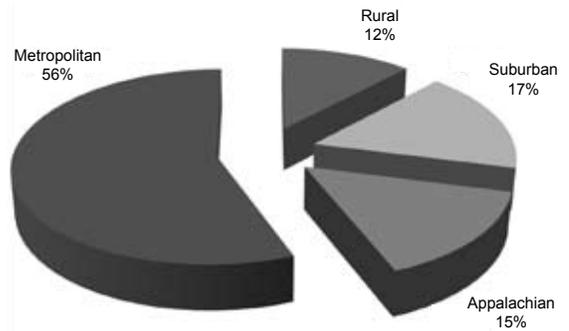
Chart 6

Most uninsured Ohioans are living in urban areas.

56% of uninsured adult Ohioans live in a metropolitan area (Chart 6).

Distribution of Nonelderly Uninsured by Geographic Region 2004

100% = 1.3 million



Source: Health Policy Institute of Ohio, Ohio Family Health Survey, 2004.

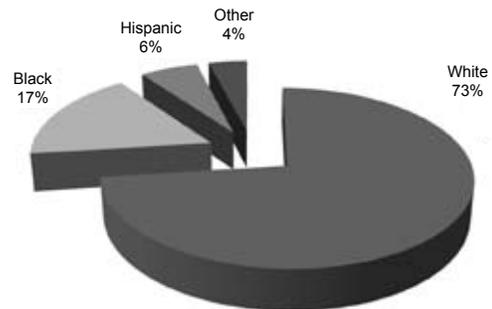
Chart 7

Most uninsured Ohioans are white.

73% of uninsured adult Ohioans are not racial minorities (Chart 7).

Distribution of Nonelderly Uninsured by Race / Ethnicity in Ohio (2004-2005)

100% = 1.3 million



Source: Urban Institute and Kaiser commission on Medicaid; Census Bureau's March 2005 and 2006 Current Population Survey; Health Policy Institute of Ohio, 2004 Ohio Family Health Survey.

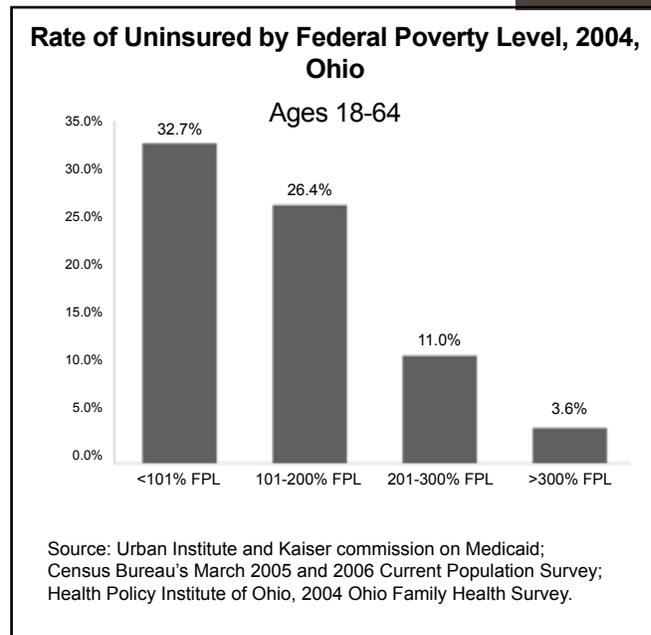
B. Who Among Ohio's Uninsured are Disproportionately Impacted?

In addition to considering who in Ohio is uninsured, the SCI team and Advisory Committee worked to uncover why people are uninsured. The SCI team therefore looked at the characteristics that make a person more likely to be uninsured. Based on the available information, we found the following populations are disproportionately impacted by having no insurance.

Low-Income Ohioans are more likely to be uninsured.

59% of working age adult Ohioans (18-64) earn below 200% Federal Poverty Level (Chart 8).

Chart 8



Racial minorities are more likely to be uninsured.

Although most uninsured Ohioans are white, Ohioans are much more likely to be uninsured if they are Black or Latino/a (Chart 9).

Chart 9

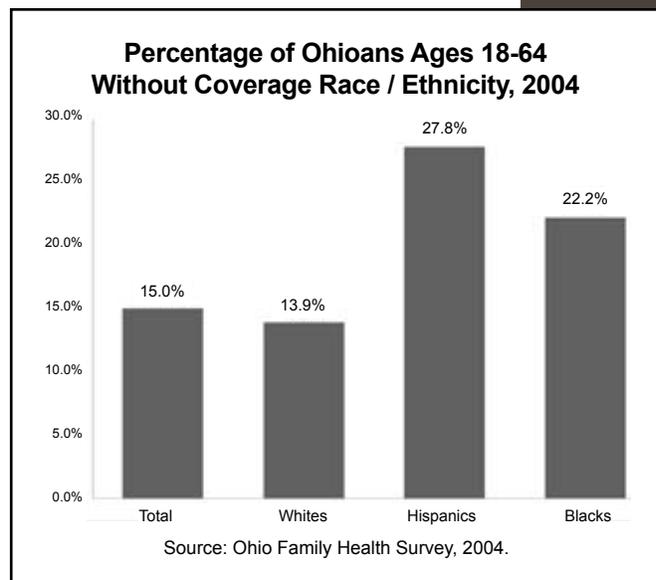


Chart 10

People living in Appalachia are more likely to be uninsured.

People living in Appalachia, Youngstown and Akron have the highest rates of being uninsured (Chart 10).

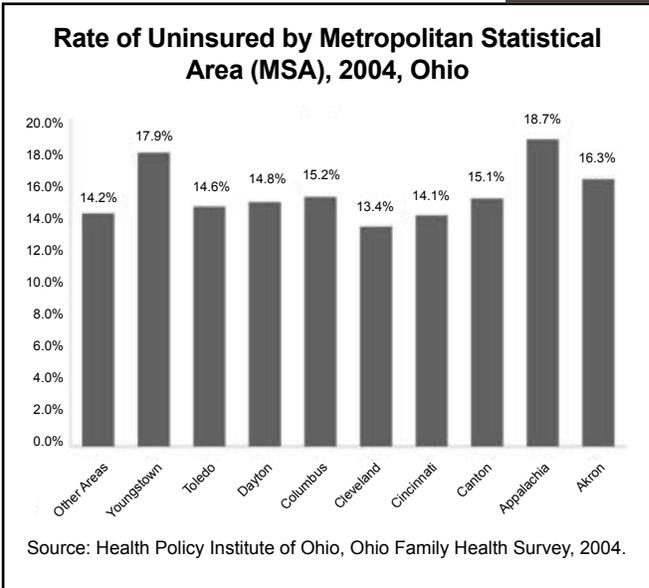


Chart 11

People in fair to poor health or with chronic conditions are more likely to be uninsured.

24% of uninsured Ohioans are in fair to poor health. They have trouble getting comprehensive coverage because of pre-existing conditions. (Chart 11).

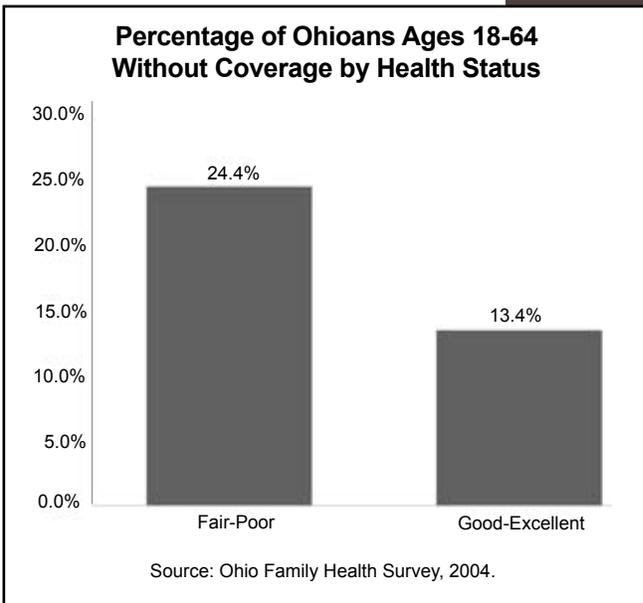


Chart 12

Young adults are more likely to be uninsured.

People age 18 to 34 are much more likely to be uninsured compared to other age groups. Often young adults in their twenties have difficulty accessing health coverage through their employers or their parents (Chart 12).

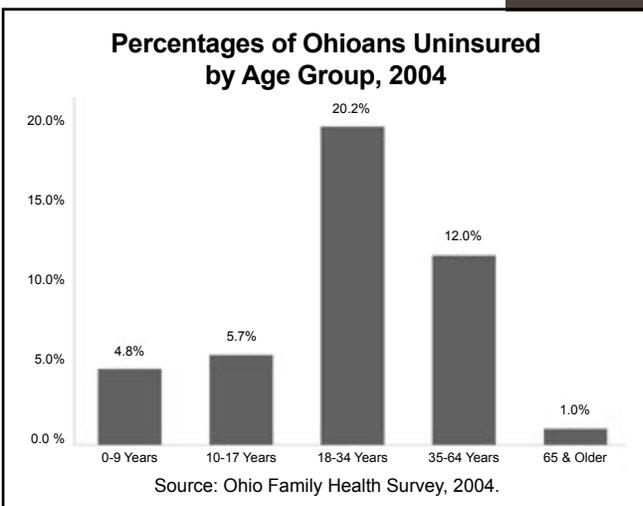
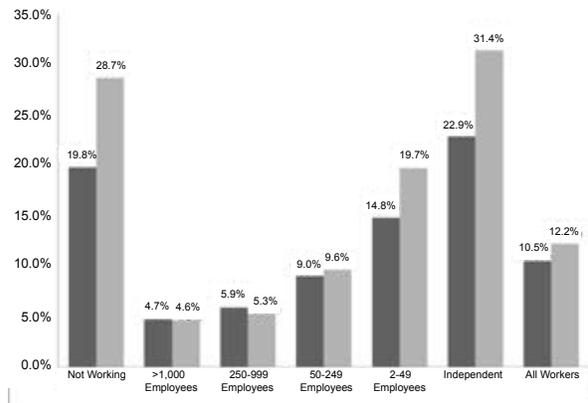


Chart 13

People who are independently employed or work at small businesses are more likely to be uninsured.

At 31.4%, the independently employed are most likely to be uninsured, followed by those who are not working (Chart 13).

**Uninsured Adults by Gender for Firm Size, Ohio
Adults Ages 18-64**



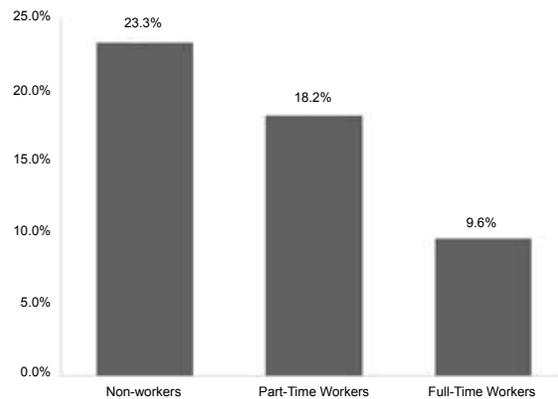
Source: Ohio Family Health Survey, 2004.

Chart 14

People who are unemployed or work part-time are more likely to be uninsured.

People who are unemployed, temporarily employed or employed part-time often do not qualify for employer-sponsored insurance or cannot afford it (Chart 14).

**Rate of Uninsured by Work Status, 2004, Ohio
Adults Ages 18-64**



Source: Urban Institute and Kaiser commission on Medicaid; Census Bureau's March 2005 and 2006 Current Population Survey; Health Policy Institute of Ohio, 2004 Ohio Family Health Survey.

C. Where are the Opportunities to Cover Uninsured Ohioans?

The SCI team also looked at the statistics concerning Ohio's uninsured populations with an eye toward where there are opportunities to get more people covered. The available information shows opportunities in the following areas.*

Medicaid

- Many uninsured Ohioans are currently eligible for Medicaid. Of the 1.3 million Ohioans who are uninsured, about 250,000 are eligible for Medicaid but not enrolled.¹

Employer-sponsored coverage

- Many uninsured Ohioans work for employers that offer coverage to workers. Based on the 2004 Ohio Family Health Survey, about 192,000 Ohioans are offered coverage by their employers but do not elect to take up that coverage.
- About 132,000 uninsured Ohioans work at employers that do not offer any coverage to workers. An additional 82,000 uninsured Ohioans are self-employed. If these workers are not eligible for a public program, they must purchase coverage in Ohio's individual health insurance market with after-tax income.

Young adults

- Many uninsured Ohioans are young adults in good health. Health insurance coverage is relatively affordable for these people.
- Young adults are much more likely than children and seniors to be uninsured. 5.4% of children are uninsured. 1.0% of seniors are uninsured. 20% of young adults between the ages of 18 to 34 are uninsured.

Lower income Ohioans

- There are about 182,000 Ohioans who are ineligible for Medicaid who earn less than 100% FPL.² These people cannot afford to buy coverage in the individual market.

The SCI team was particularly interested in seeing a break-down of uninsured Ohioans by income, work status and health status. Using these factors as a guide, the Health Policy Institute of Ohio developed charts showing who in Ohio is uninsured in these categories. This data is found in Appendices "A" and "B."

* The best available data comes from a variety of sources including but not limited to the 2004 Ohio Family Health Survey, the Current Population Survey, and data collected by Lewis & Ellis of Ohio's insurance markets. It is important to note that the Ohio Family Health Survey will be going back into the field in 2008. Over 40,000 Ohio households will be surveyed and the results will be the best, most up to date information available about Ohio's uninsured residents. As a consequence, the data and estimates contained in this report should be reviewed when the 2008 Ohio Family Health Survey results are in.

Many uninsured Ohioans are young adults in good health.

D. How Healthy are Ohioans?

The available evidence shows that most Ohioans are healthy, but there is great room for improvement. In terms of how Ohioans report their own health status, 87% report they are in good to excellent health while 13% report they are in fair to poor health.³ Although Ohioans report they are for the most part healthy, they are getting older, and as a result their health status is slowly getting worse. Chart 15 shows how Ohioans have aged from 2002 to 2006.

Ohioans are getting older, and as a result their health status is slowly getting worse.

The Age of Ohioans (2002-2006)⁴

Chart 15

Age	2002 - % of population	2006 - % of population
1-17	26%	24%
18-34	22.3%	22.5%
35-54	30.0%	29.1%
55-64	9.6%	11.4%
65+	12.2%	12.45%

And, Chart 16 shows how the health status of Ohioans has changed from 2002 to 2006.

The Health Status of Ohioans (2002-2006)⁵

Chart 16

Health status	2002 - % of population	2006 - % of population
Excellent	34.1%	32.6%
Very good	31.6%	31.8%
Good	23.2%	23.4%
Fair	8.1%	8.8%
Poor	2.9%	3.3%

This data shows that the number of people in self-reported excellent health declined at a rate of 1% per year from 2002 to 2006. During that same period, the number of people in fair health increased by 2.2% and those in poor health increased by 1.3%.⁶

The available data also shows that many Ohioans suffer from chronic disease(s). In fact, in 2003, more than 6.7 million cases of seven chronic diseases were diagnosed -- cancer, diabetes, heart disease, hypertension, stroke, mental disorders, and pulmonary conditions.⁷ Over one in four Ohioans suffered from at least one of these conditions. Chart 17 shows the number of reported cases for these conditions in Ohio, the percentage of Ohioans who had these conditions, and a comparison to national figures.

Reported Cases of Chronic Diseases, Ohio 2003⁸

Chart 17

	Ohio incidence	Ohio %	National %
Cancers	377,000	3.3%	3.6%
Diabetes	595,000	5.2%	4.7%
Heart Disease	875,000	7.6%	6.6%
Hypertension	1,549,000	13.5%	12.6%
Stroke	113,000	1.0%	0.8%
Mental Disorders	1,432,000	16.0%	10.4%
Pulmonary Conditions	1,835,000	16.0%	16.9%

Overall, Ohio ranked 29th out of the 50 states in terms of the prevalence of these diseases, with the highest ranking state having the lowest prevalence.⁹

The 2007 Behavioral Risk Factor Survey conducted by the Centers for Disease Control shows that Ohio's rates of incidence of disease are worse than the national average. Chart 18 compares Ohio to national averages with respect to seven important health indicators.

Prevalence of Risk Factors for Disease, Ohio 2007¹⁰

Chart 18

	Ohio	National Average
Adult smokers	23.1%	19.7%
Obese adults	28.1%	26.3%
Adults with asthma	32.0%	27.5%
History of diabetes	9.5%	8.1%
Adults with arthritis	32.2%	27.5%
Adults with high blood pressure	39.6%	37.5%
Adults with fair to poor health status	15.8%	15.2%

In June of 2007, the Commonwealth Fund issued its "State Scorecard on Health System Performance," which included a comparison of states in several "healthy lives" categories. Overall, Ohio ranked 41 out of 50 states in terms of its "healthy lives" performance.

One of the important measurements used by the Commonwealth Fund to rank healthy lives was "mortality amenable to health care," which measures the number of deaths in each state that could have been delayed or prevented with proper health care. In Ohio, in 2002, there were 111 deaths per 100,000 people that were amenable to health care, which put Ohio 35th out of the 50 states in this category. This factor suggests that greater access to health care, which can be improved with health coverage, can lengthen the lives of many Ohioans.

In other “healthy lives” areas, Commonwealth Fund data showed that Ohio scored as follows:

Infant mortality

- Infants experienced 7.9 deaths per 1,000 live births, ranking Ohio 36th out of the 50 states.

Breast cancer deaths

- Breast cancer resulted in 28 deaths per 100,000 in the female population, ranking Ohio 46th out of the 50 states.

Colorectal cancer deaths

- Colorectal cancer resulted in 21 deaths per 100,000, ranking Ohio 36th out of the 50 states.

Adults limited in activities

- 15.5% of adults age 65 and older are limited in their activities, ranking Ohio 29th out of the 50 states.

Importantly, in just about every category of health status, uninsured people are less healthy than insured people.¹¹ For example, uninsured adult Ohioans report that they are in fair to poor health 24% of the time, in comparison to insured Ohioans who report they are in fair to poor health only 13% of the time.¹² Uninsured people are also more likely to:

- be disabled¹³
- experience pain every day¹⁴
- have a chronic condition¹⁵
- be diagnosed with late stage cancer¹⁶
- be hospitalized with preventable conditions¹⁷
- die in the hospital¹⁸

E. What will happen if Ohio does nothing to cover its uninsured residents?

Not moving forward with reforms to cover Ohio’s uninsured residents will leave many Ohioans without access to coverage and in poorer health. If changes are not made to our health coverage system now, the evidence shows that the following will occur:

- **More Ohioans will be uninsured.**
 - A 2006 study conducted by the Department of Insurance showed that over 1.4 million Ohioans will be uninsured by 2010, and the rate of uninsured will continue to grow, if no action is taken.
- **Premium rates for uninsured individuals and workers will rise.**
 - Premium rates have increased much faster than general inflation and wages over the past decade and this is expected to continue.

Ohioans suffered more than 6.7 million cases of seven chronic diseases.

In 2002, there were 111 deaths per 100,000 people that were amenable to health care.

In just about every category of health status, uninsured people are less healthy than insured people.

- **More employees working at small businesses will lose coverage.**
 - Trends indicate that fewer Ohio businesses will offer employer and dependent coverage as premium rates rise. Between 2001 and 2007, the percentage of firms with 10-199 employees that offered coverage declined from 69% to 61%. For firms with 3-9 employees, the percentage dropped from 57% to 45%. This trend is expected to continue if no action is taken.¹⁹
- **Fewer people will be able to afford individual coverage.**
 - A 2006 study conducted by the Department of Insurance showed that between 2007 and 2010, rising premium rates in the individual market will cause 36,000 fewer people to be insured in that market, representing 12% of the individual market.
- **People in poor health will continue to be rejected for coverage.**
 - Currently, people in poor health are rejected for coverage in Ohio's regular individual market. They have limited options, if any at all.
- **As compared to people with insurance, uninsured Ohioans will continue to:**²⁰
 - Be in poorer health;
 - Have less access to primary care;
 - Receive less timely care;
 - Receive less preventive care;
 - Have worse health outcomes;
 - Have more medical debt;²¹
 - Be less productive; and
 - Live shorter lives.
- **Uninsured Ohioans will continue to have a diminished quality of life.**
 - The Institute of Medicine (IOM) has estimated the average annual discounted value of lost health over time due to being uninsured. Using the concept of "health capital" which takes into account the following: (1) is the person alive? (2) is the person in pain? (3) does the person need care? (4) is the person unable to work? and (5) is the person able to function normally? The IOM estimated that the average value of lost health capital ranges from \$1,600 to \$4,400 per uninsured person per year.²²
- **The cost of care for Ohio's uninsured residents will continue to be shifted to the government, employers and the insured.**
 - About \$3.5 billion was spent on Ohio's 1.3 million uninsured residents in 2006, which is roughly equivalent to \$2,700 per uninsured person.²³ About half is paid for by government programs, such as Medicaid, Medicare, workers compensation, and state and local programs.²⁴ For care that is uncompensated,

If nothing is done to cover Ohio's uninsured residents:

Ohio business will continue to drop employer and dependant coverage as premium rates rise.

Uninsured Ohioans will continue to live shorter lives.

costs are shifted to paying customers, such as employers, insurers and consumers through higher premiums. An estimated 7.8% of the premiums paid for health insurance coverage in Ohio is due to costs shifted by providers for uncompensated care. In 2006, this equaled \$330 of the premium paid for an individual policy and \$950 of the premium paid for a family policy, raising the cost of coverage.²⁵

F. What will happen if Ohio does create programs to cover its uninsured residents?

In contrast to doing nothing, by extending coverage to Ohio's uninsured residents, we can expect to see improvements not only to the health of Ohioans but to Ohio's economy. In this regard, providing coverage to Ohio's uninsured residents that focuses on prevention, primary care and chronic care management can do all of the following.

- **Help to prevent serious illness in a more cost effective manner.**

Early detection and preventive care can be more cost-effective than treating an illness after it becomes serious and requires extensive treatment.²⁶ Acute care tends to be capital-intensive and high cost, whereas preventive care provided at the primary care level can be more cost-effective and less capital-intensive.²⁷

- **Increase the number of Ohioans with a usual source of care.**

Expanding coverage to 500,000 more Ohioans can increase the number of Ohioans with a usual source of care by as much as 149,000.²⁸ This is expected to increase the number of cholesterol, mammogram, prostate and colorectal screenings and also increase the number of adults receiving care management plans, lifestyle counseling and blood pressure management.²⁹

- **Stimulate economic growth and improve business productivity.**

If 500,000 additional Ohioans are covered, Ohio stands to gain \$1.3 billion in economic value from improved health and increased productivity of previously uninsured Ohioans.³⁰

A healthier work force stimulates economic development by improving productivity and reducing expenditures for preventable health care services.³¹ Poor health causes problems with both presenteeism (workers who are present at their jobs but are not able to focus on work due to illness) and absenteeism (workers who miss work), and this accounts for significant losses in productivity. The value of these productivity losses can be reduced by providing people with preventive care management services.³²

By extending coverage to Ohio's uninsured residents, we can expect to see improvements not only to the health of Ohioans but in Ohio's economy.

If 500,000 additional Ohioans are covered, Ohio stands to gain \$1.3 billion in economic value from improved health and increased productivity of previously uninsured Ohioans.

Additional investments in health care coverage in Ohio will also stimulate health care demand which will lead to more health care jobs in Ohio.³³ The economic value of increased health care spending because 500,000 more Ohioans have coverage will likely exceed \$1 billion. Dollars spent on health care coverage in Ohio will mostly stay in Ohio due to increased job creation.³⁴

- **Reduce job-lock created by a reliance on employer provided coverage.**

In some instances, individuals are less likely to leave their jobs due to fear of losing health care benefits. This creates job-lock and raises the potential for presenteeism.³⁵ Expanding coverage to the uninsured will reduce job-lock, expand mobility and potentially increase productivity.³⁶ Studies indicate that job-lock reduces mobility by 23% to 38% and that expanding coverage can reduce job-lock by two to three percentage points in the first year.³⁷

- **Reduce health care disparities.**

Social determinants of disease (such as income, employment-status, race/ethnicity or gender) expose the vulnerable to greater risks and barriers. Racial and ethnic disparities are reduced when disadvantaged groups get coverage that provides access to a usual source of health care.³⁸ Improved access to prevention, primary care and chronic care management can put people on more equal footing by improving their health status which improves their chances for better jobs and financial stability.³⁹

- **Reduce medical debt and bankruptcies.**

Since 2000, five million American families filed for bankruptcy following a serious health problem. In all, approximately half of all bankruptcies are related to medical expenses.⁴⁰ More than 51% of uninsured adults have reported medical debt and, of those, nearly half (49%) have used up all their savings to pay their medical bills.⁴¹

Lack of adequate health coverage frequently leads to medical debt. Coverage for prevention and primary care services can improve health status by providing timely screenings and interventions which help to prevent and detect serious, expensive health conditions.⁴² Health insurance coverage gives people a measure of protection against debt and bankruptcy.⁴³

- **Reduce mortality and rates of disability, and improve quality of life.**⁴⁴

Studies have shown that reduced coverage can lead to deteriorating health, and adequate coverage can lead to improved health.⁴⁵ When uninsured people become continuously insured, their mortality rates are reduced by 5 to 15 percentage points.⁴⁶ As a result, on average, the lives of 150 Ohioans can be saved each year by giving them coverage.⁴⁷

Racial and ethnic disparities are reduced when disadvantaged groups get coverage.

When uninsured people become continuously insured, their mortality rate falls.

As a result of covering 500,000 more Ohioans, up to \$742 million could be realized in 2011 by providers, insurers, firms, and individuals as the result of reduced cost-shifting.

- **Improve the overall quality of health care services.**

When uninsured populations begin to access health care regularly in a community, it improves the overall quality of care that everyone receives.⁴⁸

- **Reduce cost-shifting to government, employers and consumers by reducing uncompensated care.**

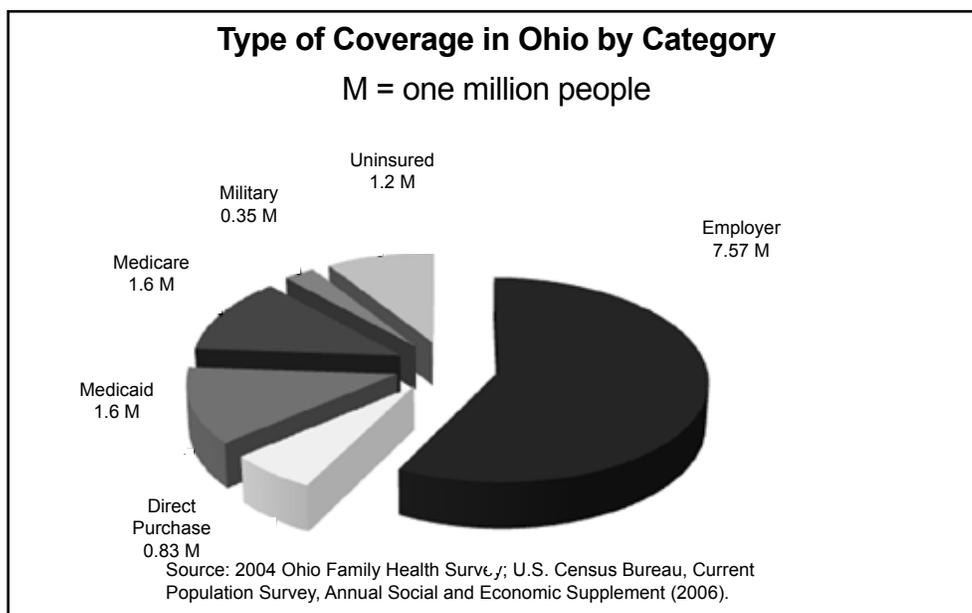
Ohioans with health insurance coverage are now paying for the care provided to uninsured Ohioans through cost-shifting. Currently, 7.8% of health insurance premiums in Ohio are due to the cost of uncompensated care given by providers.⁴⁹ If at least 500,000 more Ohioans were covered by health insurance, cost shifting could be reduced by up to 50% depending on the reforms adopted.⁵⁰ As a result of covering 500,000 more Ohioans, up to \$742 million could be realized in 2011 by providers, insurers, firms, and individuals as the result of reduced cost-shifting.⁵¹

G. How do people in Ohio get coverage and where are there gaps in the system?

The SCI team looked carefully at the current health care coverage system to understand where people currently get coverage and where there are gaps in the system. This review was essential to developing reforms that build upon the current system.

People with health coverage in Ohio get their coverage from a variety of sources. Sixty-five percent of Ohioans receive their coverage through private insurance plans offered by employers.⁵² Some Ohioans purchase it directly from an insurance carrier. Seniors (age 65 and older) usually get their coverage through Medicare. Lower income children and their parents, and certain aged, blind and disabled populations, obtain coverage through Medicaid. Some Ohioans with military service get their coverage through the federal Tri-Care program. Chart 19 shows the number and the percentage of Ohioans who get their coverage in these categories.

Chart 19



1. Public Programs

a. Medicare

Medicare is health insurance provided by the federal government primarily to people 65 years of age or older. Medicare provides coverage to about 1.6 million Ohioans.⁵³ Because of Medicare, less than 2% of Ohioans above the age of 65 are uninsured. Medicare provides coverage to the following groups:

- people age 65 and older;
- people under the age of 65 who are Social Security or Railroad Retirement Board beneficiaries entitled to disability benefits for two years or more; and
- people with end-stage renal disease or Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease) regardless of income.

There are several parts to Medicare. Medicare Part A covers hospitalization; Part B provides medical coverage if the senior pays a premium; Part C (or Medicare advantage Plans) involves private insurance companies approved by Medicare providing Part A, Part B and prescription drug benefits; and Part D covers prescription drugs, subject to copays and deductibles. An enrollee can supplement Medicare coverage (Part A, B and D) by purchasing additional coverage through a private insurance carrier. Only individuals covered by Medicare are eligible for the supplemental insurance.

b. Ohio Medicaid

Medicaid is Ohio's largest health program. It combines federal and state funds to provide coverage for over 2 million children, families, elderly persons, and disabled persons throughout the year. As of June, 2008, about 1.7 million Ohioans had Medicaid coverage at any one time.⁵⁴

There are two major types of Medicaid eligibility categories: Covered Families and Children Medicaid (CFC Medicaid) and Aged, Blind, and Disabled Medicaid (ABD Medicaid).

Current income eligibility standards for CFC Medicaid are generally as follows:

- Uninsured children are eligible in families of a combined income up to 200% of the federal poverty level (FPL);
- Pregnant women may earn up to 200% FPL; and
- Adults with children ("Parents") are eligible up to 90% FPL.

Income eligibility standards for ABD Medicaid are as follows:

- Adults determined to be blind or disabled and certain aged adults may earn up to 64% FPL for individuals and up to 75% FPL for couples. In addition, applicants must meet asset requirements to be eligible.

In 2007, Governor Strickland and the Ohio General Assembly attempted to expand Medicaid coverage for children by increasing income eligibility for uninsured children applying for CFC Medicaid from 200% FPL to 300% FPL.⁵⁵ For Ohio to implement this expansion, approval from Centers for Medicare and Medicaid Services (CMS) was required. Unfortunately, CMS did not approve the proposed expansion up to 300% of FPL and Ohio is

waiting to hear whether CMS will approve an expansion up to a lower income level.

Ohio administers other smaller, targeted state funded health coverage programs that offer limited assistance to certain individuals. These programs include: condition-related coverage for children through the Bureau for Children with Medical Handicaps; prescription coverage through the Disability Medical Assistance Program for very low-income adults who have a chronic health condition, and the Children's Buy In program.

In addition to providing health coverage, Medicaid funds some uncompensated medical care provided by hospitals through the Hospital Care Assurance Program (HCAP).

2. Private coverage

Ohioans who do not have coverage through a public program can obtain coverage either through their employer or they purchase it directly from an insurance carrier. Historically, employers have provided coverage to more people than any other source of coverage combined, but over the years employers have found it increasingly difficult to provide coverage to their workers. Rising health care costs are largely to blame.

a. Employer-sponsored coverage statistics for Ohio

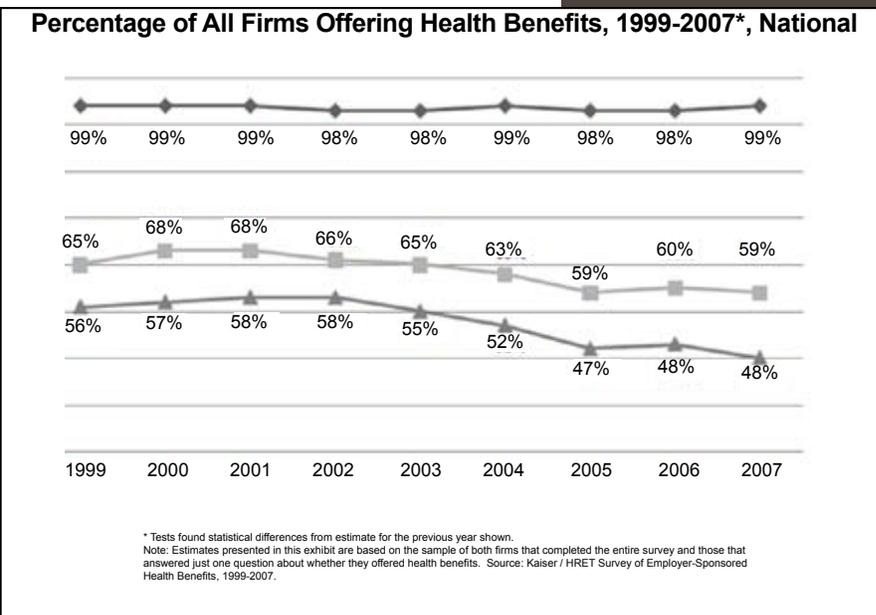
To understand why many Ohioans are uninsured, it is important to understand recent trends in employer sponsored coverage.

Over the past decade, there has been a consistent decline in the percentage of employers that offer coverage to their workers. While large employers usually offer coverage, smaller employers offer coverage far less

frequently. Chart 20 shows the percentage of large and small employers who offer coverage to their workers, and how the percentages have changed over the last decade.

Employers have provided coverage to more people than any other source of coverage combined

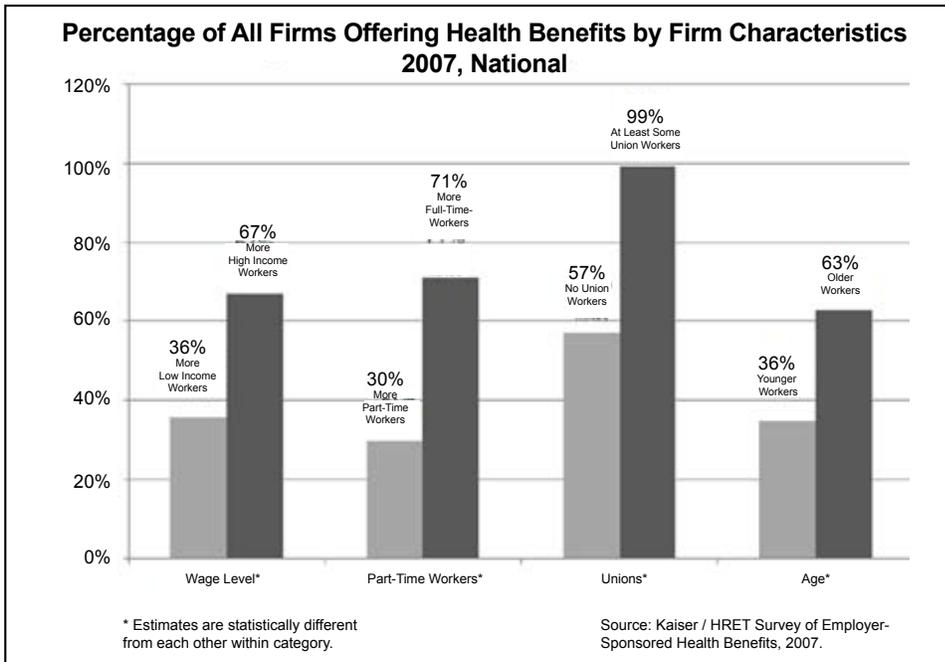
Chart 20



The bottom line is that in 1998, about 71% of all employers offered coverage to workers, and this percentage declined to about 65% in 2006.⁵⁶

While there has been a general decline in employer-sponsored coverage overall, there are certain kinds of businesses that offer coverage less frequently than others. Businesses with low-wage, part-time, non-unionized and younger workers are less likely to offer coverage than other businesses as chart 21 shows.

Chart 21



Even when an employer offers coverage, not all workers are eligible. Nationally, only about 24% of firms offering coverage offer it to part-time workers, and less than 4% offer it to temporary workers.⁵⁷ In fact, only about 80% of people working at firms that offer coverage are eligible for it.⁵⁸

Even when an employee is eligible, some workers do not elect to take up coverage. Nationally, eligible workers take up coverage only about 80% of the time.⁵⁹ As a result, considering both eligibility and employee take up rates, only about 65% of workers at firms offering coverage are covered by the employer's plan.⁶⁰

Most agree that increasing health insurance costs are the primary reason that fewer employers are offering and fewer employees are taking up coverage. As the following chart shows, over the last 20 years, health insurance costs for employers have risen much faster than inflation and worker's earnings.

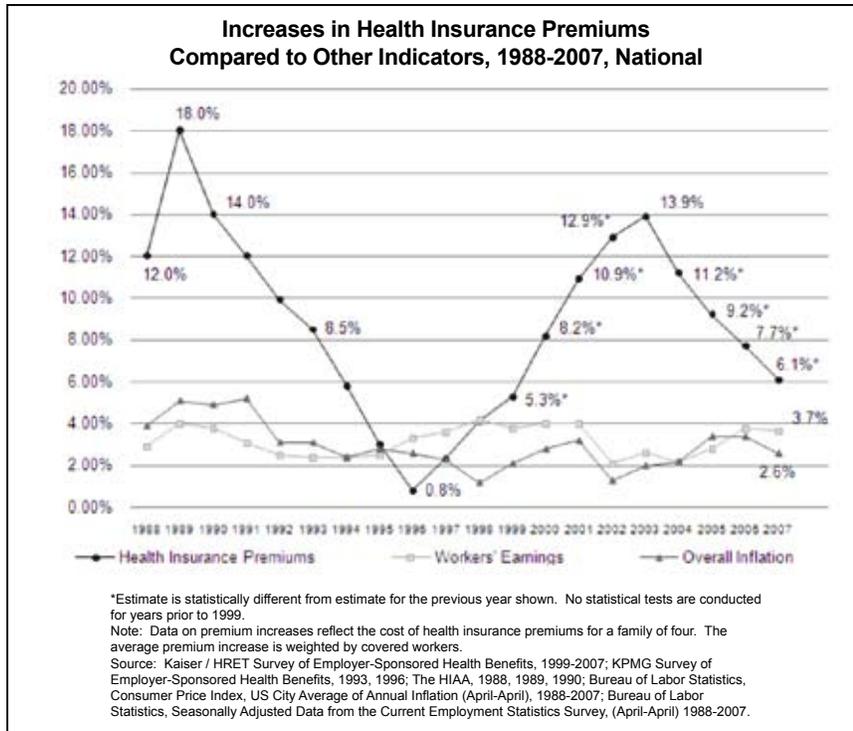
Nationally, these rate increases have caused total premiums for employer purchased coverage to exceed \$4,400 for individual coverage and \$12,000 for family coverage in 2007.⁶¹ Chart 22 shows average premium rate increases for individual and family health coverage nationally over the past five years.

Nationally, only about 24% of firms offering coverage offer it to part-time workers.

Only about 80% of people working at firms that offer coverage are eligible for it.

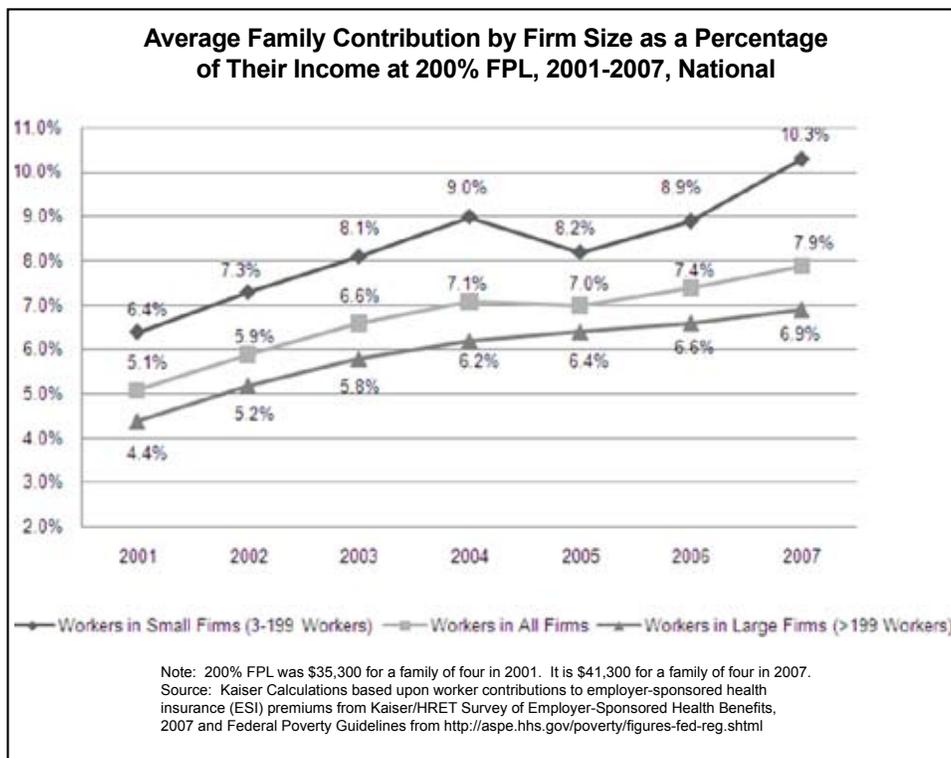
Health insurance costs for employers have risen much faster than inflation and worker's earnings.

Chart 22



Because employer-sponsored coverage has become more expensive, employers are asking employees to contribute more to the cost of coverage. More than 80% of workers pay part of the total monthly premium. On average in 2007, workers contributed 16% of the premium for single coverage and 28% of the premium for family coverage, which amounts to \$58 per month and \$273 for family coverage, respectively. Over the past five years, employee contributions as a percentage of income have risen, particularly for workers at small businesses, as chart 23 shows.

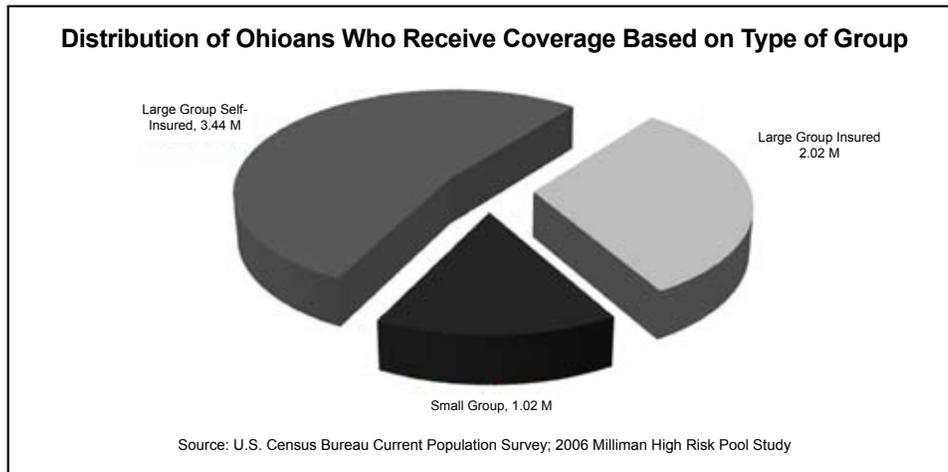
Chart 23



b. The laws that apply to employer-sponsored coverage

Different laws apply to employer-sponsored coverage depending upon the size of the employer and the type of health plan. From a legal perspective, there are three types of employer-sponsored coverage in Ohio: (1) self-insured coverage, (2) large group coverage purchased from an insurance carrier and (3) small group coverage purchased from an insurance carrier. Chart 24 shows the distribution of the 7.2 million Ohioans who get employer coverage in these three categories:

Chart 24

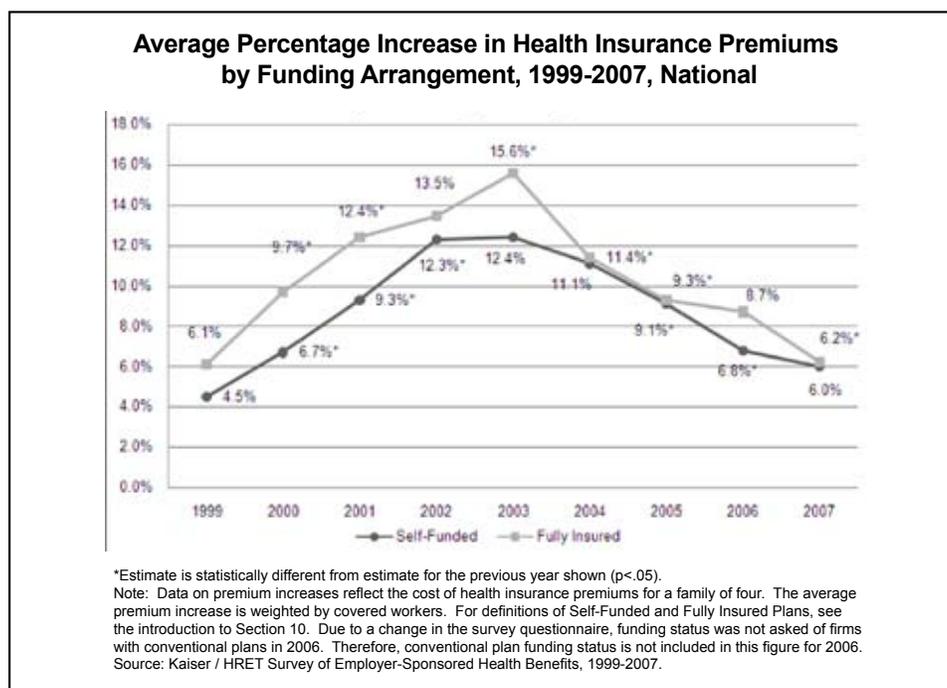


i. Self-insured coverage

Many large employers have self-insured health plans. A self-insured employer does not buy insurance from a carrier but instead pays for worker medical claims on their own. Large employers choose to self-insure because it is often less expensive compared to purchasing insurance.

National statistics show that self-insured employers do slightly better than insured employers in terms of annual rate increases, as chart 25 shows:

Chart 25



Both public and private organizations self-insure. The State of Ohio, for example, and many county and local governments self-insure, as do most large private sector employers.

It is important to note that self-insured benefit plans sponsored by private businesses are governed by the federal Employee Retirement Income Security Act (ERISA). ERISA has broad preemption standards that limit the ability of states, like Ohio, to regulate private self-insured employer plans.⁶² As a consequence, the State of Ohio has only limited authority over self-insured ERISA plans, and no authority over benefits offered by such plans.

ii. Insured coverage for large employers

Some large employers purchase health insurance from an insurance company, in which case the health insurer and the coverage is subject to Ohio's insurance laws.

Large employers that buy insurance may be underwritten, meaning they can be denied coverage. Although large employers can be underwritten, they are rarely denied coverage because large employers are better risks to insure from the insurer's perspective. The larger the group, the more predictable the risk, and the more willing insurers are to offer coverage.

In terms of premium rates, large employers are often "merit rated," meaning the premium rates they pay are based on the group's claims experience. A rate for a new year may be based on the group's prior claims experience, plus the increased cost of medical care (called "trend"), administrative expenses and profit.

iii. Insured coverage for small employers

In Ohio, small employers are defined as employers with 2 to 50 employees for health insurance purposes.⁶³ These employers make up the small group market.

Insurers must accept all small groups that apply, and must renew all small groups that want to renew. Insurers must also enroll all eligible employees and dependents that apply for coverage in a timely way.⁶⁴

Premium rates in the small group market are, for the most part, based on the risk characteristics of the employer. In setting premium rates, insurers will consider the age, gender, geography and health status of workers.⁶⁵ Higher risk groups get higher rates.

There are limits on insurers' ability to consider the "health status" of workers in setting rates for small groups. Ohio has a "rating band" for small group coverage, which prohibits insurers from varying premium rates based on the health status of workers by a factor of more than plus or minus 40%.⁶⁶ It is important to note that insurers may consider risk characteristics other than "health status" in setting rates for small groups,

The State of Ohio has only limited authority over self-insured ERISA plans, and no authority over benefits offered by such plans.

Premium rates in the small group market are, for the most part, based on the risk characteristics of the employer.

Small group premium rates in Ohio commonly vary by as much as a factor of 17 to 1, meaning high risk small employers can pay as much as 17 times more than low risk small employers.

including the age and gender of workers and industry classification.

Based on information developed by Lewis & Ellis as part of its actuarial study of Ohio's market, small group premium rates in Ohio commonly vary by as much as a factor of 17 to 1, meaning high risk small employers can pay as much as 17 times more than low risk small employers.⁶⁷ In fact, the age of workers alone can cause rates to vary by as much as 10 to 1 from one small employer to the next.⁶⁸

Ohio's small group laws also limit rate increases at renewal because of a change in the health status of workers.⁶⁹ An insurer can raise premium rates because medical costs have increased, the employer's case characteristics have changed, or the plan design has changed. Beyond these adjustments, an insurer may not raise premium rates more than 15% from one year to the next for the same small groups because of a change in the health status of workers for that employer.⁷⁰

Small group rating rules do not prevent insurers from raising rates because medical expenses have increased. The small group rating rules only limit the variation in rates from one small employer to the next. Thus, if the cost of medical care increases from one year to the next, premium rates will also increase.

As for benefits, small employers are subject to the same mandated benefits as insured large groups, with limited exceptions.

c. Individual coverage

Individual coverage is sold by a carrier directly to an individual or family. Carriers selling individual coverage are permitted to "underwrite," with limited exceptions.⁷¹ Underwriting allows insurers to deny coverage to people who are at greater risk of incurring claims, such as older people and people with health conditions. In the individual market, insurers use strict underwriting rules when it comes to "health status." As a result, people with chronic or serious health conditions are often denied coverage.

Another common practice in the individual market is to exclude coverage for specific conditions. If a person has a health problem, such as diabetes, the carrier may offer a policy that excludes coverage for that condition. This is accomplished by attaching a "rider" to the insurance policy that excludes coverage for medical expenses related to the condition.

If a person passes underwriting and is offered a policy, with or without a rider excluding a specific condition, he or she will be charged a premium rate that is based on his or her risk characteristics, which can include age, gender, occupation, and health status. Consequently, even if a person is offered a policy, they can be charged a high premium rate if they have a chronic or serious health condition. Conversely, people in good health get lower rates.

In the regular market, there are no limits to the premium rates insurers can charge. Generally, premium rates for young, healthy people can be as low as \$30 per month, whereas rates for older or less healthy people

People with chronic or serious health conditions are often denied coverage.

can exceed \$900.⁷² However, because insurers underwrite in the regular individual market, people with serious health conditions can be denied coverage at any price. Examples of conditions that cause insurers to deny coverage include autism, bipolar disorder, epilepsy, uncontrolled or newly discovered hypertension, a current pregnancy and sickle cell anemia.⁷³

One exception to the underwriting rule in the individual market is a program called “open enrollment.” Insurers selling in the individual market must hold open enrollment⁷⁴ at certain times of the year and accept all people who apply, with limited exceptions. In the open enrollment program, there are limits to the rates insurers can charge, but those limits are extremely high. Many people with health conditions are charged in excess of \$2,500 per month in open enrollment.

Open enrollment is usually limited to people in poor health because people in good health can pass underwriting and get affordable rates in the regular individual market. Because rates are so high, less than 2,000 people had open enrollment coverage in 2004.⁷⁵ Open enrollment was originally intended to guarantee the availability of coverage to all Ohioans. However, because rates are so high, open enrollment is not effective.

d. Benefit levels

In terms of benefits, Ohio has a number of laws that require certain benefits be included in health plans sold to employers and individuals. The benefits that must be included depend on the type of insurer selling the product. Two kinds of health insurers operate in Ohio: (1) Health Insuring Corporations (“HICs,” or “HMOs”) and (2) traditional indemnity insurers which include Preferred Provider Organizations (PPOs). With respect to benefits, HICs are required to cover “basic health care services” which include:⁷⁶

- Physician services;
- Inpatient hospital;
- Outpatient services;
- Emergency health services;
- Urgent care services;
- Diagnostic laboratory and radiologic services;
- Mental health services for biologically based mental illness; and
- Preventive services.

HICs cannot impose pre-existing condition exclusions, but may impose copays and deductibles up to certain limits.⁷⁷

Traditional indemnity insurers, including PPOs, are subject to fewer mandated benefits. Traditional indemnity insurers may charge deductibles, copays and cost-sharing requirements and often offer policies with high deductibles.

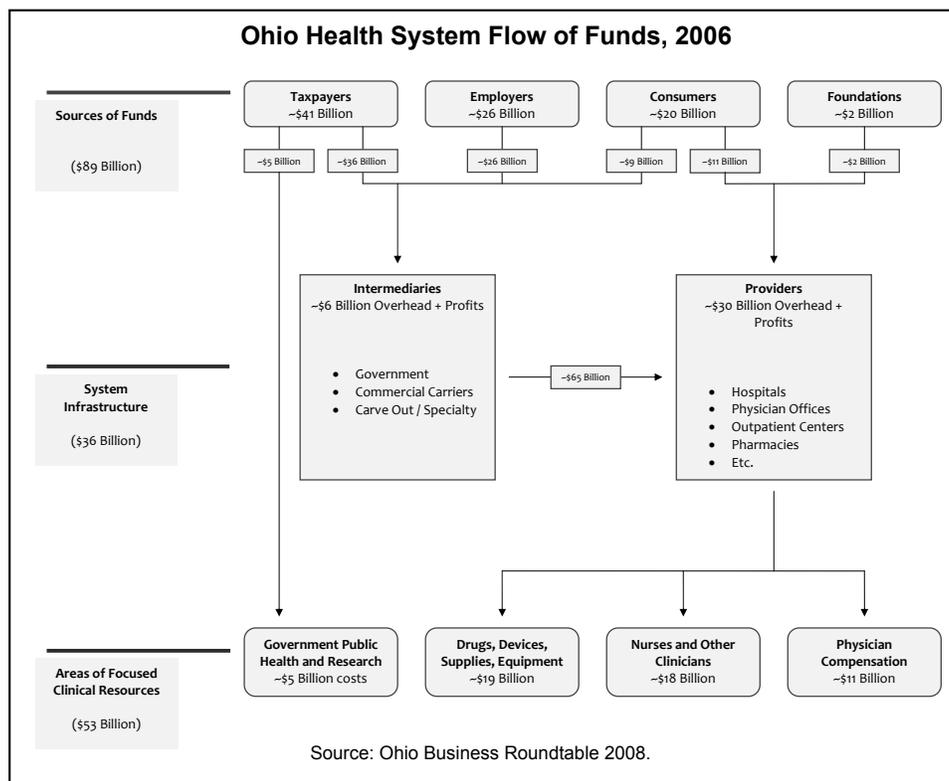
Attached as Appendix “F” is a chart of the mandated benefits that apply to HICs and traditional indemnity insurers under Ohio law. In comparison to other states, Ohio has relatively few mandated benefits.⁷⁸

During open enrollment, insurers must offer a basic and standard plan to people who apply.⁷⁹ These plans have significant cost-sharing requirements including copays and deductibles. Copies of the basic and standard plans are attached to this report as Appendix “G.”

H. Health Spending in Ohio

In 2006, approximately \$89 billion was spent within Ohio's health care system by various payers including consumers, employers, taxpayers and foundations. Those funds went to pay intermediaries (such as insurance companies) and health care providers including doctors, hospitals, pharmacies and others. Below is a chart of the flow of funds through Ohio's health care systems using 2006 estimates.

Chart 26



Estimated spending for medical care for non-institutionalized Ohioans, including care provided to Ohio's uninsured residents, totaled \$62.2 million in 2006. The total and per capita health care expenditures in Ohio by insurance status and source of payment are shown in chart 27.

Chart 27

Total and Per Capita Expenditures in Ohio by Insurance Status and Source of Payment, 2006

	All Types of Insurance	Medicare	ESI	Medicaid	Non-Group	Other Insurance	Uninsured
Annual Population	11,240,041	1,501,218	6,909,922	931,430	233,145	342,411	1,321,915
(Unweighted MEPS Observations)	(19,905)	(2,802)	(11,180)	(2,141)	(362)	(598)	(2,822)
Total Expenditures (\$ millions)							
All Sources	\$ 62,204	20,954	31,009	4,767	592	1,344	3,537
Per Capita Expenditures (\$)							
Out of Pocket	\$ 788	1,872	654	183	1,060	721	726
Medicare	1,074	7,405	37	109	3	6	63
Private	2,450	2,816	3,599	253	1,404	2,011	228
Medicaid	776	945	63	4,219	4	42	476
Donated Care	52	0	0	0	0	0	409
All Other	394	920	135	353	67	1,146	774
All Sources	\$ 5,534	13,958	4,488	5,118	2,538	3,926	2,675

Source: Meyer and Hadley, Mapping Health Care Spending and Insurance Coverage In Ohio, Health Policy Institute of Ohio 2007

As chart 27 shows, about \$3.5 billion was spent on Ohio's 1.3 million uninsured residents in 2006, which roughly averages \$2,700 per uninsured person.⁸⁰ This is about half of the average amount spent for non-elderly adult Ohioans with health insurance coverage.⁸¹

Notably, a significant amount of the total spending on Ohio's uninsured residents— about half — is funded by government programs including Medicare, Medicaid, the Veterans Administration, Tri Care, Workers Compensation and various other state and local programs.⁸² Thus, medical care provided to Ohio's uninsured residents is not free and is a "hidden cost" to taxpayers through these public programs.⁸³

About \$3.5 billion was spent on Ohio's 1.3 million uninsured residents in 2006, which roughly averages \$2,700 per uninsured person.

III. Vision, Goals, and Principles

A. The Vision Statement

During the summer of 2007, Governor Strickland identified the need for a unified vision for a healthy Ohio to direct the activities of the State of Ohio. To develop this unified vision, Governor Strickland convened the state agency directors involved in public health, health care and health coverage. As a result of these efforts, the Strickland administration developed the following Envisioned Future State for a Healthy Ohio.

Ohioans are achieving and maintaining optimal health through personal wellness management and a health care delivery system that focuses on the promotion of health and the prevention of disease. At each stage of life, every Ohioan should have access to timely, patient-centered, and efficient physical and behavioral health care choices. All Ohioans have access to primary and preventive services as well as education and opportunities for healthy lifestyles and the incidence of preventable diseases are at the lowest levels in the nation across all population groups. Services and care are coordinated through widespread use of health information technology, thereby improving health outcomes and delivering effective, efficient and culturally competent health care.

At each stage of life, every Ohioan should have access to timely, patient-centered, and efficient physical and behavioral health care choices.

B. The Goals of the Governor

One goal reflected in the Envisioned State for a Healthy Ohio is to provide Ohioans with access to timely, patient centered care. When Governor Strickland took office, about 1.3 million Ohioans were uninsured, representing 12% of the population. To address this problem, Governor Strickland established the following goals.

1. Reduce the total number of uninsured Ohioans by 500,000 by 2011.
2. Increase the number of small employers that are able to offer coverage to their workers.

C. Principles Identified by the SCI Team

The SCI team was asked by Governor Strickland to develop reforms that would accomplish his goals. To that end, the SCI team developed a number of principles to guide development of recommendations to cover to Ohio's uninsured residents. The principles adopted by the SCI team related to its recommendations are as follows:

- All Ohioans, including people with lower incomes and serious health conditions, must have access to affordable health coverage.
- Everyone in Ohio must help to make health care affordable.
- We all must take personal responsibility for reducing health care costs, which includes taking action to keep ourselves healthy.
- Many Ohioans cannot achieve good health without a partnership of government, business and Ohio's health care community to equip people with the tools and services they need to stay healthy. This commitment includes a responsibility to provide everyone with the appropriate care at the right place and time.
- Health care coverage for Ohio's uninsured residents must be aligned with prevention, primary care, continuity of care, positive outcomes and quality.
- Reforms must be financially viable, sustainable and have measurable impacts.
- In developing strategies to cover Ohio's uninsured residents, Ohio should leverage funds currently available in the existing system, including federal and employer contributions to health care benefits.
- Reforms should be built on the strengths of Ohio's existing public and private health care systems.
- The task of the SCI team – to improve access to health insurance coverage– can not be considered alone. The SCI team's recommendations are an important first step, but equally important is the focus on the cost and quality of Ohio's health care system, and improving the health of Ohioans through population health strategies.

IV. SCI Team Recommendations

To fully realize our vision for a healthy Ohio and comprehensively address the problems that uninsured Ohioans and small businesses face in obtaining coverage, bold action is needed.

The SCI team is proposing a range of initiatives that involve numerous public and private partners. We recommend insurance market reforms that include pairing a requirement for guaranteed issuance of all products in the individual market to each and every Ohioan who applies – including those currently excluded from coverage because of pre-existing conditions – with an individual mandate that every Ohioan who is able to purchase affordable coverage be required to do so. We recognize that coverage could remain unaffordable for some small businesses, families, and individuals without additional market reforms, so we are also recommending:

- a major new reinsurance initiative;
- sliding scale subsidies for Ohioans between 100% and 300% of the federal poverty level;
- phasing in a compression of the rate variance in the individual market; and
- requiring the collection and disclosure of metrics that will allow meaningful comparisons of coverage options and plan performance.

Because the coverage offered by these new programs must be readily accessible to Ohioans, we also recommend building a one-stop “connector” where Ohioans can obtain information on coverage options, enrollment procedures, plan performance, and eligibility for subsidies or other programs.

In making these recommendations, we also considered the fiscal challenges currently facing our state. While fiscal challenges should not be the only consideration in meeting the Governor’s objectives, cost is a factor in the timing of reform initiatives as well as program sustainability. During the course of this initiative, the SCI team has learned that expanding coverage to 500,000 more Ohioans will require significant allocation of state resources. In addition, since Governor Strickland gave the SCI team its charge to develop strategies to cover 500,000 more Ohioans, it has become increasingly difficult for the state to meet this goal because falling state revenues have made it very difficult to fund new programs with existing resources. As a result, the SCI team recognizes that it may be necessary for the Governor and General Assembly to adopt and implement some reforms over a period of years, in a step by step approach, that could extend beyond 2011. Certainly, some of the reforms recommended by the SCI team can be adopted immediately, but others can be adopted and implemented over a longer time period.

Accordingly, the recommendations below are organized to reflect the potential for sequential or partial implementation. We realize that some recommendations may be more readily agreed upon and achieved in the context of limited resources. Other recommendations may be more challenging in terms of the cost and impact. Therefore, implementation of reforms should consider available resources in light of Ohio’s budget situation and the need to mitigate the potential for market disruptions. As we work toward a comprehensive approach to assure affordable health insurance coverage for all Ohioans, the SCI team also recommends the

ongoing assessment of implemented reforms, the changing health care environment, and budgetary realities. We also recognize that Ohio's conversation about health care reform is occurring against a broader context of health care reform occurring at the national level that leaders may want to take into consideration in reviewing the following recommendations.

Additionally, the recommendations below identify if a particular strategy can be implemented independently or can only be successfully adopted in conjunction with others.

The recommendations of the SCI team are as follows.

1. Recommendations Focused on Employer-Sponsored Coverage

These recommendations are designed to help employers, employees and their dependents obtain affordable health insurance coverage.

1.1. Require Ohio employers to adopt Section 125 premium-only plans to allow employees at employers not currently offering coverage to purchase coverage using pre-tax dollars.

According to the 2004 Ohio Family Health Survey, about 303,000 uninsured Ohioans are employed at firms that do not offer health coverage or are not eligible for coverage that is offered. To the extent these workers are not eligible for public programs (such as Medicaid), they must purchase coverage in Ohio's individual health insurance market. As a result, these people purchase health coverage using after-tax dollars. In contrast, if coverage is provided through an employer plan, pre-tax dollars can be spent – meaning the employee is not taxed on amounts spent toward health insurance.

Ohio employers, by simply establishing Section 125 premium-only plans, can provide employees with a mechanism to purchase individual health coverage using pre-tax dollars. A Section 125 plan, also known as a "cafeteria plan," is a health benefit plan that complies with Section 125 of the Internal Revenue Code. With the help of the State of Ohio, these plans can be created by employers at little or no cost. Once established, employers can deduct amounts from a worker's paycheck and then remit those funds to an insurer in payment of the worker's individually purchased health insurance coverage. By doing so, the worker's income devoted to health insurance is not subject to state or federal taxation.

For workers at moderate income levels, the establishment of a Section 125 plan can mean a savings of between 21% and 34% off the cost of health insurance coverage, depending on income level. For higher income workers, the savings can exceed 40%.

The SCI team estimates that by implementing Section 125 premium-only plans for workers at firms that do not offer coverage or for workers who are not eligible for coverage that is offered, an additional 37,000 Ohio workers will take up coverage at a cost to the State of Ohio in lost tax revenue of \$5.7 million.

1.2. Ohio should adopt a reinsurance program to fund coverage for uninsured individuals and uninsured workers at small businesses.

Ohio should adopt a state-sponsored reinsurance program, similar to the Healthy New York program, that provides affordable coverage to uninsured small businesses, sole proprietors, workers and individuals. The idea behind a state-sponsored reinsurance program is that private insurers would develop comprehensive yet streamlined benefit packages to sell to uninsured small businesses, sole proprietors, workers and individuals. The state would then support these plans by providing reinsurance to cover high-cost claims. The Healthy New York program, for example, covers 90% of claims paid by an insurer between \$5,000 and \$75,000 on behalf of a member during a calendar year. By providing this reinsurance protection against high-cost claims, the state partners with insurance carriers to offer more affordable coverage to uninsured businesses, their workers, and individuals. An added benefit is that reinsurance stabilizes premium rates, making the cost of coverage more predictable from year to year.

The Healthy New York program is geared toward small businesses and their workers who are uninsured. The reinsurance program the SCI team proposes would also extend coverage to all uninsured individuals. To prevent employers from dropping current coverage and switching to state reinsured coverage, the SCI team recommends that only people uninsured for six months or more be eligible for the reinsured coverage with certain need-based exceptions which include the unexpected loss of a job.

At the request of the SCI team, Lewis & Ellis modeled a reinsurance program similar to Healthy New York with a number of differences designed to make coverage affordable for both individuals and small businesses. The modeling showed that if Ohio were to adopt a reinsurance program tailored to Ohio without an individual mandate the premiums would be reduced by about 25% for eligible businesses and individuals as compared to market rates without reform. As a result, 181,000 more Ohioans would become insured at a cost to the state of about \$157 million.

The SCI team recognizes that this proposal may create a competitive advantage for small businesses who can obtain coverage financed in part through reinsurance, whereas other small businesses could not take advantage of the program. The SCI team therefore recommends affordability standards be established for small businesses such as those implemented by the Healthy New York program, which limit eligibility to employers with a low-wage work force.

Another possible strategy to address the competitive advantage issue would be a broader reinsurance program that would provide reinsurance coverage to all health plans sold to small businesses. This type of program would reduce rates for all small businesses, thus stabilizing the small group market. Based on the best available information, the cost of a reinsurance program designed to reduce rates in the small group market by about 25% could cost approximately \$850 million. A more moderate reinsurance program could be implemented at a lower cost and still provide some benefit to the small group market. Although such a program would help uninsured small businesses purchase coverage, it will also bring down rates for small businesses that currently have coverage, and thus, it is not a program targeted at only the uninsured. While recognizing that the cost of this reform may be prohibitive in the short term, we believe this option should be considered to help achieve the second goal of helping small businesses provide insurance to their employees.

1.3. Extend coverage to dependents up to the age of 29.

Young adults (age 19 to 29) are one of the largest and fastest-growing segments of the U.S. population without health insurance. Even though young adults represent 24.3% of the non-elderly population, they represent 37.3% of the non-elderly uninsured. 23.2% of young adults are uninsured. This equals 371,000 Ohioans between the ages of 19 and 29 without coverage.

Young adults often lose health insurance coverage under their parents' policy when they turn 19 or they graduate from high school or college. During their transition from school to work, they often become uninsured. Jobs available to young adults are often low paying, or part-time, temporary, and many do not come with health insurance benefits. This places young adults at risk.

A simple, cost effective way to get young adults covered by health insurance is to add them to their parents' health insurance policies. Under current law, a child is generally considered a dependent, and is thus eligible to be covered under a parent's policy, if the child's principal residence is with the parent for at least half of the year and the child falls into one of the following categories:

- the child is under 19;
- the child is under 24 and a full time student; or
- the child is totally and permanently disabled.

Extending dependent coverage to Ohio children up to the age of 29 whether or not they live at home, is an easy, cost effective way to get younger adults insured. The cost of coverage for many young adults is less expensive than the cost of coverage for older adults and consequently, many children can be added to their parent's plan at a cost lower than coverage available in the individual market.

The SCI team therefore recommends that, with respect to policies covering parents that include or have available dependent coverage, insurers should make dependent coverage available to children beyond the current age of dependency. This can be done by having the child continue on the parent's policy, or making available riders or even separate policies providing coverage at dependent rates.

We estimate that 325,000 adults between the age of 19 and 29 are uninsured and not eligible for employer sponsored coverage. To determine how many of these children could be added to a parent's plan, it is important to look at the situation of the parents. Some of the parents are uninsured and others are on Medicaid or in self-insured employer plans that will not be affected by this recommendation. We therefore estimate that about 113,000 adult children have parents with employer-sponsored coverage that would allow the parent to add the child if the dependent age limit were raised to 29. If 10% of these parents decided to add their adult child to their health insurance plan, about 11,300 adult children would be covered.

1.4 Provide premium assistance to workers to help them take up employer-sponsored coverage.

Approximately 120,000 uninsured Ohioans are eligible for health insurance at work. While some uninsured workers make a voluntary choice not to take up coverage, other uninsured workers do not have a choice. They simply cannot afford to pay the cost-sharing

requirements needed to take up coverage. Currently in Ohio, there are about 29,000 uninsured workers offered coverage who earn less than 100% FPL and an additional 70,000 uninsured workers offered coverage who earn between 101% and 300% FPL. If the state were to provide these lower income workers with sliding scale subsidies up to 300% FPL to help them take up coverage, an estimated 50,000 more workers could be insured at a cost to the state of \$106 million. If premium assistance were extended to spouses as well, more people would be covered at an increased cost to the state.

Encouraging workers to take up coverage offered by their employer is a cost-effective approach because employers typically contribute more than 50% to the cost of health coverage for their workers.

2. Recommendations Focused on Covering Lower Income Ohioans

2.1 Enroll more uninsured Medicaid eligible Ohioans into Medicaid.

Currently, approximately 250,000 Ohioans are eligible for Medicaid but not enrolled. The SCI team recommends that Ohio streamline its Medicaid enrollment requirements and conduct additional outreach to enroll more eligible Ohioans. Specifically, the SCI team recommends that the Governor and General Assembly consider the following Medicaid enrollment simplification reforms:

- Increase the role of Medicaid managed care companies in re-enrollment of Medicaid eligible individuals;
- Increase re-certification periods for adults from 6 to 12 months, and synchronize re-certifications with food stamp renewal;
- Increase reliance on the Ohio Benefit Bank as an entry-point for enrollment and re-enrollment;
- Adopt pre-populated re-enrollment forms;
- Utilize self declaration/administrative re-verification of income at renewal; and
- Utilize presumptive eligibility for children.

In addition, the SCI team recommends the following outreach strategies to enroll more Ohioans in Medicaid:

- Establish grants for community-based outreach programs; and
- Partner with other programs and providers such as schools, faith-based organizations, free clinics, W.I.C., childrens hospitals and local health departments to reach potential Medicaid enrollees.

If Ohio adopted these reforms and had the same success other states have experienced by implementing similar strategies, it is estimated that enrollment will grow by about 3%, which equals about 75,000 more Ohioans with Medicaid coverage. By enrolling more people in Medicaid, the State of Ohio can draw down federal funds, currently equal to 62% of the cost of coverage.

Chart 28 shows the estimated take up rates, per member per month costs, and the state and federal share for enrolling 3% more people in Medicaid if reforms were implemented in 2010.

**Enroll People Currently Eligible for Medicaid into Medicaid
Cost Estimates**

Chart 28

Year	Average enrollment per month	Estimated cost per enrollee per month	Estimated cost
Fiscal Year 2010	31,500	\$263	State: \$38 million Federal: \$61 million Total: \$99 million
Fiscal Year 2011	75,000	\$280	State: \$96 million Federal: \$156 million Total: \$252 million

2.2 Expand Ohio’s Medicaid eligibility to cover more of the uninsured population.

In Ohio, the Medicaid eligibility income limit for parents of Medicaid eligible children is 90% FPL. Expanding Medicaid eligibility for parents up to 200% FPL could be done without having to obtain a waiver from the federal government. Expanding Medicaid for these parents would ensure that Ohio could draw down federal funding, currently equal to 62% of the cost of coverage.

The SCI team considered two Medicaid expansion options for parents: (1) expanding eligibility up to 150% FPL or (2) expanding eligibility up to 200% FPL. In terms of benefit levels, newly covered parents between 90% and 100% FPL must receive full Medicaid benefits under federal law. For newly covered parents above 100% FPL, the SCI team recommends scaled-down benefits as permitted by the Deficit Reduction Act of 2005 (DRA). Under the DRA, parents above 100% FPL may have cost-sharing requirements not to exceed 10% of the cost of the service and 5% percent of family income.

An expansion up to 200% FPL would result in an estimated 135,000 uninsured Ohioans taking up coverage by 2011. As an alternative, an expansion up to 150% FPL would result in an estimated 83,000 uninsured Ohioans taking up coverage.

One of the issues highlighted by the projected impacts of a Medicaid expansion is that a significant number of insured Ohioans could switch to Medicaid, which is a phenomenon known as “crowd out.” To implement crowd out provisions beyond the cost-sharing allowed in the DRA, a waiver may be required from the federal government. The SCI team recommends that Ohio Medicaid consider what steps can be taken to prevent crowd out from occurring. If crowd out can be prevented, the cost of a Medicaid expansion would be significantly reduced. At a minimum, we would recommend an expansion up to 150% FPL and if crowd out can be prevented, up to 200% FPL.

The SCI team also recommends that, in conjunction with an expansion of Medicaid eligibility for parents, programs be established to use Medicaid funds to buy eligible individuals into employer sponsored coverage when available and cost effective. By using Medicaid funds in this manner, Ohio can leverage not only Federal matching funds, but the contributions of employers toward coverage of their workers.

Chart 29 shows the impact of raising Medicaid eligibility for parents up to 150% FPL or 200% FPL, respectively.

Expand Medicaid for Parents Up to 150% FPL

(DRA Cost Sharing from 101 to 50% FPL; without crowd out protection)

Chart 29

Year	Insurance Status Prior to Expansion	Estimated Number of Eligibles	Average Enrollment Per Month	Estimated Cost per Enrollee per Month (State and Federal)	Estimated Annual Cost (State and Federal)	Estimated State Share
Fiscal Year 2010	Total	244,000	87,000	\$271.25	\$282 million	\$105 million
	Insured	142,000	32,000		\$106 million	\$39 million
	Uninsured	102,000	54,000		\$176 million	\$66 million
Fiscal Year 2011	Total	244,000	133,000	\$283.08	\$451 million	\$168 million
	Insured	142,000	49,000		\$164 million	\$61 million
	Uninsured	102,000	83,000		\$287 million	\$107 million

Expand Medicaid Up to 200% FPL

(DRA Cost Sharing from 101 to 200% FPL; without crowd out protection)

Chart 30

Year	Insurance Status Prior to Expansion	Estimated Number of Eligibles	Average Enrollment Per Month	Estimated Cost per Enrollee per Month (State and Federal)	Estimated Annual Cost (State and Federal)	Estimated State Share
Fiscal Year 2010	Total	519,000	162,000	\$266.19	\$519 million	\$193 million
	Insured	352,000	77,000		\$245 million	\$91 million
	Uninsured	167,000	86,000		\$274 million	\$102 million
Fiscal Year 2011	Total	519,000	257,000	\$278.45	\$858 million	\$319 million
	Insured	352,000	121,000		\$406 million	\$151 million
	Uninsured	167,000	135,000		\$452 million	\$168 million

2.3 Allow non-Medicaid eligible adults below 100% FPL without access to employer-sponsored coverage to obtain coverage, with state subsidies, through Medicaid managed care or other similar organizations.

Enrolling more people in Medicaid and expanding coverage to parents up to 200% FPL are steps in the right direction, but there still remains a significant number of very low-income Ohioans who do not have access to Medicaid or any other affordable health insurance coverage. Childless adults who are not aged, blind or disabled are not eligible for Medicaid at any income level. Currently, there are about 182,000 uninsured Ohioans living below 100% FPL who are uninsured and not eligible for Medicaid.

The SCI team believes that insuring low-income Ohioans is a priority and that people below 100% FPL cannot afford to pay for the cost of coverage on their own. An effective solution to getting these Ohioans covered is enrolling them in plans offered by Medicaid managed care organizations. By providing these adults with coverage through managed care organizations and their networks, comprehensive coverage can be provided in an appropriate and cost-effective way.

One of the challenges of providing coverage through Ohio's Medicaid managed care system is incentivizing provider participation. As a result, the SCI team recommends that with respect to non-Medicaid eligible adults offered coverage through the Medicaid managed care system, provider reimbursement rates must be sufficient to ensure adequate provider participation. Reimbursement rates would not be raised across the board, but would be larger than average for preventive and primary care services and for geographic areas with limited access to providers. The SCI team believes that these higher reimbursement rates will help to ensure that coverage provided to non-Medicaid eligible adults will provide appropriate access to care and fairly compensate providers for their services.

In addition, the SCI team recommends that only uninsured Ohioans below 100% FPL be eligible for subsidized coverage under this program. There are a significant number of Ohioans below 100% FPL that have coverage from other sources, and "crowd out" protections should be adopted to prevent people from dropping private coverage and switching to state-sponsored coverage. One possible eligibility requirement would be that a participant must be uninsured for at least six months to be eligible for this public program.

The SCI team also recommends that the benefit package offered through this reform focus on prevention, primary care and care management. Inpatient and outpatient hospitalization coverage would not be included. This coverage would wrap around the services currently being provided by hospitals to non-paying, low-income patients, giving patients coverage for services that will prevent acute conditions from occurring and also help them to recover from acute conditions with care outside hospital settings.

Pricing this recommendation with a benefit package focused on prevention, primary care and care management, with cost sharing requirements appropriate to income, and reimbursements rates for providers based on current Medicare rates, the following chart shows the estimated take-up rates, per member per month costs, and the state cost for this coverage expansion.

**Estimated Caseload and Expenditures
for a State-Sponsored Health Insurance Program
for Non-Parents Adults up to 100% FPL**

Year	Insurance Status Before Expansion	Estimated Number of Eligibles	Average Enrollment Per Month	Estimated Cost per Enrollee per Month (State Funds Only)	Estimated Annual Cost (State Funds Only)
Fiscal Year 2010	Uninsured	182,000	91,000	\$405	\$442 million
Fiscal Year 2011	Uninsured	182,000	149,000	\$426	\$761 million

3. Reforms Focused on Providing All Ohioans, Including Those Who are Older and/or Unhealthy, With Access to Affordable Health Coverage

The SCI team recognizes that the reforms discussed thus far do not address all the problems with Ohio’s individual health insurance market. Currently, people who are not eligible for employer-sponsored coverage or public programs must buy coverage in the individual market. People who are older and/or have health conditions can be denied coverage, issued policies with riders that exclude coverage for existing ailments, or issued coverage at extremely high premium rates. Older and less healthy people are currently locked out of the individual market and have nowhere else to go. The problems with the individual market cannot be ignored.

Another population not yet addressed are individuals who do not have access to employer-sponsored coverage or public programs and need sliding scale subsidies to help them purchase coverage. The SCI team recommends that these subsidies be phased in at the same time the individual market is reformed.

The SCI team believes that the other recommendations contained in this report are not a substitute for reforms needed to fix Ohio’s individual market. In fact, reforms to Ohio’s individual market help to implement some of the other recommendations. For example, establishing Section 125 Plans will allow employees to purchase health insurance in Ohio’s individual market more cost-effectively. It is therefore important that the individual market serve workers regardless of health status, instead of turning them away or offering them only unaffordable rates.

Although the SCI team recommends reforming Ohio’s individual market, it recommends that such reforms be phased in over a number of years to soften market disruptions, account for fiscal challenges, and allow for analysis of incremental reforms to determine if they are having intended effects. One of the impacts of market reforms is that for some people, premium rates will increase substantially, particularly for people who are young and healthy. Although young and healthy people will experience initial rate increases, it is important to understand that their investment in the system through higher premium rates today will be returned to them in full

with more affordable rates as they grow older or experience health problems. The SCI team appreciates that market reforms will have a near term effect of raising premium rates for some people and therefore recommends that the individual market reforms be phased in over time so people can adjust to the new market cost structure.

Under current market rules, insurance companies are allowed to underwrite, meaning they can deny people coverage if they have health conditions, with limited exceptions. If a person passes underwriting and is offered a policy, insurance companies are allowed to attach riders to the policy permanently excluding coverage for ailments the consumer has, with limited exceptions. If a policy is offered to an individual, insurance companies are allowed to charge more to people who are older and have health problems. Most Ohioans who are in fair to poor health cannot afford the premium rates in Ohio's individual market.

To address these fundamental problems, the SCI team recommends the following comprehensive solution. When fully implemented, the recommendations would work in concert to provide access to affordable coverage to all Ohioans regardless of income level or health status.

3.1. Insurance companies in Ohio's individual market must offer coverage to all individuals and families that apply.

Ohio needs to move to a system of guaranteed issuance of all products to individuals and families in the individual market. The current system of open enrollment, where carriers hold open enrollment at certain times of the year, does not work. Ohio's insurance companies writing in the individual market should be required to offer coverage to each and every individual and family that applies. This will bring fairness and equity to a system that is currently unfair and harshly discriminates against people in poor health. It would transform a market currently intent on avoiding higher risks to a market where all Ohioans can get coverage regardless of health status. It would allow insurance companies to offer a variety of products to consumers, while ensuring that all Ohioans have access to defined, meaningful benefit plans. Steps should be taken to ensure that a sufficient number of insurers write in the individual market.

3.2. Ohioans who are able to purchase affordable coverage should be required to purchase at least a basic benefit plan.

The SCI team recommends an individual mandate for those Ohioans who have access to affordable coverage to complement guaranteed issuance of coverage and increased rating restrictions in the individual market. An individual mandate should be implemented only with the other market reforms because they will work together to create affordable coverage in a market that will have a good mix of young and old, healthy and unhealthy Ohioans.

An individual mandate for those Ohioans who have access to affordable coverage improves the mix of people in the insurance market, increases the number of people with coverage, and makes coverage more affordable. An individual mandate is an effective deterrent against "adverse selection," which is the well established principle that in a guaranteed issuance market a significant number of people who can afford to buy coverage will not buy it until it becomes economically advantageous for them to do so. That is, if people can choose to wait to buy insurance in a market where insurers must sell insurance to everyone who applies, a significant number of people who can afford coverage will wait to buy insurance until they are sick or will soon incur medical expenses. In addition, some people will drop coverage if they are healthy

and pick it up again when they think they need it.

Over the course of the last year, the SCI team has heard from experts around the country on health system change. All the experts agree that an individual mandate for people who have access to affordable coverage is needed to make an individual health insurance market with guaranteed issuance of coverage and rating restrictions work over the long term. The individual mandate brings into the insurance pools healthy, low-risk individuals that would otherwise choose to voluntarily remain uninsured, making coverage more affordable by spreading risk across a broader population. An individual mandate for those who are able to buy affordable coverage recognizes that everyone will need health care services, and having continuous coverage throughout one's life is the best way to pay for it. Affordability standards would need to be developed as a part of implementing market reforms as explained in Section 4.1, which addresses the functions of a connector board.

One key component of the SCI team's recommendation about an individual mandate is that it must only apply to people who have access to affordable coverage. It is therefore critical that any mandate for lower income Ohioans be accompanied by: (1) subsidies to help people afford coverage and (2) an affordability standard that allows people who cannot find affordable coverage to be exempt from the mandate. It is unfair and unacceptable to require people to buy coverage if affordable coverage is not available. For this reason, it does not make sense to adopt an individual mandate without also significantly reforming Ohio's individual market. Only in a market that guarantees the issuance of coverage to everyone who applies, and limits the rates charged to people who are older and/or in poor health, can an individual mandate for people who can afford coverage be tolerated.

To make sure an individual mandate works as intended, the SCI team also recommends that the individual mandate be accompanied by a penalty sufficient to ensure compliance.

One key impact of an individual mandate is that it will not only affect people buying coverage in the individual market, but it will also affect costs and take-up rates related to the SCI team's other recommendations. For example, an individual mandate will cause more people to take-up employer sponsored and Medicaid coverage, causing the cost and number of covered lives to grow. To illustrate the impact of an individual mandate, attached as Appendix "H" is a chart that shows the projected impacts of the SCI team's recommendations with and without an individual mandate.

3.3. Ohio should adopt increasingly progressive and restrictive rating rules to be implemented over a period of time to reduce the variance in rates in the individual market to eventually reach a rating variance of 5 to 1.

Guaranteed issuance of coverage means very little if insurance companies can charge rates that are unaffordable. Currently, carriers in the individual market can charge rates that exceed \$2,500 per month for individual coverage. The actuarial work done by Lewis & Ellis showed that for the majority of Ohioans in Ohio's individual market can be as low at \$30 for a young and healthy person to \$900 for an older less healthy person. This means that rates usually vary by more than 30 to 1. Rates can be much higher for very unhealthy Ohioans such as those in Ohio's open enrollment program.

The 30 to 1 rating variance common in the individual market is unacceptable. It is the result of competition among carriers in a market that is governed by rules that allow this

variance to occur. In the current market, insurance companies compete by charging the lowest possible rate to people who are low risk. Enrolling people who are low risk is important to insurance companies because they want a diverse risk pool with healthy individuals participating to the fullest extent possible. As a result, carriers charge young and healthy people very low rates to entice them to buy coverage. While young people benefit from market based rates, older people do not. Rates charged to older and less healthy people are high because they must cover the high cost claims. The risks of older and less healthy people are not being spread effectively across the market because young and health people pay very little for coverage. These market forces have caused some of the problems we currently see in Ohio's individual market.

The SCI team recommends that Ohio adopt progressively more restrictive rating rules to be implemented over a period of time to reduce the variance in rates in the individual market. Over a period of years, rating restrictions should be phased-in such that Ohio's rating rules move through a number of interim steps that would potentially lead to a 5 to 1 maximum rating variance in the individual market. For example, the individual market rules could first move to Ohio's small group rating rules with limitations on the use of health status as a rating factor, then to a 10 to 1 maximum rating variance, and then to a 5 to 1 maximum rating variance over a period of several years.

The phasing-in of progressively tighter rating rules over a period of years should be accompanied by the collection of data from insurance carriers and a comprehensive analysis of Ohio's individual market. The individual market must be closely monitored to ensure that each interim step is having its intended effect of expanding access, improving affordability, and promoting a healthy and inclusive insurance market. If careful monitoring shows that progressively tighter rating rules are not having their intended effect, then adjustments should be made to the implementation plan to ensure that Ohioans have the best possible access to the most affordable coverage.

The SCI team believes that applying progressively tighter rating restrictions to insurers offering coverage in Ohio's individual market will put insurers on the same footing in terms of competing for consumers. It will make coverage affordable for high risk people, but also allow insurance companies to charge below average rates to people who are young and healthy. Ohioans are likely to reap the benefits of this change over their lifetime because rates will be affordable not just when they are young, but when they are older and less healthy as well.

The SCI team realizes that these recommendations may raise the cost of coverage, but appreciates that Ohioans should be able to find affordable coverage as they age. Notwithstanding, careful monitoring of the individual market will ensure that near term rate increases for certain people will be controlled and directly linked to more affordable coverage overall in the individual market. The SCI team also recommends consideration of premium assistance programs to help people whose premiums rise substantially to afford those increases.

3.4. The State of Ohio should provide low-income subsidies to help people afford coverage.

The recommendations thus far have largely focused on the following groups:

Everyone below 100% FPL;
Parents between 100 and 200% FPL; and
People offered employer sponsored coverage.

Even with these coverage expansions, a significant number of lower income Ohioans would still be in need of affordable coverage. For the individual market to work for these people, even after reforms, they would need sliding scale subsidies to afford coverage. The amount of the subsidy to be provided must depend on what they can afford to pay. The amount of subsidies can be determined by the board described in more detail below.

Given the adoption of the other reforms outlined in this report, if these four market reforms are adopted together – guaranteed issuance, rating restrictions, an individual mandate and sliding scale subsidies to lower income Ohioans – an estimated 154,000 more Ohioans would have insurance coverage at a cost to the State of Ohio of about \$687 million in 2011.

3.5. The State of Ohio should adopt a number of other market reforms to make sure the market is running smoothly and people are not being denied coverage or charged rates outside the bounds permitted by law.

In addition to the market reforms mentioned above, the SCI team also recommends:

- a. Insurers should be prohibited from excluding coverage for specific health conditions on a person by person basis via a rider or other addendum to the policy except for re-existing condition exclusions permitted by law.
- b. Measures must be considered to increase administrative efficiencies to ensure that premiums paid by consumers and state subsidies pay for medical expenses to the greatest extent possible.
- c. Insurers should not be permitted to impose pre-existing condition exclusions on Ohioans that take up coverage on a timely basis following implementation of reforms. If, however, certain people continue to refuse to purchase affordable coverage after a period of time following implementation, pre-existing condition exclusions may be imposed consistent with Ohio and federal law.
- d. All Ohioans should be required to report their insurance status on their Ohio tax return.
- e. Employers should be required to report whether they offer insurance and which of their workers are covered.
- f. Insurance companies should be required to file their individual and small group rating manuals, and any amendments thereto, with the Ohio Department of Insurance. Rates charged to consumers should be transparent and readily accessible.
- g. Continuation coverage under Ohio law should be extended from 6 months to 12 months, and such coverage should be available to all employees losing their job, not just those eligible for employment compensation.
- h. Metrics should be established and data should be collected and analyzed to make sure reforms are working as intended.

4. Recommendations Related to Implementation of Coverage Reforms

4.1 The state should create a quasi-public/private organization a connector controlled by a board that would help to implement coverage expansion programs and assist Ohioans to enroll in available health plans.

A connector board, jointly appointed by the Governor and President of the Senate and Speaker of the House of Representatives, should be authorized by law to make critical decisions regarding implementation of coverage expansions.

The principal function of the connector would be to match uninsured Ohioans with the coverage and health insurance subsidies that they qualify to receive. At a macro level, this involves several policy functions that we believe should be performed by a new connector board. These functions include, but are not necessarily limited to: determining minimum coverage standards for a basic and standard guaranteed-issue plan (drawing from CHAT session data, among other sources), developing affordability standards based on income level that would be used to determine sliding scale subsidies and any exemptions from an individual mandate, negotiating and contracting as needed with insurers, determining appropriate metrics and data disclosures that measure and encourage success, and other policy matters.

There are also several subsidiary activities that must occur to successfully match uninsured Ohioans with the coverage and subsidies created by the reforms we are recommending. These include, for example: marketing and outreach efforts to educate and enroll Ohio's uninsured; providing information to Ohioans about available health insurance plans and prices; determining eligibility for subsidies and distributing them in accordance with standards established by the connector board; ensuring that premium contributions from consumers, employers, and the state are remitted to insurers in a coordinated and timely fashion; and coordinating activities by related state government agencies, nonprofits, correctional institutions and other resources so that Ohio's uninsured experience "no wrong door" as they are connected to the coverage and, ultimately, the care they need.

Whether these activities should be performed by the connector directly, by existing elements of our public and private health care infrastructure (such as Ohio's extensive network of brokers and agents, community health centers, the Department of Insurance, the Department of Health, County Job and Family Services, the Ohio Benefits Bank or other organizations), or by new public or private entities should be for the connector board to evaluate and decide, consistent with the following principles:

- Administrative obstacles for employers, providers, Ohioans seeking coverage, and other health care system constituents should be minimized to the greatest extent possible.
- The connector board should utilize existing capacity where possible and efficient. For example, if metric or data disclosures from insurance companies become needed to help reforms succeed, the connector should maintain and respect the Department of Insurance's traditional responsibility for this function, while also making sure that the Department of Insurance shares any data needed by the connector board.

4.2 Benefit plans offered to uninsured Ohioans through coverage expansion programs should be affordable and must focus on prevention, primary care and chronic care management.

Benefit plans offered to uninsured Ohioans should be defined by the connector board using the following principles:

- Benefit plans should provide consumers the means to maintain their health by providing reasonable access to care for the prevention and treatment of illness.
- Benefit design should consider available funding.
- Plans should be targeted to the populations they are intended to serve. Plans covering lower income Ohioans should have cost sharing appropriate to income.
- Plans should require that consumers use health care wisely and work to improve their own health.
- Incentives should be included to encourage preventive care, healthy lifestyles, compliance with care management recommendations, and the provision of care in the proper setting.
- Benefits should be affordable. Affordability should be based on total spending (premium sharing plus point of service expense) compared to personal income.
- Benefit plans should focus on care that has proven value and is evidence based.
- Plans should include health management components, including:
 - o Health risk assessments
 - o Case management
 - o Chronic disease management
 - o Health coaching
 - o Lifestyle behavior change programs
- Coverage should encourage the establishment of a medical home, and better support primary care.
- Coverage should be portable.
- Insurers should not be able to deny claims solely because of alcohol or drug use.

5. Funding Recommendations

The SCI team recognizes that these are tight fiscal times for the State of Ohio and its citizens. Nonetheless, it cannot be denied that in order to provide health insurance coverage to Ohio's uninsured residents, state funding will be required. Over 80% of Ohio's uninsured adults earn less than 300% FPL, and therefore, to get these Ohioans covered, subsidies to help them pay for coverage are needed. Thus, the SCI team makes the following recommendation related to program funding:

5.1 Programs to cover Ohio's uninsured residents must be as cost-effective as possible, to reduce the need for funding.

The SCI team has made every effort to recommend health coverage reforms that are the most cost effective options available to provide affordable coverage to Ohio's uninsured residents. At the outset of the work done by the SCI team, a number of comprehensive reform proposals were identified for modeling. These proposals were designed to ensure that middle and lower income Ohioans and people with health conditions could have access to affordable health

insurance. The SCI team and Advisory Committee learned early on in the process that over 80% of Ohio's uninsured adults live at or below 300% FPL, which made it clear that any program to cover Ohio's uninsured residents would need to rely on subsidies to make coverage affordable.

Based on modeling results, the SCI team learned that comprehensive reforms to Ohio's health insurance markets, coupled with sliding scale subsidies for lower income Ohioans, would likely cost in excess of \$1.5 to 2.0 billion in annual state funding. Even with state subsidies, there were also significant market impacts as a result of the proposed reforms, including substantial rate increases for small employers. As a result, the SCI team modeled new scenarios trying to offset the adverse impacts, only to learn from the modeling that these new scenarios were more costly, some exceeding \$2.5 billion in annual state funding. As a consequence, the SCI team changed course a bit and developed the recommendations contained in this report, which is a collective effort to provide meaningful coverage to uninsured Ohioans more cost effectively. Thus, in developing the reforms contained in this report, the SCI team worked to make the reforms as cost-effective as possible.

5.2. In developing strategies to cover Ohio's uninsured residents, Ohio should try to leverage existing funding wherever possible, including federal funding and employer contributions to health care.

As the SCI team considered various approaches to covering Ohio's uninsured residents, it recognized that it is important to leverage existing funding for health care reform wherever possible.

As a result, the recommendations contained in this report rely on Medicaid expansions to cover lower income Ohioans. It makes little sense to provide subsidies to lower income Ohioans using only state dollars when federal dollars are available to cover the same population. For this reason, two of the SCI team's recommendations rely on Medicaid: (1) enrolling more people in Medicaid and (2) expanding Medicaid for parents up to 200% FPL. Under these two proposals, the federal government will pay 62% of the cost of coverage while the state will pay only 38%.

In addition, two other recommendations also rely on federal funding: (1) adoption of Section 125 plans by employers and (2) providing subsidies to help uninsured Ohioans take up employer provided coverage. In both cases, the fact that coverage is provided through an employer means that in most cases the employer and the employee receive federal tax deductions. The cost of coverage is cheaper, sometimes by more than 40%, simply because the strategy involves providing coverage through an employer sponsored plan.

Again, it makes little sense to provide subsidies to lower income Ohioans using only state dollars when federal dollars are available to pay for part of the coverage. The recommendations of the SCI team attempt to leverage available dollars wherever possible.

5.3. The state should look within its existing budget to pay for health coverage reforms.

The SCI team believes that the strongest possible effort should be made to fund any new reform strategies from reallocation of existing revenues as well as efforts to obtain cost savings within existing programs. However, we recognize the difficulty of this recommendation given the economic challenge our state government is currently facing. The administration recently ordered all state agencies to implement restructuring plans and other reforms to address a \$700

million budget deficit. Moreover, continued phase-in of the tax reforms passed in HB66 will result in less revenue, and a tighter state budget, in the coming biennium.

In the face of these budgetary realities, we believe it is important for state agencies to engage in continuous process improvement to find efficiencies and cost savings to cover priorities. We recommend that the SCI team be permitted to continue its work – supplemented by the time and expertise of OBM, the legislature’s finance staff and other financial and policy advisors in and outside of government - to identify revenues and savings that might help finance reforms.

5.4. As for additional funding, health coverage reform proposals should be paid for with broad based funding.

If sufficient revenues to fund the SCI team’s proposals cannot be secured by re-prioritizing allocations within the current state budget, the SCI Team believes policy leaders should take a shared responsibility approach to funding. This shared responsibility principle is based on the recognition that all stakeholders in this process – insurers, providers, employers, citizens, and government – will benefit from adoption of the SCI team’s proposals.

We have reviewed the funding approaches in other states, including stakeholder assessments, “sin” taxes (alcohol, tobacco, etc.), Medicaid maximization, Medicaid waivers, tobacco settlement funds, re-direction of safety net funds, and savings from improved quality, prevention and disease management. All should be considered in identifying the best and most equitable funding methods which would require additional consultation with budget and financial experts within OBM, the Department of Taxation, Legislative Services Commission, and possibly other experts inside and outside government. Here again, we recommend retaining an SCI team – supplemented with finance experts from some of the above constituencies – to work on identifying sustainable revenue sources.

6. Recommendations For Sustainable Programs

SCI team has focused on developing reforms to meet the Governor’s goals of extending affordable coverage to Ohio’s uninsured residents. However, in order for such programs to be effective, affordable and sustainable, reforms to other aspects of Ohio’s health care system are also required. Improvements to health care cost, quality, and access are closely tied and need to work together to bring health insurance costs under control. As a result, the SCI team recommends that the following reforms also be considered by Governor Strickland and the General Assembly to ensure that programs expanding coverage are sustainable into the future.

6.1 An Advisory Group should continue to meet and work on health care system reforms and population health proposals.

The Advisory Committee has proved to be an excellent forum to discuss and develop health care reform proposals with the input and insight of interested parties. The SCI team therefore recommends that the Advisory Committee continue to meet and work on reforms that go beyond providing coverage to Ohio’s uninsured residents. As the Advisory Group takes on new issues, membership should reflect changes to the Committee’s charge as well as bring relevant expertise and representation to the issues. Possible topics may be those related to the

sustainability of the coverage recommendations, such as health care cost, quality and efficiency.

6.2. Ohio should support development of provider networks in underserved areas of Ohio and, as part of that effort, increase support for community health centers, free clinics and other community based providers.

Throughout Ohio, there are areas that do not have enough providers to treat patients. As a result, the state should develop and implement strategies to attract and retain a diverse workforce of providers in these medically underserved areas. The Advisory Group would be a good forum to discuss and develop solutions to this problem.

During its work on coverage reforms, the SCI team came to recognize that community health centers, free clinics and other community based providers are an excellent way to provide preventive and primary care to insured and uninsured Ohioans in medically underserved areas around the state. For example, federally qualified community health centers are expanding into new areas and regions that are in need of health care providers. Federally qualified health centers receive significant funding from the government, and therefore, new or additional funding provided by the state can be used to leverage additional federal funding.

One key take-away from the Advisory Committee meetings is that providing coverage to Ohio's uninsured residents is not enough if there are no doctors or hospitals to treat patients. An increased commitment to community health centers, free clinics and community based providers would help to alleviate access problems in medically underserved areas. As a consequence, the SCI team recommends increased funding and support for federally qualified community health centers, free clinics and community based providers as an effective and responsible way to deliver preventive and primary care to Ohio residents.

6.3. Ohio should support local programs that promote medical homes and provider networks focused on the coordination of preventive and primary care.

The SCI team supports the notion that local communities are often better able to address the needs of local populations. Therefore, the SCI team supports the establishment of a community based collaborative that can serve as pilot or demonstration projects to serve as medical homes to provide primary care, health promotion and care coordination for patients. Community collaboratives have been found to effectively deliver preventive, primary and chronic care services in states that have adopted the concept. Incentives should be built into the health care system to require that participants take a health risk assessment, provide a history, take a physical and agree to work with care givers to develop and comply with care and treatment recommendations. The state could support local collaboratives with grants and work to change Ohio law to reduce barriers to the development of such programs. While the SCI team did not spend time working out the details of a community collaborative proposal, the SCI team recognizes that community collaboratives are a good idea, and the Advisory Group should move forward to work out the details of such programs.

6.4. Ohio should continue to work toward the adoption of health information technology.

One important element of transforming Ohio's health care system is the development and adoption of health information technology to facilitate the exchange of health information between providers, participants and payers. The SCI team supports the creation of a statewide

health information technology infrastructure and the development of policies and programs that address health information technology issues, paving the way for the widespread adoption of health information technology by providers, payer and government. The SCI team also recommends that the Advisory Group, in its continued operation, coordinate with the Health Information Partnership Advisory Board (created by Executive Order 2007-30S) wherever possible.

6.5 Ohio should adopt transparency/reporting requirements for hospitals and insurance companies to enable more informed decision-making by consumers and third-party payers.

The SCI team believes an important element of health care reform is increased transparency with regard to the finances of our health care system. Lack of transparency in health care pricing and financing has been a recurring theme in our discussions with health care experts, and transparency-based reporting requirements would promote greater public confidence in the administration, efficiency and fairness of our health care system. Public reporting of cost information would provide consumers and payers with information they can use to make decisions regarding utilization and payment and policymakers with sufficient information to be able to monitor the impact of adopted reforms on uninsured and newly insured individuals.

The SCI team recommends that a team be formed to develop a reporting mechanism and criteria to achieve the following goals:

- 1) Track the success of reforms in reducing the number of uninsured;
- 2) determine the impact of coverage expansion programs on hospital finances and uncompensated care;
- 3) assess the experience of the remaining uninsured in the state with regards to access to health care; and
- 4) provide greater transparency in the cost of both health insurance and health care services.

6.6 Ohio should continue to work on improving the health of its citizens through population-based and other strategies that promote wellness and prevent disease and injury.

Through the state's Healthy Ohio initiative, a foundation is in place to move the health system to a focus on wellness. The state should continue to pursue priorities such as the development of a comprehensive strategy to prevent and reduce obesity, especially among children, in schools, worksites, and communities.

In addition, Ohio recently was accepted as one of eight states participating in the "State Quality Improvement Initiative" (SQII) Program. Supported by AcademyHealth and the Commonwealth Fund, an SQII team was recently appointed and, like the SCI team, will involve other interested parties in the development of effective strategies to improve the health of Ohioans. The SQII team will focus on improving Ohio's performance in two areas: (1) increasing the percentage of Ohioans age 50 and over who receive recommended screenings and preventive care; and (2) increasing the percentage of adults with diabetes

receiving recommended preventive care.

6.7 The Governor and General Assembly should advocate for the federal government to become a partner with the State of Ohio to develop innovative and effective solutions for covering Ohio's uninsured residents.

Federal law and the federal government play a huge role in Ohio's health care and coverage systems. Federal law governs the Medicare and Medicaid programs and impacts employer sponsored coverage and Ohio's individual and small group health insurance markets. The Governor and the Ohio General Assembly should partner with the President and Congress to develop innovative solutions for providing affordable coverage to Ohio's uninsured residents. Federal laws and programs, particularly the Medicaid program, should be flexible to allow Ohioans to leverage federal funding and tax incentives to obtain affordable coverage.

V. Options Considered but Not Adopted

Over the course of its work to develop reforms to cover Ohio's uninsured residents, the SCI team reviewed and considered a number of reform proposals that have merit but were not adopted. These proposed reforms include the following;

A single payer plan. The SCI team determined that there was not broad based support for this reform option in the Advisory Group, and that the majority favored a public/private approach building on existing systems.

A high risk pool. The SCI team did not adopt this reform strategy, not because it does not have merit, but because the SCI team believed its strategy to focus on lower income Ohioans, employer sponsored coverage, and Ohio's individual market was the best, most cohesive plan for offering coverage to all of Ohio's residents.

Reinsurance for the entire individual market. The SCI team also considered establishing a reinsurance program across the entire individual market to lower rates across the board. The SCI team did not adopt this proposal because it was not targeted at Ohioans who could not afford to buy coverage on their own and the team's recommendations for the individual market included market reforms and subsidies to reduce costs.

VI. Overview of Activities

A. The Robert Wood Johnson Foundation State Coverage Institute

In June of 2007, the State of Ohio was accepted into a Robert Wood Johnson Foundation (RWJF) Program called the State Coverage Initiative (SCI). SCI seeks to help states like Ohio develop and implement policies that expand access to health insurance coverage in order to reduce the number of uninsureds. The program provides states with technical assistance and financial support to assist them as they develop and refine coverage expansion strategies and implement expansion programs.

In connection with SCI, Governor Strickland appointed a 12 member team (the SCI team) to work together to develop reforms to cover Ohio's uninsured residents. The SCI team has met regularly since September of 2007 to develop the recommendations contained in this report. Throughout the process, the SCI team worked closely with RWJF and AcademyHealth, which provided expertise, data and analysis to support the SCI team's recommendations.

B. The Health Care Coverage Advisory Committee

Recognizing that the SCI team did not include many key stakeholders in Ohio's health care system, Governor Strickland appointed a larger Advisory Committee.

The task of the Advisory Committee was to serve as a resource that would inform the decisions and recommendations of the SCI team. It was made clear at the beginning of the process that the Advisory Committee would help and support the SCI team as the SCI team worked to make recommendations to cover Ohio's uninsured residents.

The Advisory Committee has met regularly since September of 2007. In partnership with the Ohio Department of Job and Family Services, the Ohio Department of Insurance hosted 11 full or half day meetings of the Advisory Committee. These meetings were facilitated by Steve Wall of the Ohio Department of Administrative Services and occurred approximately every three weeks. The minutes from the Advisory Committee meetings are contained in Appendix "I" of this report.

C. Benefits Team

As part of the Healthcare Coverage Initiative, a Benefits Team was formed to investigate and report on innovative and cutting edge strategies used by Ohio employers to promote and incentivize healthy lifestyles, wellness, disease prevention, and chronic care management programs. The Benefits Team reported its findings to the Advisory Group at a meeting held on December 11, 2008. The Benefits team subsequently issued a report, a copy of which is attached as Appendix "J".

Based on a review of employer strategies and programs to improve the health of employees and encouraging the efficient use of healthcare services, the Benefits Team recommended the following components be included in health plans offered to uninsured Ohioans.

- health assessments and biometric screenings as a means of detecting unhealthy lifestyle choices, identifying disease early and monitoring chronic conditions;
- lifestyle behavior change programs to assist participants with lifestyle improvements;
- case management to assist patients managing high cost conditions;
- chronic disease management to include asthma, diabetes, and heart disease programs;
- value-based insurance design with low or no copays on select pharmacy and physician visits for chronic conditions;
- primary care coverage focused on a medical home and to discourage inappropriate use of health care resources; and
- preventive services.

The Benefits Team also identified some participant responsibilities related to coverage. The Benefits Team recommended that participants be required to:

- complete an annual health assessment;
- have a primary care physician;
- receive all recommended preventive services each year;
- participate in a chronic disease management program for those with a chronic condition; and
- participate in a lifestyle behavior change program if sufficient risk exists (i.e., for smokers and overweight individuals).

According to the work of Lewis & Ellis, the savings resulting from these types of programs would offset their costs in the long run.⁸⁴

D. CHAT

The SCI team and Advisory Committee thought it was important to get the direct input of uninsured Ohioans into the kinds of benefit plans that would be offered to uninsured Ohioans. To get this input, the Ohio Department of Insurance initiated a project known as “CHAT” (Choosing Health Plans All Together). CHAT is a facilitated, computer based, focus group program where both uninsured and insured Ohioans are asked to choose the desired components of a benefit plan with a limited budget.

As of the time of this report, the Department of Insurance had conducted nine CHAT sessions with the uninsured in various parts of the state. A total of 29 sessions are planned with the uninsured. Each CHAT session involves 12 participants who select components of a benefit plan. Participants cannot choose all available benefits because each available benefit is assigned a cost equal to its actuarial value and participants are given a limited budget to select their preferred plan.

Participants are also asked why they made the choices they did, and subsequently all of their feedback is documented. A pre and post CHAT survey will also gather data on areas such as: income-level, employment status, insurance status, health status and other demographics. When this information is aggregated across all participants, a picture emerges of what uninsured Ohioans value most in terms of health benefits and why they make the choices they do. Based on the 9 CHAT sessions conducted thus far, the Department of Insurance has seen the following trends:

- The uninsured want a high level of preventive services and they are willing to pay for affordable and accessible plans. Catastrophic and episodic coverage is equally important to the uninsured.
- The uninsured want to have a choice in the doctors and hospitals they use.
- The uninsured are willing to have reasonable copays and deductibles if it means they can supplement their coverage in other areas.
- The uninsured are willing to comply with care management recommendations, even if it means they must attend educational classes. Notwithstanding, the uninsured want policymakers to know that many individuals, particularly low-income individuals, face barriers to access including child care issues, lack of reliable transportation, and inflexible work schedules. Penalties for noncompliance with care recommendations can be unfair to some people.
- Mental and behavioral health coverage is very important to most of the uninsured. Many of the uninsured raised the issue of addiction as both a health problem needing coverage and a societal problem with broader negative implications.

The uninsured want a high level of preventative services and they are willing to pay for affordable and accessible plans.

Mental and behavioral health coverage is very important to most of the uninsured.

In response to suggestions from the SCI team and Advisory Committee, the CHAT team will also engage participants on the issue of depression. Once all the CHAT sessions have been completed, the Department of Insurance will release a full report of its findings. This information can be used to decide the types of benefits that should be included in benefit plans offered to Ohio's uninsured residents.

E. Actuarial Analysis of Health Coverage Reform Scenarios

The Department of Insurance hired the actuarial consulting firm of Lewis & Ellis to model health care coverage reform scenarios for the SCI team and Advisory Committee. Lewis & Ellis provided a separate report of its findings which attached as Appendix "D". The following is a summary of its analysis and projections.

To build the actuarial and economic models needed to predict the impacts of proposed reforms, the Department of Insurance conducted a data call from the top ten insurance companies writing in the individual and small group markets in Ohio. This data showed:

- Average annual premium rates per person in Ohio's individual market were \$189 in 2006. Rates in the individual market commonly varied from a low of \$30 (for young and healthy people) to a high of \$900 (for older less healthy people). This reflects a rating variance of about 30 to 1.
- Average annual premium rates per person in the small group market were \$234 in 2006. Rates for small business varied from a low of \$60 (for small groups with young and healthy employees) to a high of \$1,000 (for a small group with older and less healthy employees). This reflects a rating variance of about 17 to 1.
- The average uninsured Ohioan is about 20% higher risk than an average insured person.

The SCI Team and Advisory Group identified several comprehensive reform scenarios designed to meet the Governors' goals for covering uninsured Ohioans. In total, Lewis & Ellis modeled 13 scenarios. The first 6 scenarios modeled included the following components:

- emerging Ohio's individual and small group health insurance markets;
- requiring insurance carriers to offer coverage to every individual and family that applied for coverage on a guaranteed issuance basis;
- imposing restrictions (rating bands) on premium rates insurers could charge for coverage by limiting the spread between the highest rate and lowest rate charged to consumers based on risk characteristics;
- creating an alternative market (a connector) where Ohioans could obtain information about coverage and be directed to the appropriate plan; and
- providing subsidies to lower income Ohioans.

With respect to these first six scenarios, some of the scenarios were modeled with an individual mandate which would require people to buy coverage if affordable coverage is available, and other scenarios were modeled without an individual mandate.

After reviewing the first six scenarios, at the request of the SCI team, Lewis & Ellis modeled four other scenarios, including two that did not involve merging the individual and small group markets. Lewis & Ellis also modeled a reinsurance program that was designed after the Healthy New York program. Under this scenario, a state funded reinsurance program would help insurance carriers pay high cost claims for uninsured Ohioans, thereby reducing the cost of coverage and causing more people to buy coverage.

The following are some important results from Lewis & Ellis's work:

- The reform scenarios that involved guaranteed issuance of coverage, tighter rating restrictions, and low income subsidies resulted in between 349,000 and 633,000 more Ohioans getting coverage, at a cost to the State of Ohio of between \$1.4 billion to \$1.9 billion (depending on the scenario) due to state funded subsidies to lower income Ohioans.
- Tighter rating restrictions raise average rates for individuals and small businesses, but reduce the spread between the highest and lowest rates. Tighter rating restrictions mean young and healthy people pay more and older and less healthy people pay less – significantly less. Tighter rating restrictions result in more of a pooling of risk across high- and low-risk people. Over time however, young and healthy people who pay more now will see savings in the future as they get older.
- Creating a reform market, though a mechanism like a connector, is an effective way to subsidize low income Ohioans so that they have access to affordable health insurance products.
- An individual mandate improves the mix of people in the insurance pool, increases the number of people with coverage, and makes coverage more affordable. An individual mandate is also an effective deterrent against “adverse selection,” which is the well established principle that in a guaranteed issuance market, a significant number of people will tend not to purchase coverage until it becomes economically advantageous for them to do so. That is, in a guaranteed issuance market where people can choose not to buy coverage, a significant number of people will choose not to buy coverage until they need medical services, thus raising the cost of coverage.
- A reinsurance program modeled after Healthy New York can be a cost-effective way to help small businesses provide coverage to their uninsured workers. A reinsurance program could lower rates by about 25% for individuals and small businesses, resulting in an additional 187,000 Ohioans taking up coverage at a cost to the state of \$157 million in 2011. With an individual mandate, these numbers increase to 294,000 Ohioans taking up coverage at a cost to the state of \$230 million. In later years, the individual mandate makes coverage much more affordable.
- Expanding coverage to Ohio's uninsured populations will increase revenues for hospitals, doctors, pharmacies, pharmaceutical manufacturers and other health care providers. Using Scenario 1 as an example, the following chart shows total revenues that would be earned by hospitals and health care providers in 2010 without any reforms, and projected revenues that would be earned if health reforms were adopted to cover Ohio's uninsured residents.

**Estimated Annual Revenues Earned By Provider Type
Under Lewis & Ellis Scenario "1"
(\$ in billions)**

Chart 32

Type of Service	No reforms 2010	With Reforms 2010	With Reforms 2011
Hospital	6.23	6.69	7.40
Physician	4.17	4.30	4.77
Drug	2.11	2.25	2.57
Dental	1.30	1.30	1.45
Other Professional	1.03	1.03	1.16
All Other	0.83	0.83	0.98
Home Health	0.68	0.68	0.78
Medical Equipment	0.38	0.38	0.42
Total	16.73	17.46	19.52

Healthcare expenditures are expected to increase by \$700 million which is approximately 4% across all provider types. Hospitals are expected to provide \$460 million in additional services, primary care and specialists are expected to provide \$130 million in additional services, and prescription drug expenditures are expected to increase by \$140 million.

Endnotes

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