



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

The Pathway to Covering America



Ensuring Quality, Value and Access

2008

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Executive Summary

The Blue Cross and Blue Shield System strongly believes that everyone in America should have health insurance. However, we are concerned that a healthcare system that is unaffordable for many today will not work for even more people tomorrow. We must make addressing both rising healthcare costs and extending coverage to everyone a national priority.

We know Americans without the benefit of health insurance get sicker and die sooner than those with coverage. We also know that rising healthcare costs – driven by an epidemic of chronic illness that accounts for 75 cents of every health dollar – have made coverage unaffordable for many.

But the problems only begin with the cost. We do not know enough about what works in medicine – and even when we do, the advice is often not followed. For the \$2.3 trillion we spend annually on healthcare, we should expect more than a system where patients have only a 50-50 chance of getting the most advisable care and where 30 cents of every dollar may be spent on care that is ineffective, inappropriate or redundant.

We can get to tomorrow's coverage, but only if we attack the cost and change incentives to improve the quality of healthcare. With this report, the Blue Cross and Blue Shield Association (BCBSA) lays out detailed recommendations to improve the quality and value of our healthcare system, while simultaneously expanding access and coverage to all Americans. Achieving better healthcare quality and value and expanded coverage begins with America undertaking five initiatives:

Improving Quality and Value

1. Encourage Research on What Works

America needs an independent institute to support research comparing the relative effectiveness of new and existing medical procedures, drugs, devices and biologics. We also must provide incentives to deliver safe, high-quality care.

2. Change Incentives to Promote Better Care

The incentives in our system must be changed to advance the best possible care, instead of paying for more services that may be ineffective, redundant or even harmful.

3. Empower Consumers and Providers

We must give consumers and providers the information and tools they need to make informed decisions. This starts with information systems to manage personal health records. In addition, consumers need to know how much they are paying and what they are getting for it.

4. Promote Health and Wellness

We must promote healthy lifestyles to prevent chronic illness and work aggressively to help patients with chronic illnesses manage their own health.

Expanding Coverage

5. Foster Public-Private Coverage Solutions

We need to tailor our coverage plans to capture the diversity of the uninsured population so that no one gets “squeezed out” by cost, “misses out” on available government assistance or “opts out” because they do not think they need coverage.

Clearly, there is no single answer for improving quality and value and expanding coverage. Meaningful change will depend on thoughtful, coordinated contributions from everyone – and it will require payers, patients, hospitals, physicians and policymakers to accept responsibility for taking part in the solution.

As leaders in the healthcare community for more than 75 years, the Blue Cross and Blue Shield System looks forward to working with all stakeholders to make quality healthcare affordable and accessible for all Americans.

Blue Cross and Blue Shield Association Recommendations for:

Ensuring Quality, Value and Access

BCBSA believes every American should have health insurance. In achieving this goal, the underlying problems of our current system must be addressed.

Following is what the Blue Cross and Blue Shield System is currently doing to enhance the quality and value of healthcare and to expand coverage, along with recommendations on what the government should do. Together, we can build upon the employer-based system with tailored solutions to enhance and sustain this system, while providing affordable options for those without employer-sponsored coverage. This will require America to undertake five initiatives:

An Overview of BCBSA Recommendations for Assuring Quality, Value and Access

1. Encourage Research
on What Works

2. Change Incentives to
Promote Better Care

3. Empower Consumers
and Providers

4. Promote Health
and Wellness

5. Foster Public-Private
Coverage Solutions



What the Blues Are Doing:



What the Government Should Do:

- Spearheading evidence-based assessments through the Technology Evaluation Center
- Creating the nation's largest healthcare database – Blue Health Intelligence

- Create an independent institute to support research on the effectiveness of procedures, drugs and devices

- Designating Blue Distinction Centers
- Using incentives to encourage quality care
- Promoting greater use of generic drugs
- Piloting Patient Centered Medical Homes

- Incorporate pay-for-quality incentives in Medicare
- Promote management of chronic illness through Medicare Advantage
- Increase access to generic drugs
- Enact effective medical liability reform

- Providing easy-to-understand information on quality and cost
- Giving consumers improved access to their health information and helping providers adopt health IT
- Offering all members a personal health record (PHR) by the end of 2008
- Offering Consumer-Directed Health Plans
- Offering savings and payment options through Blue Healthcare Bank

- Promote greater quality and cost transparency
- Encourage adoption of health information technology

- Partnering with employers and consumers through Engaging Consumers@Work
- Offering specialized disease management and care coordination programs

- Encourage employee wellness programs
- Educate children on healthy lifestyles
- Provide incentives and education on nutrition and health

Helping Those "Squeezed Out"

- Offering more affordable products for low-income individuals

Enrolling Those "Missing Out"

- Educating consumers on federal/state assistance programs

Attracting Those "Opting Out"

- Designing innovative coverage plans
- Developing consumer-friendly tools

Help Those "Squeezed Out"

- Provide four new tax credits
- Extend public coverage to everyone up to the federal poverty level
- Require all states to have high risk pools or other mechanisms to assure access

Enroll Those "Missing Out"

- Help states enroll Medicaid/SCHIP eligibles

Attract Those "Opting Out"

- Launch a public-private educational campaign



1 Encourage Research on What Works

Researchers and policymakers agree there is insufficient information on what medical treatments work best. Providers and patients must make important decisions without knowing how different treatments compare.

Ineffective, redundant and inappropriate care is estimated to account for about 30 percent of healthcare spending (Wennberg, 2003).

In part, this is due to a lack of evidence – e.g., only 15 percent of clinical practices are based on clinical trials (D. Eddy, 2005). Also, it is due to a failure to provide treatments that follow the evidence – e.g., only 54 percent of acute care and 56 percent of chronic care conform to medical literature and overall, adults receive about half of recommended care (McGlynn et al., 2003). It is critical that we provide incentives to promote quality care and put what we know works into practice.

What the Blues Are Doing



The Blue Cross and Blue Shield System is committed to ensuring that members have access to the right care at the right time, and that providers have access to the information necessary to assist them in providing this optimal level of care. BCBSA and our member Plans are leading efforts to promote evidence-based medicine and give providers and consumers better tools to make more informed healthcare decisions.

Technology Evaluation Center: *Putting Clinical Research into Practice*

Founded in 1985 by BCBSA, the Technology Evaluation Center (TEC) pioneered the development of scientific criteria for assessing the effectiveness of medical technologies through comprehensive reviews of clinical evidence. TEC evaluates drugs, medical devices, procedures and biological products. It is one of 14 Evidence-based Practice Centers (EPCs) for the U.S. Agency for Healthcare Research and Quality. TEC and the other Centers produce evidence reports and technology assessments to inform coverage decisions, quality measures, educational materials and tools, guidelines, and research agendas.



TEC assessments are based on objective clinical and scientific evidence and evaluate whether a technology improves health outcomes, such as length of life, quality of life and ability to function. TEC publishes an average of 15 to 20 assessments per year, providing healthcare decision-makers with timely, rigorous and credible information on clinical effectiveness.

Key TEC advancements include: (1) pharmacogenomics, where TEC has worked to identify which pharmacogenomic tests (e.g., how a person's genetic make-up interacts with a drug's effectiveness) might reliably steer patients toward the best drug; and (2) imaging, where the latest TEC research is focused on the proliferation of CT scans and whether cumulative exposure to these types of tests could increase the risk of cancer.

Blue Health Intelligence: *Using Information to Improve Care*

Blue Health IntelligenceSM (BHI) will be the nation's largest, HIPAA compliant, multi-Plan database that will bring together the claims experience of 80 million Blue Cross and Blue Shield members nationwide. Blue Cross and Blue Shield Plans will use BHI, which only houses de-identified data, as an analytical tool to assist in understanding healthcare trends, cost drivers and other important factors related to the delivery of healthcare. This data analysis allows the Plan and employer accounts to proactively design products to meet identified needs and provide higher quality care to their members. For example, high rates of cardiac disease could trigger targeted wellness initiatives.



As BHI expands, it will have the potential to provide policymakers and healthcare stakeholders with a steady flow of data, providing insights into healthcare trends by:

- providing physicians and hospitals with powerful insights into the appropriateness and/or effectiveness of emerging medical trends and treatment options
- profiling performance of physicians and hospitals to identify and implement best practices
- strengthening movement to greater healthcare transparency
- creating opportunities for health services research
- giving policymakers information on issues such as drug safety, drug efficacy, disease spread and the impact of new technologies and procedures

What the Government Should Do



BCBSA recommends the government take the following actions to encourage research on what works best and put it into practice:

Create a New Comparative Effectiveness Research Institute

The Institute Should Support a Broad Range of Research, Including Clinical Trials

The Institute should prioritize and fund a variety of research – including clinical trials, cohort studies, literature reviews and other studies – evaluating the comparative clinical and cost effectiveness of different procedures, drugs, devices and biologics. The Institute may contract with existing entities (e.g., the Agency for Healthcare Research and Quality (AHRQ)) to facilitate research. The Institute also should encourage improved efficiency by collaborating with the institutions that receive comparative research contracts to identify best practices and efficiencies in order to maximize research dollars.

The New Institute Should Be an Independent Entity

The Institute should be structured as an independent, federally chartered, not-for-profit entity so that political pressures are not a factor in the Institute’s decision-making, establishing priorities or releasing results. The Institute should be governed by a board of experts that reflects the perspectives of a wide range of stakeholders (e.g., providers, consumers, government, health insurers, employers and manufacturers).

Stable Funding Should Be Assured By Asking All Healthcare Payers to Contribute

The most significant challenge in creating the new Institute will be ensuring a stable and significant funding source. BCBSA believes that the Institute should be funded by assessments on all private coverage (insured and self-funded) and public healthcare coverage such as Medicare, Medicaid and other government programs. BCBSA recommends a budget not to exceed \$375 million annually.

Significant Education and Incentives Are Needed to Ensure New Research that Improves Clinical Practice

The Institute should ensure that new comparative information is disseminated to providers, patients and others. Because experts estimate that medical research currently takes 17 years to be incorporated into practice, it is especially important that this information be provided in formats providers easily can use (Balas and Boren, 2000). The Institute should work with medical societies to develop consensus practice guidelines drawing on the Institute’s research. Electronic medical records should be required to incorporate these guidelines into their clinical decision support systems. Medicare and other public programs should be required to consider the Institute’s research in developing pay-for-performance, coverage, reimbursement and other policies.

Evidence-based Standards Should Inform Medical Malpractice

In addition, the guidelines’ evidence-based standards should create rebuttable presumptions concerning the standards of care that providers are expected to meet in medical malpractice cases. Providers that reasonably rely on the guidelines should be given safe harbors for noneconomic (e.g., pain and suffering) and punitive damages. Similar protections should apply to insurers in adjudicating claims.



2 Change Incentives to Promote Better Care

To promote the best care for patients, the incentives in our healthcare delivery system must be changed. Today, providers are generally paid based on the number of services they provide – even if these services are ineffective, redundant or even harmful. Our healthcare delivery system encourages patients to visit multiple specialists and have multiple tests and procedures – with little or no coordination of care.

The incentives in our system must be changed to advance the best possible care, not just more services. Providers should be rewarded for delivering high quality care with incentives to coordinate care, especially for the increasing number of Americans with chronic illnesses.

What the Blues Are Doing



Blue Distinction: *Recognizing and Incenting Quality Care*

Blue Distinction is an innovative program that assesses hospitals based on objective, evidence-based criteria. The program is designed to help enable consumers make more well-informed decisions in selecting providers, while it encourages improvement in the overall delivery of patient care. Through Blue Distinction Centers for Specialty Care, Blue members have national access to providers with Blue Distinction designations for transplants, bariatric surgery, cardiac care and, coming shortly, complex and rare cancers. Each Blue Distinction Center has been designated based on rigorous selection criteria developed in collaboration with medical specialty societies and medical experts in the field. Though individual results may vary, aggregate data confirm that Blue Distinction Centers have achieved improved outcomes. For example, the inpatient mortality rate for heart attacks at facilities that fell below the Blue Distinction criteria – and did not qualify as Blue Distinction Centers – reaches a high of as much as 40 percent. That compares to a highest mortality rate of about 15 percent at Blue Distinction Centers for Cardiac Care – a dramatic difference.

Pay for Quality: *Rewarding Quality Care*

Blue Plans are increasingly reimbursing providers based on outcomes and quality of care. Most Blue Plans offer some kind of Quality-Based Incentive Program (QBIP), which modifies reimbursements to hospitals and physicians based on consensus quality standards designed by third party experts such as the National Quality Forum and the Hospital Quality Alliance.

Blue Cross and Blue Shield of Illinois has seen improvement in both performance and health outcomes from implementing a program that pays and publicly recognizes physician groups in its HMOs for meeting annual clinical performance targets. The measurements include rates of Pap smears, mammography, colorectal cancer screening, influenza vaccination, childhood immunizations, and mental health follow-ups and indicators related to the management of chronic conditions, such as diabetes, asthma, hypertension and cardiovascular disease.

Blue Cross and Blue Shield of Hawaii has a Quality Service Recognition (QSR) program that is a voluntary program for its PPO participating physicians and hospitals. It provides financial incentives for meeting national clinical quality benchmarks in the delivery of care. In 2006, the program paid \$16.9 million to 17 hospitals and 2,575 physicians. QSR has been in place for more than eight years. The Hawaii Plan was the first health plan in the nation to develop and implement such a pay-for-performance incentive program.

Access to Generic Drugs: *Reducing Costs while Ensuring Safety and Efficacy*

With prescription drug costs skyrocketing, generic drugs offer consumers a safe, equally effective and lower-cost alternative to brand name prescriptions. According to estimates, the use of generics in place of brand names could save consumers between \$8 billion and \$10 billion each year (Congressional Budget Office, 1998). Blue Plans believe the best way to improve affordability of prescription drugs is to assure a competitive pharmaceutical market and take action to promote generic use. Of course, no drug can be helpful if not taken. Longtime adherence to drugs prescribed for chronic illnesses is essential if such diseases are to be managed effectively.

Blue Cross and Blue Shield of Michigan has been educating consumers about generic prescription drugs through the “Generic Drugs – The Unadvertised Brand” initiative since 2001. The initiative has raised use of generic prescriptions from 38 percent of total prescriptions to more than 58 percent, saving consumers more than \$71 million in out-of-pocket costs. Through a consumer Website (www.theunadvertisedbrand.com), the Plan provides a cost and quality calculator, generic drug educational information and alerts about new generic drugs. It also allows users to check if their drugs are available as generics.

Patient Centered Medical Homes: *Encouraging Evidence-based Care to Prevent and Manage Chronic Illness*

BCBSA and Blue Plans are working with the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association to pilot “patient centered medical homes” that will encourage a more “hands-on” physician approach and more active patient involvement in preventing and managing chronic conditions. The goal is to develop reimbursement mechanisms that strengthen the physician-patient relationship and assure better coordination and management of chronic care.

Medicare Advantage: *Improving Care through Prevention, Coordination and Management*

Blue Medicare Advantage (MA) Plans have ongoing initiatives to improve care for those with chronic conditions. MA plans identify and provide support to those who could benefit from more specialized care or who have not received recommended preventive care. Through partnerships with physicians and other caregivers, MA plans work to coordinate and improve care for these beneficiaries.

Blue Shield of California’s Congestive Heart Failure Program coordinates personalized care through the collaborative effort of a team of physicians and nurses using special home monitoring equipment. The program reduced expected inpatient admissions and emergency room visits in 2005 by about 20 percent.

Among Medicare HMO members, **Highmark Blue Cross Blue Shield’s** colorectal cancer screening program increased screening rates for members by over 9 percentage points from 2003 – 2005. During that timeframe, its osteoporosis management program had a nearly 9 percent increase in the number of members receiving management services after a bone fracture, and its diabetes disease management program demonstrated improvement in HEDIS diabetes care measures, with scores that exceeded national averages in all measured areas.

What the Government Should Do



Pay for Quality

The government should continue its efforts to incorporate pay-for-quality incentives into Medicare and other government programs. For example, the Centers for Medicare and Medicaid Services' (CMS) Hospital Quality Initiative gives a hospital paid under the inpatient prospective payment (IPP) system its full Medicare annual payment update if the hospital reports a set of quality measures. In addition, under the CMS Premier Hospital Quality Incentive Demonstration, CMS is awarding varying incentive payments to participating hospitals for their performance in several clinical areas. In year three of this initiative, hospitals that do not achieve performance improvements above certain baselines will face financial penalties.

Preserve Medicare Advantage

BCBSA also recommends Congress promote management of chronic illness by preserving and building upon the Medicare Advantage (MA) program.

MA plans provide traditional Medicare benefits plus supplemental coverage in a comprehensive plan with a reimbursement structure that encourages a focus on prevention and care coordination. The evidence shows the coordinated care programs in MA are working. The National Committee for Quality Assurance's State of Health Care Quality 2006 report shows significant quality improvements in MA plans across multiple health conditions, including improved treatment after a heart attack, improved colorectal cancer screening rates and increased numbers of members whose high-blood pressure is controlled.

Several years of efforts to bring vital chronic care management programs available through MA to the traditional Medicare program have been unsuccessful. BCBSA urges Congress not to take any action to unravel the wise investment the government has made in developing a high quality, coordinated delivery system under MA.

Improve Access to Generic Drugs

To promote competition and bring down drug prices to consumers, Congress should remove barriers to safe, effective and affordable drugs.

To allow a competitive market for biopharmaceuticals – an ever-growing share of the pharmaceutical market – Congress should give the FDA authority to approve scientifically feasible and safe generic versions of biological products, without imposing inappropriately long periods of market exclusivity for brand biopharmaceutical products.

Congress should also provide the FDA with sufficient resources to pare the growing backlog of generic applications.

Enact Comprehensive Malpractice Reform

BCBSA also recommends Congress enact medical liability reform legislation to address rising medical malpractice insurance premiums, which threaten the ability of patients to receive quality care. Rising malpractice premiums are fueling the rise in the practice of defensive medicine – increasing utilization of unnecessary, and sometimes harmful, healthcare services.

While medical malpractice laws were enacted to protect patients in the event of an egregious error in medical judgment or treatment, our current medical liability system needs be reformed so that physicians do not recommend inappropriate or unnecessary services for patients out of fear of being sued. Congress also should ensure that providers who reasonably rely on the guidelines from the Comparative Effectiveness Research Institute be given safe harbors from punitive and non-economic damages in malpractice cases.



3 Empower Consumers and Providers

Too often, consumers and providers do not have the information and tools they need to make informed decisions about quality and cost when it comes to healthcare. Enhanced transparency of information on quality and cost of healthcare services and greater use of health information technology are key to achieving this goal.

For example, electronic prescribing (e-prescribing) is a tool that can improve healthcare quality by helping to reduce errors due to drug-to-drug interactions and allergic reactions. In addition, it can provide embedded clinical decision support tools to assist providers in making the best decisions. This is significant because an estimated 1.5 million preventable adverse drug events occur each year in the United States (Institute of Medicine, 2007).

What the Blues Are Doing



The Blue Cross and Blue Shield System is committed to improving the quality, safety and efficiency of healthcare. By promoting greater quality and cost transparency, the Blues are helping consumers participate as partners in their care and make informed healthcare decisions based on quality and cost. Blue Plans also are advancing health information technology initiatives within their communities.

Transparency: *Giving Consumers Information to Make Quality-Based Decisions*

Last year, 17 Blue Cross and Blue Shield Plans launched a national transparency demonstration to identify the most effective ways to help consumers learn about the costs of medical services, including physician and hospital services. The demonstration leveraged innovative Blue Plan initiatives to share quality and cost information with consumers. These initiatives served as the basis for extensive consumer research to evaluate effective measures and for design of provider selection tools. Below are two examples of approaches that were included in the research:

Blue Cross and Blue Shield of Minnesota's Healthcare Facts program delivers healthcare information as easy to understand as a nutrition label. Consumers can obtain relative cost information (\$ - \$\$\$) on hospitals, along with quality information, including number of patients treated for select conditions, nurse-patient ratios and other information. For more information, visit: www.healthcarefacts.org.

Anthem Blue Cross and Blue Shield offers a transparency tool program called "Care Comparison" in select areas of Indiana, Ohio and Kentucky. It provides customers with side-by-side cost comparisons for nearly 40 common medical procedures among local healthcare providers on an episode-of-care basis. The tool is coupled with Anthem's Healthcare Advisor Hospital Quality Tool to help consumers make informed decisions when selecting among healthcare providers. It will be expanded to additional markets soon.

Based on the results of consumer research, Blue Plans have been working to define a set of baseline standards for the sharing of quality information regarding doctors and hospitals. These standards will be implemented over the course of 2008 on BCBS provider locator Web sites across the country, and will evolve over time to include additional measures and design features.

Health IT Initiatives: *Enabling Access to Information to Better Manage Care*

Blue Plans are diligently working towards meeting the goal of widespread adoption of health information technology, including adopting electronic and personal health records (PHRs). Plans are leading efforts to:

- promote interoperability through state health information exchanges to enable information to be securely available wherever a patient is being treated
- empower consumers by giving them improved access to their medical information through PHRs
- help providers adopt health IT and improve information at the point-of-care by giving them access to electronic prescribing and electronic health records (EHRs)

Horizon Blue Cross and Blue Shield of New Jersey is helping equip physicians with e-prescribing tools and training them on appropriate use. Not only does this improve safety and quality by reducing medication errors and drug-to-drug interactions, but physicians also report e-prescribing can improve efficiency, allowing them to spend more time with patients. In addition, this tool is able to promote generic and formulary use, saving the consumer money.

Blue Cross and Blue Shield of South Carolina offers physicians a sophisticated swipe-card reader that within seconds sends back information on a patient's eligibility and how much the Plan will pay the physician and how much the patient owes the provider.

Personal Health Records: *Helping Consumers Better Manage Their Care*

BCBSA strongly believes a PHR can help consumers be better informed and more actively involved in their healthcare. A PHR is a patient-centric summary of personal health information that a patient can access, control and authorize their providers to view. Health plans can auto-populate a PHR with claims data on recent doctor visits, hospital stays, lab results, prescriptions and other information. Patients can add personal and family medical history to form a continuously updated patient medical history.

To help spur adoption and ease of use, BCBSA and America's Health Insurance Plans are collaborating on an industry initiative to identify core elements of a PHR and portability standards so that a consumer's information will transfer from one PHR to another if he or she switches health plans. All Blue Plans are committed to offering PHRs to all our members by the end of 2008.

WellPoint is offering personal health records software to all 34 million of its insured members, based on a pilot program developed by Empire Blue Cross and Blue Shield of New York. It offers members a secure, Internet-based personal health record that is auto-populated with data from processed claims, including doctor visits, lab results, immunizations, hospital stays, reported diagnoses and prescriptions.

Blue Cross and Blue Shield of Florida and Humana announced plans for statewide deployment of the nation's first multiple payer electronic health record, the Availity® Care Profile (ACP). The ACP is an electronic health record that provides a consolidated view of patients' healthcare services across physicians and providers to help improve patient safety, eliminate duplicate procedures and aid in reducing unnecessary services and fraud. The launch of the ACP facilitates improved sharing of health information and interoperability between clinicians and multiple payers, resulting in efficiencies and cost savings.

Consumer-Directed Health Products: *Helping Consumers Make Informed, Cost Conscious Healthcare Choices*

Blue Plans across the country are offering a variety of consumer-driven health plans (CDHPs) that include a financial account funded by the consumer, employer or both and are tied to a health insurance product that will cover large expenses. These products allow consumers to take greater personal responsibility for their own health and healthcare. While these products are still new, a 2007 study by BCBSA revealed the following:

- CDHP consumers were more likely to seek information about insurance as well as about doctor and hospital quality and cost.
- Americans covered by CDHPs were 17 percent more likely to participate in an exercise program – and more likely to see positive results.
- Sixty-three percent of consumers in CDHPs tracked their healthcare expenses compared to 43 percent of non-CDHP consumers.

Blue Healthcare Bank: *Engaging Consumers in Their Own Healthcare Management*

The Blue Healthcare Bank was created to serve the healthcare financial needs of a growing number of consumers choosing CDHPs offered by Blue Cross and Blue Shield Plans in communities across the country. Supporting the rapid convergence of healthcare and financial services, Blue Healthcare Bank enables participating Blue Plans to offer members a range of CDHPs, which combine high-deductible health plans (HDHPs) with personal savings accounts (PSAs), such as Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs) and Flexible Spending Accounts (FSAs). Blue Healthcare Bank helps members make the most of their health, money and time by giving them the resources they need to simplify healthcare financing while more actively engaging them in their own healthcare management.

What the Government Should Do



Promote Greater Quality and Cost Transparency

The federal government should continue to partner with the private sector to promote greater quality and cost transparency for consumers and providers. BCBSA is very supportive of the Administration's initiative to build a value-driven healthcare system. This initiative is designed to empower consumers with easily accessible information on healthcare quality and cost.

Given the significant variation in quality and costs among healthcare providers, it is important information be made available to consumers in easy-to-understand formats to help them make informed healthcare decisions for themselves and their families. Specifically, the government should:

- continue using consensus-based quality measures, such as those developed by the National Quality Forum (NQF), the Hospital Quality Alliance (HQA) and the Ambulatory Quality Alliance (AQA) to promote transparency with patients
- ensure that any price information released is linked to quality and based upon episodes of care rather than per-provider prices

Encourage Adoption of Health Information Technology

A national health information network – with electronic health records (EHRs) in every doctor's office – should be established to support the exchange of information among providers, payers and consumers. To achieve this vision, all stakeholders must be involved to assure the following is attained:

- Interoperable data standards should be used by all stakeholders to support the exchange of information. This must include a workable process and timeline for standards adoption by all.
- Strong, uniform privacy and security policies should be used to assure information is well-protected and to instill trust in the accuracy and integrity of the data.
- Widespread provider adoption, which is the key to achieving a nationwide health IT system should be established to provide clinical value and increased efficiencies.
- Consumer engagement should be developed so that consumers understand the value and benefits of health IT and are empowered to use IT to make better, more informed health decisions.



4 Promote Health and Wellness

One of the greatest challenges facing the healthcare system is managing the care for the growing number of people with chronic illnesses.

In 2000, approximately 120 million Americans had a chronic illness, such as asthma, diabetes or heart disease. The costs of treating chronic illness are estimated to account for 75 percent of healthcare spending (Anderson and Knickman 2001).

The prevalence of chronic illness is especially acute for Medicare. A study by Ken Thorpe of Emory University traced virtually all growth in Medicare spending from 1987 to 2002 to a 20 percent increase in the share of Medicare patients receiving treatment for five or more conditions. Some of the most costly and prevalent chronic diseases, such as heart disease, diabetes, chronic obstructive pulmonary disease and asthma, are also ones where adverse events can be avoided with better management. However, traditional fee-for-service Medicare does little to encourage coordinated, preventive and primary care that could save money and produce better health outcomes, according to a 2006 report by the Institute of Medicine.

The fact that many Americans fail to follow a healthy lifestyle also contributes to rising healthcare costs. According to the Centers for Disease Control and Prevention (CDC), nationally 33 percent of adults are obese, with 14 percent of children age 2-5 overweight, 18 percent of children age 6-11, and 17 percent of those age 12-19. Obesity is estimated to generate \$36.5 billion in healthcare costs annually (Thorpe, et al., 2005). In addition, the CDC found more than 24 percent of men and 21 percent of women smoke, and tobacco use is estimated to cause \$75 billion in medical costs annually.

What the Blues Are Doing



The Blue Cross and Blue Shield System is pioneering programs to encourage consumers to adopt healthy lifestyles, which has shown to be beneficial to health outcomes, cost of care and overall quality of life. BCBSA also recommends greater incentives in the system to promote prevention and public health.

Engaging Consumers@Work: *Helping Americans Live Healthier, More Active Lives*

BCBSA launched WalkingWorks in 2005 to encourage healthier lifestyles and combat obesity and related diseases. A daily routine of brisk-paced walking can help individuals lose weight, lower cholesterol, strengthen the heart and reduce the likelihood of serious health problems in the future. In 2006, six Blue Cross and Blue Shield Plans participated in a pilot program, working with the Harvard Medical School Department of Health Care Policy, National Opinion Research Center at the University of Chicago, the National Business Group on Health and eight employers to empirically test the impact of worksite-based employee education materials and activation programs, such as WalkingWorks. The effort included both an educational component with tailored worksite communications (posters, table tents and direct mail postcards) for employees, as well as a 10-week walking program incorporating a multi-worksite team competition. Research results validate that these programs have a demonstrated influence on both consumer awareness of how lifestyle choices affect their health and consumers' engagement in activity to promote better health.

Prevention and Disease Management Programs: *Encouraging Healthier Lifestyles*

Blue Plans are offering innovative prevention and disease management programs on a number of fronts. Following are some examples of the many initiatives underway:

Blue Shield of California's pilot Healthy Lifestyle Rewards program motivates and enables members to make lifestyle changes to lower their risks for chronic conditions and illnesses. This online program includes interactive health promotional tools on diet and meal planning, stress management, exercise and smoking cessation and financial incentives to participants. At the end of two years, participants reduced their average health risks by 24 percent, with an associated average savings of \$277 in avoided costs per individual per year.

In response to the obesity epidemic, **Blue Cross and Blue Shield of Massachusetts** implemented a multifaceted health and wellness program to help members move toward increased activity and a healthier weight. FitBlue combines personal coaching, fitness and nutrition programs, educational material and individual phone consultations with a registered nurse or registered dietician to help members overcome obstacles and reach their goals. The personal coaching provides the motivation that is often needed to help members take control of their ability to develop healthier habits. Goals of the program are healthier members with better quality of life, lower rates of chronic disease, such as coronary artery disease, stroke and diabetes, weight loss, increased physical activity, and reduced stress and depression.

What the Government Should Do



Encourage Employee Wellness Programs

BCBSA recommends the government enact reforms to support employer efforts to promote healthy lifestyles:

- providing wellness incentives for individual workers by removing legal barriers that hinder employer efforts to encourage healthy employee lifestyles (e.g., requiring employers to give non-smoker discounts to smokers who enroll in, but do not successfully complete, cessation programs)
- establishing lifestyle factors for group rating by preempting state rules that limit insurers' ability to give group discounts for smoking and wellness rating factors
- offering other employer incentives such as tax incentives to encourage employers to adopt smoking bans, providing employees with exercise time during the work day and offering subsidized gym memberships and implementing OSHA workplace best practices

Educate Children on Healthier Lifestyles

BCBSA also believes one way to influence long-term health costs is to provide federal support for school-based programs that ensure children learn healthy lifestyles. BCBSA recommends the following:

- establishing new federal funding to support increased physical education requirements to five days a week at all grades, providing health education on diet/nutrition and tobacco use prevention and implementing body mass index (BMI) screening programs
- conditioning existing federal funding for school meal/snack programs on better nutritional quality (e.g., more vegetables and fruits and other healthy choices)
- funding school-based programs to ensure recommended vaccinations are provided to all children

Provide Incentives and Education on Nutrition and Health

BCBSA also recommends a variety of approaches to help low-income families lead healthy lifestyles:

- creating incentives and improving coverage for smoking cessation for Medicaid enrollees and incorporating wellness and disease management program features into Medicaid
- offering nutrition and meal planning/preparation education to Food Stamps enrollees and providing incentives to use Food Stamps for healthy foods
- providing tax and other incentives for grocery stores to locate in underserved low-income neighborhoods



5 Foster Public-Private Coverage Solutions

BCBSA believes every American should have health coverage. The uninsured is a diverse group composed of three key segments: those who are “squeezed out” by cost, those already eligible but “missing out” on public coverage and those with higher incomes who “opt out” of coverage (see Appendix for detailed summary).

BCBSA developed a series of tailored solutions to reduce the uninsured by addressing each of these segments. The solutions envision a role for both the public and private sectors. Whether people are uninsured because they have difficulty affording coverage within their family budgets, are low-wage workers in small firms, or are confronted with government paperwork – we need incentives to make sure people get the healthcare they need.

What the Blues Are Doing



Helping Those ‘Squeezed Out’

Fifty-six percent – about 25 million – uninsured individuals are ineligible for public programs such as Medicaid and the State Children’s Health Insurance Program (SCHIP) but have difficulty affording health coverage (Urban Institute, 2006). Some may be between jobs or recent college graduates who decide to go without coverage, or they work for firms that don’t offer health benefits. Others cannot afford health insurance because they are unemployed or do not earn enough to pay for coverage on their own. Some may be offered coverage from their employers, but cannot afford their share of the premium.

Helping Low-Wage Workers in Small Firms

Many Blue Plans have developed products and programs to help make coverage more affordable for employees of small businesses.

Blue Cross and Blue Shield of Oklahoma was instrumental in creating a premium assistance program for Oklahoma – a program closely tracking BCBSA’s recommendation to provide tax credits based on the cost of insurance. Funded by a tobacco tax, the Oklahoma program provides premium assistance to low-income workers (less than 200 percent of the federal poverty level (FPL)) in eligible small firms offering a qualified health plan. Employers contribute 25 percent of the monthly premium; employees pay up to 15 percent of the premium (up to 3 percent of their income). Currently over 3,400 lives are covered, and eligibility for the program was recently expanded.

BlueCross BlueShield of Western New York launched Aqua in 2007, a small group product aimed at reducing costs for employers while providing members with exceptional coverage. Members are given a \$500 (single) or \$1,000 (family) Aqua Allowance to be used as “first dollar” coverage for eligible medical expenses, with members able to carry over up to \$500 single/\$1,000 family in their allowances to the next year. After the allowance is used, deductibles and coinsurance are applied. In-network hospitalization and well-child visits are covered in full. Preventive care also is an important aspect, with members given \$250 (single) or \$500 (family) for gym memberships or other health and wellness services.

Blue Cross and Blue Shield of Kansas offers the Value Blue plan at 50 percent savings to eligible individuals and small groups with incomes up to 200 percent of FPL who have been uninsured for 12 months. Healthcare providers accept a 50 percent discount and BCBS of Kansas absorbs all administrative costs. The Value Blue plan provides the first five office visits for a \$25 co-pay, then a \$1,000 deductible with 20 percent coinsurance is applied with no annual benefit limit.

Helping Individuals Struggling with Healthcare Costs

Many Blue Plans offer innovative products and programs for individuals who may have trouble affording health coverage. These products can cost significantly less by reducing administrative costs and negotiating deeper discounts with providers for select populations.

Blue Cross of Northeastern Pennsylvania developed a new product in early 2007 called Blue Care Direct for individuals who have traditionally had trouble finding insurance – young and healthy individuals, retirees not yet eligible for Medicare and self-employed individuals. BlueCare Direct eliminates the gap between what individuals perceive they can afford and what is available in the individual health insurance marketplace. BlueCare Direct was designed with four deductible options, prescription drug coverage, health and wellness programs and an extensive network of local and national doctors and hospitals.

Blue Cross and Blue Shield of Florida created a series of products for individuals and groups to provide a range of coverage options. Called BlueOptions, these plans include a routine care plan as well as a hospital and surgical care plan. The Plan negotiated lower payment agreements for this population with providers that resulted in lower costs to members. The Plan is rolling out additional enhancements to its BlueOptions plans, including adding a 90-day retail benefit for pharmacy, lower cost sharing for e-visits (online visits between doctors and patients in lieu of an in-person office visit), access to a new discount program for prescription drugs not covered under an existing pharmacy plan, and a hospital network utilizing the most efficient hospitals.

Blue Cross & Blue Shield of Rhode Island has a premium assistance program for its individual market members. The program works with all direct coverage offered by the Plan, with the amount of assistance provided determined by a members' gross annual household incomes and whether they have an individual or family plan. The Plan set aside \$9 million in 2006 for premium subsidies.

Blue Cross and Blue Shield of Oklahoma worked with local hospitals in 2004 to encourage the Oklahoma legislature to enact the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). This program provides premium assistance to both individuals without employer coverage as well as employees with coverage through their small employers. Blue Cross and Blue Shield of Oklahoma currently participates in O-EPIC by offering policies that qualify for the subsidies.

Mountain State Blue Cross & Blue Shield works closely with the West Virginia Workforce Agency to help displaced manufacturing workers obtain health coverage eligible for the federal health coverage tax credit. When the state workforce agency meets with workers to explain the trade adjustment assistance benefits available to them, Mountain State representatives provide literature and answer workers' questions about health coverage.

Helping States Develop Tailored Initiatives

Blue Cross and Blue Shield Plans have created several innovative programs in their local communities to assist the uninsured.

In January 2007, **Blue Cross and Blue Shield of Florida's Blue Foundation for a Healthy Florida** announced over \$651,000 in grants to community organizations that serve the uninsured. Examples are a \$100,000 grant to the St. Petersburg Free Clinic to expand the clinic's Walk-In Now program, a supplemental medical care program that serves uninsured and underserved patients in Pinellas County, and a \$40,000 grant to BayCares, Inc. to establish a prescription drug assistance program for uninsured patients. In 2007, the Foundation plans to donate \$2.5 million, all focused on the uninsured.

The Blue Cross and Blue Shield of North Carolina Foundation directs much of its effort and resources to improving health outcomes for the uninsured, low income and other vulnerable populations. This includes a five-year partnership with the North Carolina Association of Free Clinics to sustain and expand services of free clinics and pharmacies, with a goal of providing statewide access by 2009. Since the partnership began in 2004, the number of clinics has increased by 27 percent. North Carolina now has the nation's largest network of free clinics. The Foundation also is in the midst of a five-year initiative with the N.C. Medical Society Foundation to support the Community Practitioner Program, which recruits primary healthcare providers to rural and other high need areas of the state. The partnership is expected to generate millions of dollars in care for the uninsured, and increase patient visits in rural and economically distressed areas by hundreds of thousands annually.

The Regence Caring Foundation for Children provides dental services for children whose parents work but do not qualify for government assistance and cannot afford dental insurance coverage. In 2006, more than 2,600 children received comprehensive dental care at no cost to their families. Regence Blue Cross Blue Shield of Utah and Regence Blue Shield of Idaho provide all the administrative support for the Foundation – which included more than \$600,000 in cash and in-kind contributions last year. This level of commitment allows 100 percent of all donations to provide direct services to children from low-income families.

BlueCross BlueShield of Tennessee Health Foundation has as one of its 2007 funding objectives “Innovations of Care for the Uninsured.” Examples of Foundation grants in 2006 include funding of about \$500,000 for community-based volunteer clinics that treat the uninsured and underinsured, and providing administrative services in a pilot program with the Memphis Church Health Center, a clinic that directs uninsured persons into physician practices and hospitals that will treat them. The Plan tracks these encounters so doctors can have a record of patient care.

What the Government Should Do



Help Those ‘Squeezed Out’

To help those who currently have difficulty affording coverage, BCBSA recommends the government take the following actions:

Provide Four New Types of Tax Assistance

1. Tax Credits for Low-Wage Workers in Small Firms

The federal government should provide a refundable tax credit to small employers (2-50 employees) where at least 50 percent of employees earn less than 250 percent of the FPL. This recommendation would work in tandem with the next recommendation so that low-wage employees would have a refundable tax credit available to help with their share of the premium. The credit would be limited to firms with low-wage workers to avoid subsidizing those who would be able to afford coverage on their own.

Low-wage workers in small firms are less likely to have employer-sponsored coverage than workers in large firms. Some small employers cannot afford coverage. Even when employers can offer coverage, they may not offer it because they know their employees cannot afford their share of the premiums (Employee Benefit Research Institute (EBRI), 2005). About 58 percent of workers in small firms earn less than 250 percent of the poverty level, compared to 26 percent of employees in firms with 100 or more employees (EBRI, 2005).

Such tax credits are likely to have a significant impact on small employers’ willingness to offer health coverage. According to surveys (EBRI, 2005), 77 percent of uninsured small employers said they would consider offering a health plan if the government provided tax credits to help them pay for coverage.

How it might work

Michael owns a gasoline station with 10 full-time employees. He selected a health plan to offer to his employees but the monthly premium of \$300 per employee far exceeded his budget, which allowed him to contribute \$100 toward the cost of his employees’ coverage. Since he knew his employees could not afford to pay \$200 a month, he cancelled his insurance application. With a 25 percent tax credit of the total premium, Michael would be able to offer coverage so that employees pay about 40 percent of the premium. Michael would pay \$100, the tax credit would contribute \$75 and the employee would contribute the remaining \$125.

2. Tax Credits for Individuals Struggling with Healthcare Costs

A new kind of refundable federal tax credit would help millions of individuals and families who are hard pressed to pay their health insurance premiums because they do not qualify for government assistance, and health insurance premiums represent a large share of their income. Importantly, the credit would be available on an advanceable basis even to those who do not pay taxes.

These innovative tax credits would vary the amount of federal support depending on the cost of insurance and income. Middle- and lower-income individuals and families whose health insurance premiums exceed a certain threshold of their income (e.g., 5 percent) would receive a refundable tax credit. The credit would be adjusted by income and calculated based on the amount of their insurance premium that exceeds the income threshold.

Individuals with employer-sponsored coverage could use the credit to help pay for their share of the premium. Individuals without access to employer coverage could use the tax credit to purchase a policy on their own.

The intent of these credits is to assure that no one would have to pay a disproportionately high percentage of their income for health insurance premiums, whether they work in small or large firms, as part-time, full-time or temporary workers, or are self-employed.

How it might work

Sally is a single 45-year-old earning just under \$14,000 per year working part-time in a department store. She is uninsured because her employer does not offer coverage to part-time workers and she cannot afford to pay the \$200 monthly premium for an individual policy. Under this proposal, Sally would be eligible for a tax credit equal to \$114 per month, reducing her cost to \$86 per month.

John is a married father of two who earns \$47,000 per year. He cannot afford the \$400 monthly premium contribution for a family policy required by his employer. However, John could afford the \$257 monthly contribution that would result if this tax credit were available.

3. Tax Credits for Those between Jobs

A refundable federal tax credit would help people who are between jobs – and who qualify for state unemployment assistance – pay their health insurance premiums. This tax credit would be offered through an expansion of the current tax credit available to those who have lost their jobs because of international trade policy. The tax credit of 65 percent of the cost of qualified coverage would help these people keep their healthcare coverage while they seek other employment.

The credit could be used to pay for the previous employer's policy under COBRA, the spouse's employer coverage or other coverage available through the state. In recognition of cash flow problems faced by people who are unemployed, the credit could be available to pay premiums upfront rather than claimed on an individual's tax return.

How it might work

Suzanne is a single unemployed computer programmer who lost her health insurance when her company eliminated her division last month. She did not elect COBRA coverage because she could not afford to pay the \$300 monthly premium. Under this proposal, the 65 percent tax credit would lower her premium to just over \$100 per month – and she would receive the subsidy on a monthly basis.

4. New Tax Deduction for Those Without Access to Employer Coverage

Currently, only the self-employed and individuals whose medical costs exceed 7.5 percent of their income may deduct the cost of health insurance premiums for federal income tax purposes. As a result, the vast majority of purchasers in the individual market must pay for coverage with no income tax advantage or deduction. This differs greatly from employees receiving coverage from their employer – where the value of the employer-provided health insurance is a tax-free benefit.

BCBSA recommends that individuals who lack access to employer coverage be allowed to deduct the full cost of individual health insurance when filing taxes. This deduction would only be available to those whose employer does not offer health insurance coverage and who cannot purchase coverage through their spouse's employer.

How it might work

Susan is the office manager at the Blue Moon Diner and earns \$40,000 per year. Her employer does not provide health insurance coverage. Right now, Susan purchases coverage in the individual market and pays \$1,700 per year for the coverage. As a single individual with no other income or deductions, this proposal would allow her to deduct the full cost of her health insurance coverage, resulting in an after-tax premium cost of \$1,275 per year.

Expand the Government Safety Net

Public program coverage should be extended to everyone with incomes at or below the FPL (\$10,210 annually for individuals/\$20,650 annually for a family of four in 2007) and not already eligible for Medicaid. This would ensure that the government can help those who are truly in need.

Currently, eligibility rules for Medicaid and the State Children's Health Insurance Program (SCHIP) vary by state and do not assure that all individuals below poverty are covered. Those most frequently ineligible for coverage are childless adults.

How it might work

Tom is a single 57-year-old former textile worker whose mill has closed. He can now only find part-time work earning \$8,500 per year. He is uninsured because he does not qualify for Medicaid (despite the fact that his income is below the FPL), and he is not eligible for employer coverage because of his part-time status. Under this proposal, Tom would be eligible for public coverage.

Provide Three Types of Targeted Grants to States

1. Help States Assure Access to Coverage for All Individuals

All states should have mechanisms to ensure that individuals with serious medical conditions have access to affordable and meaningful health insurance, while ensuring stable and competitive individual markets. A majority of states already have such mechanisms in place, but seven states do not. High risk pools play a key role in ensuring access in over 30 states.

Current federal support for state high risk pools should be made permanent and should cover at least 50 percent of pools' annual operating losses. These high risk pools should be required to ensure affordable premiums, and state funding sources should be broad-based so that the burden does not fall mainly on individuals and small employers.

To ensure that all individuals with serious medical conditions have access to coverage in the individual market, all states should be required to have high risk pools, unless they already have an alternative mechanism in place. Federal grants should be made available to help states establish risk pools to meet this requirement.

2. Help Individuals and Families Through Collaborative Private Initiatives

A new federal grant program would encourage innovative partnerships between insurers, physicians and hospitals to develop low-cost insurance products for uninsured individuals and their families. These partnerships should use new benefit design options, discounted fees or other methods to provide lower cost options.

Partnerships already created between Blue Cross and Blue Shield Plans and their local physicians are examples of initiatives to reach out to the uninsured.

How it might work

John is a 42-year-old married father of two children who started his own graphics design consulting business last year in Montana. He earns about \$33,000 per year and cannot afford the \$469 monthly premium for a non-group policy. Through an innovative product, Blue Care, developed by a statewide coalition of physicians, hospitals and Blue Cross and Blue Shield of Montana, John would qualify for family coverage that costs less than \$289 per month. The lower costs are the result of deep discounts that were negotiated with hospitals and physicians.

3. Help States Develop Tailored Initiatives

Recognizing that the states may have unique uninsured populations, a new federal grant program would allow states to develop their own initiatives. For example, some states might want to develop a special strategy to improve coverage for migrant workers, while others may want to focus on a rural strategy or improving support for community health centers.

How it might work

A series of small towns located in California would like to address the healthcare needs of migrant workers who seasonally move through their communities. Although each town has committed to fund the program on an ongoing basis, they lack the start-up funds to initiate the project. Under this proposal, federal grants would be available to jumpstart this program.



Enrolling Those ‘Missing Out’

One-fourth of the uninsured are reachable through public programs, such as Medicaid and the SCHIP program for children, and 74 percent of all uninsured children are eligible under current rules but unenrolled in public programs (Urban Institute, 2006).

There are several possible reasons for the lack of enrollment in public programs. Some may be unaware they are eligible for these programs. Others may perceive a stigma associated with government programs. Still others may be unable to maneuver through complicated application procedures, extensive paperwork and language barriers. In some cases, families themselves may not make the necessary efforts to obtain coverage.

Helping States Enroll Low-Income People in Medicaid and SCHIP

Blue Plans are educating low-income consumers on available federal and state assistance programs.

Blue Cross of Northeastern Pennsylvania serves as an administrator of the state Children’s Health Insurance Program (CHIP). Outreach efforts include working with internal and external agencies such as area Domestic Relations offices, WIC offices and county Children and Youth Agencies to provide information and education regarding the CHIP program. The Plan also participates in area children’s events and expos such as area kids’ safety events, and works with the area’s Rapid Response teams to provide CHIP and adult basic information, applications and assistance to area employers and their employees who are losing their jobs and healthcare coverage.

Capital BlueCross, the largest administrator of the Children’s Health Insurance Program (CHIP) in Central Pennsylvania and the Lehigh Valley, expanded outreach efforts to families with uninsured children. To help build CHIP awareness and encourage families to apply, Capital BlueCross launched print, billboard and radio advertising campaigns in the counties where there are large populations of uninsured children. Since the program’s inception in 1995, Capital BlueCross has enrolled over 100,000 children into the CHIP program.

What the Government Should Do



Enroll Those ‘Missing Out’

Help States Enroll Low-Income People in Medicaid and SCHIP

SCHIP should be reauthorized and expanded to ensure children currently eligible are able to enroll.

In order to enroll the millions of adults and children who could be covered by Medicaid and/or SCHIP under current rules, the federal government should provide states with increased funding to improve their outreach programs. For example, states should provide brokers with a finder’s fee for enrolling individuals eligible for Medicaid and SCHIP. In addition, states should be allowed to automatically enroll children into public programs who qualify for other programs (e.g., food stamps, free or reduced school lunches, and others.).

States should be encouraged to share best practices in effective outreach initiatives. There should be special emphasis on multi-lingual projects. In addition, states should be encouraged to streamline enrollment requirements. Possible actions could include:

- simplifying enrollment forms and processes
- eliminating burdensome requirements for verifying income and residency
- decreasing the number of face-to-face interviews for periodic re-determination of eligibility
- increasing Medicaid/SCHIP eligibility staff in hospitals and clinics

How it might work

Joe is a father of four who earns \$25,000 a year as a truck driver for a small company that does not offer health coverage. His entire family is eligible for public coverage, but Joe did not realize it. When he contacted a broker to try to purchase non-group health insurance for his family, the broker helped him enroll his family in Medicaid.

Empower States to Enroll Medicaid/SCHIP Beneficiaries in Employer Plans

States should pay the employee premium for children of working parents whose children are eligible for Medicaid and/or SCHIP, as an alternative to obtaining coverage through public programs when employer coverage is available.

In addition, states should be allowed to pay the premium not only for the SCHIP-eligible children but also for low-income parents who are not otherwise eligible for public programs.

One reason some families are not enrolled in Medicaid and SCHIP programs is the perception of a “stigma” related to enrollment in a public program. Many of these families have employer coverage available to them, but they cannot afford their share of the premium. Currently, states must meet special rules or obtain special waivers from the federal government to enroll children in their parent’s employer plan.

Requiring states to purchase employer offered coverage has many advantages. These families would be enrolled in private plans – covered by the same policy as their coworkers, they would most likely have access to a broader network of physicians, and the states would be able to leverage their funds by paying only the employee share of the premium instead of the full cost of the public program.

How it might work

Courtney is a single mother of two young children earning \$15,000 a year. Her children are covered through SCHIP, but she is not eligible for the program. She works for a hotel that offers health coverage, but she cannot afford to pay \$200 per month for her premium. Under this proposal, the federal government would pay for Courtney and her children to receive coverage from her employer.

What the Blues Are Doing



Attracting the 'Opt Outs'

Twenty-six percent of relatively high-income uninsured workers (earning \$75,000 or more annually) are eligible for employer coverage but decline it (EBRI, 2005). Some higher-income individuals may not believe they need coverage – perhaps because they are young and/or healthy. Others may be unaware of coverage options for individuals or may overestimate the cost of health coverage. Still others may not know about important tax advantages – such as the fact that self-employed individuals can deduct the full cost of coverage.

Developing User-friendly Products and Programs

The Blues are conducting research to understand the various segments of the uninsured population in order to develop education and outreach programs on the importance of health coverage. Blue Plans also are developing innovative products – to attract those who may opt out of coverage – and consumer-friendly tools to help individuals navigate and better understand affordable insurance options.

WellPoint has designed a portfolio of benefit-rich, low-cost products called Tonik. Available to all age groups, Tonik is marketed especially to young adults or “young invincibles” who might otherwise not have insurance or buy it. Tonik provides medical coverage, payment for doctors’ visits, generic drug coverage and dental benefits. It is available in California, Colorado, Connecticut, Georgia, New Hampshire and Nevada.

What the Government Should Do



Attract the ‘Opt Outs’

Educate Americans about the Importance of Being Insured

To encourage all Americans to purchase coverage, the government and the private sector should partner to launch a broad-based educational campaign on the importance of insurance, the risks – both health and financial – associated with being uninsured and the options available in the marketplace. This initiative would tailor its messages to key uninsured populations. Our health insurance system works best when everyone is enrolled. That means more people participating in the benefits and sharing the costs.

How it might work

Mark is a 25-year-old accountant who earns \$65,000 per year and lives in Houston. He grew up in Denmark but moved to the U.S. to attend college. While his employer offers health insurance and contributes to the cost of coverage, Mark declined the coverage in favor of higher retirement contributions. Under this initiative, Mark might be encouraged to enroll in his employer’s health plan after listening to a program that highlighted the risks of remaining uninsured, such as the cost of a sudden illness or accident.

Other Initiatives to Help Higher Income Individuals

Other initiatives described in this booklet also would help the higher-income uninsured. For example, BCBSA’s recommendation that individuals who lack access to employer coverage be allowed to deduct the full cost of individual health insurance when filing taxes also would be beneficial to higher income individuals.



Moving Forward

The Blue Cross and Blue Shield System calls on policymakers to make healthcare reform the nation's top domestic priority. We must immediately take action on two fronts: improve the quality and value of today's healthcare system and simultaneously expand health coverage to include everyone in America.

This will require a collective effort that depends on thoughtful, coordinated contributions and collaboration among all stakeholders. We believe our efforts need to be focused on five key areas:

- encourage research on what works and put it into practice
- change incentives to promote better care
- empower consumers and providers with knowledge to make informed decisions
- promote health and wellness
- foster public/private coverage solutions to assure everyone in America has health insurance

As leaders in the local and national healthcare communities for more than 75 years, the Blue Cross and Blue Shield System looks forward to working with all stakeholders to ensure value and access to quality healthcare for all.

The time for action is now.

Appendix

The Diversity of the Uninsured: 'Squeezed Outs,' 'Missing Outs' and 'Opt Outs'

According to the U.S. Census Bureau's Current Population Survey (CPS), 44.8 million people, or 15.3 percent of the total population, were without health insurance in 2005. The Employee Benefit Research Institute (EBRI) estimates that 17.2 percent of non-elderly Americans were uninsured in 2005 versus 16.1 percent in 2000.

The uninsured is a diverse group. In 2004, BCBSA, working with the Actuarial Research Corporation (ARC), released an analysis showing the uninsured population is composed of three key segments – those who may have difficulty purchasing coverage, those already eligible but unenrolled in public programs and those with higher incomes. Researchers from the Urban Institute and Johns Hopkins recently updated this analysis to reflect more current data. Their analysis of the uninsured (Figure A) shows that:

- Over half are ineligible for public programs but may have difficulty affording coverage. Many of these people work for small firms that do not offer coverage.
- One-fourth of the uninsured are reachable through public programs under current rules, such as Medicaid and the SCHIP program for children – and 74 percent of all uninsured children are eligible but unenrolled in public programs.
- One-fifth earn relatively higher incomes and may be able to afford coverage on their own.

Figure A – Uninsured Key Segments by Percent of Total Uninsured

	2006 Urban Institute Analysis*	2004 BCBSA BCBSA Analysis*
Ineligible for public programs but need financial assistance	56%	49%
Eligible but unenrolled for public programs under current rules	25%	30%
Higher income **	20%	21%

* BCBSA analysis based on CY2005 CPS data; Urban Institute/Johns Hopkins based on CY2004 CPS data

** BCBSA defined family income at \$50,000; Urban Institute/Johns Hopkins at \$56,550 (300% of FPL 2004)

'Squeezed Out:' Americans Ineligible For Public Programs Who May Not Be Able To Afford Coverage

Over half of the uninsured may have difficulty finding coverage they can afford.

Fifty-six percent – about 25 million - uninsured individuals are ineligible for public programs such as Medicaid and SCHIP but have difficulty affording health coverage (Urban Institute, 2006). Some may be between jobs or recent college graduates who decide to go without coverage or they work for firms that do not offer health benefits. Others cannot afford healthcare insurance because they are unemployed or do not earn enough to pay for coverage on their own. Some may be offered coverage from their employers, but cannot afford their share of the premium. Seventeen percent of very low income workers earning \$15,000 or less annually are offered but decline coverage (EBRI, 2005).

Many lower income individuals do purchase private coverage, however – 22 percent of individuals earning less than 100 percent of the FPL – and 38 percent between 100 and 149 percent of FPL purchase private coverage (EBRI, 2005).

‘Missing Out:’ Americans Reachable Through Existing Public Programs

One-fourth of the uninsured – and nearly three-quarters of uninsured children – are reachable through existing public programs.

A quarter of all non-elderly uninsured individuals are reachable through existing government health programs such as Medicaid and SCHIP under current rules.

About 8.1 million children – 10.9 percent of all children under age 18 – were uninsured in 2005. Of that number 74 percent are eligible but not enrolled in public programs. Also, 83 percent of uninsured children are in families earning less than 300 percent of the FPL (\$61,950 for a family of four). Over 70 percent of low-income uninsured children live in families already receiving other public assistance benefits such as food stamps and school lunch programs (Urban Institute, 2005).

There are several reasons for the lack of enrollment in public programs. Some may be unaware they are eligible for these programs. Others may perceive a stigma associated with government programs. Still others may be unable to maneuver through complicated application procedures, extensive paperwork and language barriers. In some cases, families themselves may not make the necessary efforts to obtain coverage.

‘Opting Out:’ Higher Income Americans

One-fifth of the uninsured earn relatively higher incomes.

One-fifth of the uninsured earn 300 percent of the FPL (\$51,510 for a family of three) or more annually and may be able to afford health insurance. Thirteen percent of the uninsured earn \$75,000 or more per year.

Of the uninsured earning 300 percent of the poverty level or more:

- Forty-four percent are young adults under age 35.
- Eighteen percent are Hispanics.
- Twenty-three percent are workers or dependents in small firms.
- Twenty-one percent are self-employed workers or dependents.

Twenty-six percent of relatively high income uninsured workers (earning \$75,000 or more annually) are eligible for employer coverage but decline it (EBRI, 2005). Some higher-income individuals may not believe they need coverage – perhaps because they are young and/or healthy. Others may be unaware of coverage options for individuals or may overestimate the cost of health coverage. Still others may not know about important tax advantages – such as the fact that self-employed individuals can deduct the full cost of coverage.



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