Child and Family Policy Center

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December 15, 2008

Honorable Chester Culver
Office of The Governor
State Capitol
Des Moines, IA 50319

Honorable John P. Kibbie
President, Iowa Senate
State Capitol
Des Moines, IA 50319

Honorable Pat Murphy
Speaker of the House
State Capitol
Des Moines, IA 50319

RE: HF 2539, Iowa Choice Health Care Coverage Advisory Council

Dear Sirs:

As Chair of the Iowa Choice Health Care Coverage Advisory Council, I am pleased to submit the attached report and recommendations regarding the Council's work.

As you'll see in the report, the Council met several times since mid-August 2008 and worked hard to develop recommendations to cover all children and adults in Iowa.

If you would like more information on the work of the Council, this report, or our recommendations, I am available as requested. I can be reached at 515-280-9027. The vice-chair, John Aschenbrenner, and other Council members may also be available.

Sincerely,

Carrie M. Fitzgerald

Carrie M. Fitzgerald
Chair, Iowa Choice Health Care Coverage Advisory Council

The Iowa Choice Health Care Coverage Advisory Council Report

Introduction:

During the 2008 legislative session, House File 2539 established an Iowa Choice Health Care Coverage Advisory Council to assist the Iowa Comprehensive Health Insurance Association with developing a comprehensive health care coverage plan. The plan must include, but is not limited to, a definition of what constitutes qualified health care coverage, and suggestions for the design of health care coverage options. Membership includes the two most recent former governors, seven members appointed by the director of IDPH, the Insurance Commissioner and the directors of DHS and IDPH, and four legislators as ex officio, nonvoting members. **(See appendix I for a list of Council members.)** The Association, in consultation with the Choice Advisory Council, shall develop a comprehensive health care coverage plan to cover all children. The Association shall consider the use and modification of existing public programs (Medicaid, ***hawk-i***, ***hawk-i*** Expansion).

The plan shall also consider and recommend options to provide access to private, unsubsidized coverage to children less than 19 years of age with family income greater than 300% of the Federal Poverty Level (FPL) and to adults and families not otherwise eligible for coverage through public programs. The plan is due to the Governor and General Assembly by December 15, 2008 and requires approval by the 2009 General Assembly before funding is appropriated.

Council Meetings and Work Focus:

The Council's members were appointed in July and the first meeting took place on August 11, 2008. Since early September, the Council met an additional seven times with the majority of members attending each meeting. Council meetings took place at the state capitol building and were open to the public.

The Council chose to work on children's coverage first and focused research and data gathering on that area. The first few Council meetings included presentations from the Iowa Medicaid Enterprise and the ***hawk-i*** Director about enrollment, retention, renewals, outreach, eligibility, cost, funding, benefits, state and federal regulations, and program coordination.

The Council broke into small work groups to address the larger issues in children's coverage:

- Benefit Review
- Definition of 'all kids'
- Coordination of the current programs
- Maximization of Funding for ***hawk-i*** and Medicaid
- Covering children who are not currently eligible for ***hawk-i*** and Medicaid

The Council also established a small work group to address adult coverage issues.

Each small group met face to face at least once and continued their work between Council meetings. Small groups brought their research and recommendations to the larger Council for review, input, discussion, and a vote.

Issues:

Although the Council worked strenuously to develop plans to meet the health care needs of all children in Iowa, there are ongoing issues that reach beyond health care coverage. Being insured does not guarantee access to medical care. Iowa faces a medical workforce shortage that impacts children, families, and adults in all walks of life. To that end, the Council supports the recommendations made by the Commission on Affordable Health care for Businesses and Families related to workforce. House File 2539 also created a task force to address workforce issues and the Council encourages that effort. Additionally, the Council supports the work being done through HF 2539 to design and establish medical homes for children at risk.

The Council also recognizes the importance of preventive, long-term, and chronic care. Each of those are not always addressed under ***hawk-i*** or private health plans. The Council supports ongoing planning to address those needs.

While working on this project it became clear to the Council that it would be beneficial to establish a single point of coordination related to health care reform in Iowa. HF 2539 addresses many issues within health care and created several councils and advisory boards. The Council recommends that the legislature review the need for coordination and leadership across departments to include all areas of health care reform, in conjunction with all of the coverage issues related to adults and children.

The following two sections of this report contain the Council's recommendations broken out by children and then adults. Though all recommendations were approved by the Council by majority vote, not all votes were unanimous. Each vote was preceded by reviews of research and best practices within other states and discussion by the full Council.

Council Recommendations
Covering Every Child

I. General

All children in Iowa should be covered under a satisfactory and affordable form of public or private health insurance and have access to appropriate health care.

A general philosophy of the council was that children should not be disadvantaged in regards to health care due to the actions or inactions of their parents.

II. All Children

A. For those eligible but not enrolled in ***hawk-i*** and Medicaid, create an environment and processes that will encourage and simplify initial enrollment and ongoing participation in ***hawk-i*** and Medicaid. Look for ways to identify these children and encourage/facilitate enrollment. **See Appendix II for more details*.***

B. Create a buy-in program so families above 300% FPL can buy-in to ***hawk-i*** on a sliding fee scale up to 400% FPL. At 400% FPL make ***hawk-i*** available for purchase at full cost.

C. After ensuring that appropriate coverage is available, investigate why children from families above 400% FPL are not being covered and build programs to encourage enrollment.

D. Immigrant Children

1. Eliminate the five year waiting period for legally documented immigrant children. Currently, federal funding cannot be used for legally present children and pregnant women to receive Medicaid or SCHIP. This federal prohibition may change under SCHIP reauthorization in early 2009.

2. Cover undocumented immigrant children. Again, those children would not currently receive federal support. **See Appendix III for supporting discussion items.**

E. ***hawk-i*** should be made available on a state funded basis to children of income-eligible state employees.

III. Benefits in a "qualified health coverage" plan

A. Current ***hawk-i*** medical and dental benefits are appropriate and no changes are recommended. **See Appendix IV for discussion items.**

B. Eliminate the $1 million lifetime maximum under ***hawk-i***.

C. Make ***hawk-i*** benefit package available to any child above Medicaid income eligibility, regardless of family income.

D. Charge a small monthly premium for ***hawk-i*** beginning at 150% FPL and increase as income increases so that families above 400% FPL are paying the full cost. **See Appendix V for an example of how this works in Illinois.**

E. Utilize a minimal co-pay in ***hawk-i*** beginning at 150% FPL and increase as income increases. Set an annual maximum on the amount of cost sharing for a family based on their income. Do not charge co-pays for regular well-child visits. **See Appendix V for an Illinois example.**

F. We recognize that there is a category of expenses (long term care, educational, etc.) that relate to long term chronic conditions and that are not covered under this recommendation. These are not expenses that are typically covered by a traditional medical reimbursement plan. Including them in ***hawk-i*** and other private coverage adds significant complexity and would make what is now expensive coverage even more difficult for many to afford. We believe these are important needs that the state should attempt to address but that it should be done outside the traditional insurance approach.

IV. Affordability – Costs including premiums and co-pays and coinsurance need to be affordable based on family income.

A. As provided in HF 2539 expand ***hawk-i*** to 300% FPL on July 1, 2009.

B. Allow families to be able to buy-in to the ***hawk-i*** benefit package between 300-400% FPL on a sliding fee scale.

C. Build grid of ***hawk-i*** premiums and co-pays to fall within family affordability criteria.

D. Ask ***hawk-i*** insurers to investigate and recommend contractual modifications that could drive care to be less expensive but within acceptable options, in an effort to keep ***hawk-i*** premiums down.

E. Implement recommendations of the Affordable Healthcare Commission aimed at controlling the high costs of health care, in an effort to keep ***hawk-i*** premiums down.

V. Access to appropriate health care – Ensure an adequate supply of health services and professionals and that all children have access to them.

A. Implement recommendations at Affordable Healthcare Commission on these issues.

B. Continue working to increase provider compensation under Medicaid so that providers will accept Medicaid patients. This is particularly important with dental reimbursements where in some areas, it can be difficult to find dentists to accept new Medicaid patients.

C. Implement a "medical home" for children, particularly at risk children.

VI. Parental Responsibility

A. Parents are responsible to:

1. Enroll their children in an appropriate public or private insurance program.

2. Pay premiums and co-pays, if any.

3. Secure appropriate medical services for their children.

B. The Council does not recommend legislating a parental mandate with or without penalties for non-compliance.

VII. Private Insurance – Many children are currently covered under private insurance, often employer based. That is an economical and efficient way to provide coverage and we don't want to build a system that will encourage large numbers to move from private coverage into public programs. Employer subsidies help to keep family costs down and encourage them to remain in the employer plan.

A. Increasing ***hawk-i*** premiums and co-pays as income increases helps make ***hawk-i*** more comparable to private insurance at increased income levels.

B. If and when state dollars are available, provide premium assistance to families below 400% FPL who access private insurance instead of ***hawk-i*** for their children.

C. The council does not favor using a waiting period between leaving a private plan and entering ***hawk-i***. However, if the state decides to use such a waiting period to discourage dropping out of private plans, it should include hardship exemptions.

D. Make a stand alone ***hawk-i*** dental plan available for those children enrolled in a private medical plan but without dental coverage.

E. Assure that ***hawk-i*** is treated as prior creditable and qualifying coverage for private market access.

VIII. Cost, Quality, and Safety

While our efforts were focused on access and funding, it is important to point out that any solution is doomed to fail unless cost, quality, and safety are also improved. We support the cost, quality, and safety recommendations of the Affordable Healthcare Commission and encourage the state to begin implementing them.

IX. State Funding/Budget

A. Given the time and resource constraints of the Council, we have been unable to estimate the cost of our recommendations. We recommend engaging the services of a consultant to estimate the costs of the various pieces, including various combinations of premiums, co-pays, and subsidy levels.

B. Recognizing the ambitious nature of our recommendations relative to available state dollars, we offer the following prioritization of our recommendations starting with the highest priority.

Priority order – State should immediately implement 1) through 4). We believe 5) is also critical to full coverage of children and should be implemented and funded immediately. 6) through 8) should be funded if and when funds can be made available.

1. Covering all kids currently eligible for ***hawk-i*** or Medicaid.

2. Eliminate five year waiting period for immigrant children.

3. Cover non-documented immigrant children.

4. Expand ***hawk-i*** to 300% FPL (hopefully with federal support) on July 1, 2009.

5. Make ***hawk-i*** plan available as a buy-in for any child above 300% FPL with higher deductibles and co-pays. Design a sliding fee scale for families between 300-400% FPL.

6. Provide premium assistance to families below 300% FPL who access private insurance instead of ***hawk-i.***

7. Provide premium assistance to those between 300% to 400% FPL with private insurance at a level that is equivalent to the sliding fee schedule to buy-in to ***hawk-i***.

8. Expand ***hawk-i*** coverage to age 21.

C. Continue efforts to maximize federal cost sharing.

1. The Department of Human Services should file a state plan amendment with the Centers for Medicare and Medicaid Services to cover children in Iowa up to 300% FPL under ***hawk-i***.

2. Upon SCHIP reauthorization at the federal level, Iowa should examine additional opportunities to maximize federal funding and expand coverage for children within the context of state priorities and available funds.

3. Iowa should examine filing a waiver to expand the premium assistance program in Iowa to include children who are eligible for SCHIP.

4. Iowa should consider applying for federal permission or if it becomes possible under reauthorization, to expand coverage to children of income-eligible state employees.

D. Review the state administrative costs associated with Medicaid and ***hawk-i*** in an attempt to add efficiencies and reduce costs.

X. Timing

While it is unlikely that we can ever achieve a real 100% coverage, we recommend a goal of attaining essentially full coverage of children in Iowa by 01/01/2012. Interim goals or thresholds must be set for each year between now and then. Failure to attain those interim goals should trigger additional reviews and actions to get back on track.

Covering Uninsured Adults

Rationale

Iowa has one of the best comparative systems in the country based on the percentage of people with health care coverage, costs and quality of care. We want to build on and improve the current system with an emphasis on sustainability and practicality. We recognize that Iowa, like other states, is affected by federal policies related to health care. Health care reform is needed at the federal level to help solve problems we face in Iowa and to support state-level efforts.

In the short time we have had since being formed, most of the time and effort of our council has been focused on children. We have been unable to devote much time and energy to addressing a major improvement in the system for adults. However the council believes that still needs to be done. In the interim, we have a number of suggestions that could be considered. These will help improve the current situation, but should not be viewed as the solution to the significant healthcare issues that we face in Iowa.

The members of the Choice Council are willing to reconvene to continue to address issues related to adult coverage.

Options for Implementation

1. Explore expansion of premium assistance through Medicaid to provide coverage for working parents. Premium assistance would build on our current employer-based system and would be consistent with federal proposals that appear to maintain an employer-based system. This would have the added benefit of keeping employer dollars on the table to help pay for health care coverage instead of just paying claims with government money, and it would eliminate concern about “crowd out” because coverage would come from the private sector. Since most of the uninsured are employed, a significant number would gain access through their employer. Families would also benefit by all members being covered by one policy rather than multiple policies.

2. Fully fund Medicaid to help lower cost shifting to the private sector.

3. Reinforce legislation that provides premium discounts or incentives for wellness, disease management, smoking cessation and other potential programs.

4. Encourage greater transparency of health care quality and cost to assist informed consumer choices.

5. Allow the marketplace the ability to offer a tiered insurance program for adults with greater variation in price and benefits. In doing so we need to be careful to avoid disincentives to offer good coverage and driving consumers to accept less if good plans are not offered at a reasonable price. A range of plans might include the following:
    a. Current plan models
    b. Current plan models minus mandates at 15% discount
    c. Restricted plan models minus mandates at 25% discount
    d. Low cost "Necessary Benefit Plan" at 50% discount
    e. Limited Benefit Plan at 50% discount.

6. Consider subsidies or support for small (under 10) employers and non-profits to offer health insurance and contribute a qualifying percentage of the cost. As an alternative, direct credits could be made available to the individual employees who work for those employers.

7. Conduct a study of a Connecticut-style plan that allows local governments, non-profits, and small businesses to buy into a state plan or other public plan.

Other Considerations

1. HIP Iowa: We believe a high risk pool is essential for the state.

2. Iowa Care: Re-examine the Iowa Care Program before submitting the next waiver to CMS. This program has greater potential if it is revamped to allow better preventative-type coverage and follow-up care, as well as making more care available locally.

3. Expand Iowa Medicaid to cover parents up to 100% FPL.

4. Promote the federal expansion of Medicaid to include all adults up to 150% FPL.

5. High deductible plans: The committee discussed these at length, but could not reach a consensus.

Appendix:

I – Council Membership
II – Coordinating current programs
III – Covering all kids protects all kids
IV – Benefit review
V – Illinois All Kids

Appendix I

Members of the Iowa Choice Health Advisory Council

Position	Name
Former Governor	Gov. Terry Branstad (resigned 12/01/08)
Former Governor	Gov. Tom Vilsack
Representative of Federation of Iowa Insurers	Janet Griffin
Iowa Health Economist	John Aschenbrenner, Vice Chair
Consumer (Children's Advocacy Organization)	Carrie Fitzgerald, Chair
Consumer (Minority)	Deb Brewer
Organized Labor Representative	Jan Laue
Representative of an Organization of Employers	Jane Knaack-Esbeck (resigned 12/01/08)
Representative of the Iowa Association of Health Underwriters	Joe Teeling
Legislative Member	Senator Jack Hatch
Legislative Member	Senator James Seymour
Legislative Member	Representative Linda Upmeyer
Legislative Member	Representative Lisa Heddens
Iowa Department of Public Health Director (Ex Officio)	Tom Newton
Iowa Department of Human Services Director (Ex Officio)	Gene Gessow
Iowa Insurance Division Director (Ex Officio)	Susan Voss

Coordination of Medicaid and SCHIP Programs

Coordination of children's health programs in Iowa in a comprehensive system is critical to accomplish the goal of covering all children. Coverage is coordinated when variations between eligibility categories, programs and automated systems are seamless and invisible to families. Important elements of a coordinated system include:

1. Minimize procedural and policy differences between Medicaid and ***hawk-i***

2. Offer dental only coverage for children who have medical insurance but not dental coverage.

3. Re-examine reimbursement policies for dental care under Medicaid.

4. Increase technology in order to streamline enrollment, renewals, and retention in programs.

5. Collect, report, analyze, and act on data on a regular basis to identify successes and pinpoint barriers and opportunities.

Appendix III

Covering All Kids PROTECTS All Kids

This is a philosophical and moral choice for the Council and the state to take.
Kids are here through no fault of their own. No child chooses where or to whom they are born, or where their parents move after they are born.

Iowans have always put kids first. A major portion of state budget is dedicated to the young – education spending, preschool and childcare, Medicaid, ***hawk-i***, foster care, adoption subsidies, etc. This is one of the principle reasons why Iowa ranks in the top states of best places to live and work for families. It is who we are and it is a value we expect our children to carry on.

Covering all kids protects all kids. Covering all kids saves money in the health care system and reduces need for charity care. When all children have health care coverage, it reduces the spread of infectious diseases.

Kids are always growing and developing and they need preventive care throughout childhood. Their growth and development need to be monitored and any concerns should be addressed early on.

All children go to school and are offered free, public education. Immigration status has no impact on their access to education.

Insured children are less likely to use the emergency room. Uninsured immigrant children use the health care system less than other children – less likely to have a medical home, to see a physician, to receive dental care, to be fully immunized.

- Legal immigrant children are currently barred from receiving SCHIP or Medicaid paid for with federal funding during the first five years they live in the States. Several states cover those children with state-only funds. Iowa could do this. (There is renewed hope that Congress will pass and the Obama administration will approve an SCHIP bill that will allow states to cover legal immigrant children.)

- Undocumented children are not eligible for federal funded programs like SCHIP or Medicaid. However, states are able to cover those children with state-only funds, as well.

Recommendation to the Council:
Cover all children in Iowa with Medicaid and SCHIP who are income-eligible. Use state-only funds when necessary, and use federal funding whenever it becomes available for any population of children.

Report and Recommendations of Benefit Review Subgroup for Iowa Choice Advisory Council

Overview

The Benefits Review Subgroup discussed an appropriate benefit package that could be offered to the estimated 18,000 uninsured children in Iowa who would remain following full implementation of HF 2539. The Subgroup focused on that portion of HF 2539 which calls for the advisory council to assist in recommending the benefits to be included in "qualified health care coverage" for children less than 19 years of age, after consideration of 16 specific benefits .

The Subgroup compared the benefits currently available under Medicaid and *hawk-i,* noting differences in the two programs today. The Subgroup also reviewed the benefits currently available to an insured population (i.e. the State of Iowa [SOI] employee group). The Subgroup noted that the SOI benefit package, like most other insurance coverage available from the private sector, does not include specific benefits targeted for children. Therefore, the Subgroup focused on Medicaid and *hawk-i* for further analysis. The major differences noted between Medicaid (T19) coverage for children and *hawk-i* include:

- Early & Periodic Screening, Diagnosis & Treatment (EPSDT) is covered by T19--*hawk-i* limits coverage for well child care to age 7
- Title 19 covers certain residential treatment/custodial services —*hawk-i* does not
- Title 19 covers children to age 21, while *hawk-I* only covers children to age 19
- *hawk-i* has a $1 million maximum lifetime benefit while Title 19 does not

The Subgroup elected to use the *hawk-i* benefit package as the starting point for defining "qualified health coverage" for children because it has been established by the members of the *hawk-i* Board based on public input. In addition, the program's benefits expressly cover each of the 16 benefits listed in HF 2539.

The Subgroup received input on additional items to consider, such as providing early childhood care coordination and developmentally appropriate assistive technology for children with special needs (i.e. hearing aids), beyond those provided by the current *hawk-i* program. There was consideration of the addition of residential treatment/custodial care consistent with that currently provided under Title 19 and a suggestion to eliminate the $1 million maximum lifetime benefit under *hawk-i*.

In particular, the Iowa Department of Public Health believes the inclusion of care coordination should be furthered explored. The Clinical Advisory Committee created as a part of Iowa's SCHIP program recommended that *hawk-i* include care coordination as part of the benefit package. It was not included because at that time there was relatively little experience with this service for the population outside of Medicaid and Special Needs Children. Since then, more information is available on the benefits of providing care coordination especially for the 0-5 population to ensure access to needed services, which may result in cost savings in the long term.

Recommendations

A. "Qualified health coverage" for children (as stated in HF 2539)

The Subgroup recommends that Qualified health coverage" as provided for in HF 2539 consist of the identical medical and dental benefits included in the current *hawk-i* program.

1. Maintain Current Benefit Levels/Cost Considerations

The current monthly premium cost for children enrolled in the existing *hawk-i* program ranges from $187 to $194 per child (ages 1-19) and varies by the carrier participating in the program. In addition there is a flat $408 monthly premium for children ages 0-1 year, although the Department of Human Services reports that there are few infants enrolled in the program. These premiums reflect current benefits and are subsidized with state and federal monies. If additional benefits are added, regardless of how meritorious, they will result in further costs for the program which in turn creates a higher demand for subsidies or corresponding affordability concerns.

2. Facilitate Seamless Transition with *hawk-i*

Retaining a benefit design that is consistent with the *hawk-i* program will support families as they transition through *hawk-i*, and possibly a *hawk-i* "buy in" option and into the private market if their income rises without disrupting their health coverage. Consistent benefits will also facilitate a common administrative structure for a single point of entry via DHS and enrollment for families.

3. Future Expanded Benefits

If funding is available to expand the current *hawk-i* benefit package to include: elimination of the $1 million lifetime maximum, coverage for EPSDT , care coordination, and/or developmentally appropriate assistive technology for children with special needs,

then consideration should be given to extending these additional benefits to the new plan under development.

B. Cost Sharing

The Subgroup also was asked to consider various cost saving features with the potential to reduce costs, including elimination of some benefits currently covered. To provide consistency and seamless transition, **the Subgroup does not recommend eliminating any of the benefits currently covered by the *hawk-i* program.** However, **the subgroup does support the consideration of cost sharing** as a potential method for moderating program costs for this population

The current *hawk-i* benefit design has limited use of cost-sharing practices. Currently, families whose income is less than 150 percent of the Federal Poverty Level pay no premium for enrollment in *hawk-i*. Families with income greater than this are required to pay a $10.00 per child per month premium payment with a maximum of $20 per family. There are no deductible or co-insurance components, other than a $25 charge for the inappropriate use of the emergency room that is waived for those families whose income is low enough to qualify for $0 premium costs. While these are the type of benefit design features which have been used successfully to control utilization and costs in the private market, they have been considered to be inappropriate in the low income population which is the target of the *hawk-i* program. Introduction of these features at higher income levels could help to moderate the program costs for the expanded population.

C. Other Recommendations of Subgroup

- Develop a “dental only” option under *hawk-i* for families without access to dental coverage. The Subgroup feels that providing appropriate dental coverage should be as important as providing appropriate medical coverage.
- Make sure *hawk-i* (current and expanded*)* and the new program are treated as prior credible and qualifying coverage for private market access.

Governor Blagojevich's All Kids Healthcare for All Kids

All Kids Premiums and Out-of-Pocket Costs Vary by Monthly Income and Family Size

To find out how much All Kids may cost you, follow these 4 simple steps:

First, find your family size in the column "Family Size." Be sure to count yourself.

1) Look only at your family size row. Read across that row to the box where your family's total monthly gross income falls.
2) The box will be in the column of the All Kids plan that matches your income.
3) Read down that column to the cost box at the bottom. The cost box shows the Monthly Premium per child, along with the maximum Monthly Premium for your family, and the Maximum Co-Payments per child, per year.

INCOME BOX*

Family Size	All Kids Assist	All Kids Share	All Kids Premium Level 1	All Kids Premium Level 2	All Kids Premium Level 3	All Kids Premium Level 4	All Kids Premium Level 5-7	All Kids Premium Level 8
1	Up to $1,153 per month	$1,154 - 1,300 per month	$1,301 - 1,733 per month	$1,734 - 2,600 per month	$2,601 - 3,467 per month	$3,468 - 4,333 per month	$4,334 - 6,933 per month	$6,934 or more per month
2	Up to $1,552 per month	$1,553 - 1,750 per month	$1,751 - 2,333 per month	$2,334 - 3,500 per month	$3,501 - 4,667 per month	$4,668 - 5,833 per month	$5,834 - 9,333 per month	$9,334 or more per month
3	Up to $1,951 per month	$1,952 - 2,200 per month	$2,201 - 2,933 per month	$2,934 - 4,400 per month	$4,401 - 5,867 per month	$5,868 - 7,333 per month	$7,334 - 11,733 per month	$11,734 or more per month
4	Up to $2,350 per month	$2,351 - 2,650 per month	$2,651 - 3,533 per month	$3,534 - 5,300 per month	$5,301 - 7,067 per month	$7,068 - 8,833 per month	$8,834 – 14,133 per month	$14,134 or more per month
5	Up to $2,749 per month	$2,750 - 3,100 per month	$3,101 - 4,133 per month	$4,134 - 6,200 per month	$6,201 - 8,267 per month	$8,268 -10,333 per month	$10,334-16,533 per month	$16,534 or more per month

COST BOX

Monthly Premium per child	None	None	1 child: $15 2 children: $25 Ea. add'l child: $5	$40 per child	$70 per child	$100 per child	$150 – 250 per child	$300 per child
Max Monthly Premium	N/A	N/A	$40 for 5 or more children	$80 for 2 or more children	$140 for 2 or more children	$200 for 2 or more children	No cap	No Cap
Max Co-Payments per Year	No co-payments	$100 per family for all services	$100 per family for all services	$500 per child for hospital services	$750 per child for hospital services	$1,000 per child for hospital services	$5,000 per child for hospital services	No Max

*Income levels have been updated for 2008.

HFS 3711AK (R-4-08)

www.AllKids.com

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ROD R. BLAGOJEVICH
GOVERNOR, STATE OF ILLINOIS