Unattributed Comments On Draft Zaniya Report By Task Force Members

Recommendation	Comments
1. Create a High Risk Pool to Extend Coverage to "Uninsurables"	• Yes – if this is only way to cover them – structure to limit numbers. • The funding here is the key – if we don't make a recommendation for how the $18 million would be obtained – this high risk pool is a must. • Excellent recommendation. • Essential to covering the uninsured. • Cannot accept the timetable proposed for legislation. There is enough data and examples from other states to allow development of legislation by Jan. 2008. • The final draft report was forwarded to my clients late Monday, September 10th. They have not had enough time to review and as such I cannot give any specific comments on their part. One general comment is that they believe the task force time lines were somewhat aggressive. With this said they will continue to come to the table and participate in all efforts associated with this project. They are supportive of continued study of all the proposals to determine whether they can be implemented in South Dakota without doing harm to the health care system while still benefiting the consumer. • The Risk Pool has been a good tool for SD to provide health insurance to some of those in need. It will work well in this situation also. • This seems to be very workable idea. However, it might be better to create a new SD Uninsurable Risk Pool with new legislation. The current SD Risk Pool does not have the legislative structure to support the uninsurable. However, the administration of a SD Uninsurable Risk Pool could be combined with current SD Risk Pool. • Concerned about cost. • I support. • 1-1 Urge that the proposed workgroup include broad cross representation of the uninsured population both demographically and socioeconomically. Important consideration for uninsured under 200% of poverty. • Creation of a risk pool containing the significant number of individuals projected to be covered by it has the potential to exacerbate the growing problem of cost-shifting to providers. These uninsurables are generally not low income individuals for whom coverage is unaffordable. There should be regulations in place to ensure that only those who are viewed by the public as truly uninsurable

	become eligible for the risk pool. There should be no free ride given here. • If there is one thing this group recommends because it is "the right thing to do" this is it. It is unconscionable that these individuals cannot purchase health insurance. • Absolutely necessary. • The size of this risk pool compared to the current risk pool (5,211 individuals compared to around 700 currently) makes the financing of the plan and the provider reimbursement critical. Replicating the current Medicaid based rates for providers and assessments on insurers (and ultimately employer plans) is **not** acceptable. • I could support this. • Good • Good idea if funded the way the current risk pool is established. • The "closed block" population should remain a priority concern in South Dakota. Broadening access to the High Risk Pool will allow individuals with pre-existing conditions to stay covered. Support. • Good idea. How about extending coverage to all of those without insurance (and those with private insurance) at an affordable premium? • Expanding government programs is not the answer to providing access to health insurance. Insurers should provide access to health insurance through the commercial market, and government should provide subsidies, as determined necessary, in order to make insurance coverage accessible. Government programs reimburse at less than cost and this causes providers to increase charges to others. Having a risk pool encourages this, and expanding the risk pool would only exacerbate the problem – which results in higher premiums to employers. Government should pay its full cost for enrolled individuals before considering expanding services. The State of South Dakota is not an experienced insurer and is already operating with significant risk in administering the current risk pool. Risk pool administration should not be handled by government agencies with multiple other roles and limited experience in managing insurance risk. The funding model used for the current risk pool is not used in any other state and is inappropriate. If a risk pool is determined to be appropriate to guarantee uninsurables have access to health insurance (as opposed to having such access through commercial insurance), and if it is determined that public subsidies should be provided, these subsidies should be funded entirely by general funds in order to spread costs to everyone. • Makes a lot of sense – not sure about the mechanism and

	the cost but something needs to be done to help these folks – devil is in the details. • There needs to be a wider range of insurance coverage that would exclude coverage in certain areas but still provide protection in other unrelated areas.
2. Develop an Employer Assistance Program	• Yes – keep incentives the employers to participate at meaningful level. • This is provided in most cases by the insurance companies right now – Tailoring program to need and budget in what the companies do. • While the end goal is positive, should this not be the role of the insurance industry to create a mechanism to provide better and more concise information for small businesses and the agricultural community? • There is no reason this should not be initiated with legislation in 2008. • This idea has definite possibilities. • I support. • Urge that need of rural and usually small employers are adequately represented in the exploration of options. • Good Idea. • Focus on helping create Sec. 125 plans. Some business owners will be more motivated when they can realize the tax savings. • Yes • Support this recommendation. It is important to support the employer system under which most people receive their insurance coverage. • I don't think this s feasible. • Should be addressed to all employers not just those who don't offer insurance now. • Would like to see additional detail before further comment. • I'm not sure that effective, supportable options exist, but I'm in favor of exploring possibilities. It is important that we avoid shifting additional burden to those employers that do offer coverage. • We need to develop an expanded pool, especially for small businesses, farmers/ranchers, hospitality, retail trade, etc. that reaches both full and part time employees. • Since the current health care system is based on employer coverage, an employer mandate should be considered to strengthen that system. • I like it. This area appears to be a missed opportunity. • I don't see this as doing anything to lower the cost.
3. Offer Additional, More Affordable Insurance continuance Options	• Yes – Include leaner options to attract people to participate. • Example please? Don't quite understand the idea here without examples. • Excellent recommendation. • Legislative action in 2008 would add ???? us to

	development of these options ahead of the proposed time table. • Providing options for a terminated employee under COBRA is a very workable idea under the current ERISA and State statues. The option of providing a lesser health care package over one that is unaffordable because the cost could be accomplished. • I support. • Very important. • Yes (2) • Support this recommendation. Reduced premiums will encourage persons leaving group plans to continue basic coverage for themselves and dependents. Potentially reducing gaps in coverage, and reducing the number of persons uninsured at a given point in time. • Good – could be extended to P-T employees? • Good idea. • Having relied on COBRA coverage before, I know that this is a real issue. The proposed recommendation makes sense. As outlined in the draft report, this should be singled out for early action. • The only option that will work is under a single-prayer system for basic benefits. Supplemental "bells and whistles" benefits could then be purchased from insurance companies for those who desire expanded coverage. The major factors that are driving affordability are the excessive profits to private insurance and pharmaceutical companies and their undue influence on the political process. • This is an excellent idea. • Makes a lot of sense. Definitely worth pursuing. • More choices such as limited benefit or benefit laps. The concept of the Association Group as used in several states would be a ???? of offering expanded choice to South Dakota citizens.
4. Institute a Financial Responsibility Standard	• Yes – not politically easy but irresponsible people must be farced. • Tie into the basic plan: if you are financially responsible this basic plan is least of which you should provide your family & self. • Extremely problematic way of installing an individual mandate. The state does not have any mechanism to evaluate on an annual basis the income and asset levels of every resident of the state nor does such a system take into account the large fluctuations in agricultural income on a year to year basis. In essence, you will be data mining from a multitude of sources to try and determine the income and assets of every South Dakota to determine their "willingness and ability" to pay for health insurance. In essence, what this recommendation proposes is that every South Dakota must, aside from filing federal taxes every

	year, file some sort of individual state "heath care" return that the state will then use to group people into classes of health care consumers. It is hard to imagine the bureaucracy that will have to be created to administer this program as well as the political ill-will created in the public by having to send financial statements to the state to prove their annual income above and beyond federal tax returns. • There are significant issues relative to enforcing a financial responsibility requirement, which make the feasibility of this recommendation dubious. • Essential • I think financial responsibility is a good concept if it were enforceable. Unfortunately, enforcement mechanisms are limited in this scenario. It's a little bit hard to imagine putting someone in jail because they don't have health insurance. I think this should be deleted. • Should adopt the presumption of financial responsibility in 2008 legislation. • Don't believe this is viable in SD. Let's concentrate on options that will work for us. • Such a standard sounds good but it would not be enforce if implemented. Therefore, this recommendation should be deleted from report. • As has been seen in Automobile Ins. A financial responsibility standard is hard to enforce and not effective in reducing the uninsured. Also, there is no enforcement mechanism or strategy outlined in the WG recommendations that would guarantee its success any more than the automobile financial responsibility. • This is very good idea in theory but that is where it ends. Similar to automobile insurance financial responsibility the enforcement piece would be a nightmare. In fact, I believe it a health insurance financial responsibility standard would be unenforceable. This is not a workable idea or solution to help the uninsured population in SD. • Disagree – this hasn't work with auto insurance why do it for health? • I oppose. • 4-1 Recommend that the Workgroup include a broad cross section of the state's core uninsured population. Experience from health care organizations (i.e. community health centers) that serve a safety net to this population could offer support in this effort. There will need to be a stronger enforcement approach then used for auto insurance requirements. • Don't believe this is viable. • Don't support this. This is <u>not</u> workable – can't be done. • Enforcement of the standard will be difficult to legislate. • Probably. • Support this recommendation. This recommendation offers

	the potential to improve risk rating in group plans with increased participation by health young adults. Will also benefit providers with reductions in bad debt and charity care. As stated in the recommendation, **enforcement** will be the key to the effectiveness of the financial responsibility standard. • This sounds like a "mandate" and we should avoid mandates. • Without tech, this is merely a statement. What are the consequences? • Concern if this will lead to a future employer mandate. • I'm skeptical that such a standard is enforceable. In my experience, South Dakota courts are already overly lax in enforcing laws which require licensed rivers to carry sufficient auto liability coverage. I understand insurers/payers want this standard, however, I doubt it will solve much or be worth the controversy it will spawn. • Yes, like with auto insurance. But only if this benefits everyone, not the insurance companies. (See #3 above that begins with The only option that will work). • Individual responsibility is an important concept. SD should educate its public in the importance of saving for health care expenses and promote the use of Health Savings Accounts for those who can afford to save monies for future medical needs. Equally important is setting an expectation that individuals have health insurance. Enforcement would be difficult in a state without an income tax, but should be pursued. Setting an expectation that good employers provide coverage for their employers is also important so as not to unintentionally cause a weakening of our employer-based system. • I do not like this option and I can not support. A mandate is not the right first step approach. Although I understand the logic and applaud the group for their efforts in trying to address a tough area, imposing an individual mandate on South Dakotans in an attempt to help them "protect themselves" is not acceptable. This is not comparable to a like financial responsibility auto insurance mandate where an accident directly effects other peoples health and life. The recommendation lacks any realistic enforcement mechanism and puts all front line healthcare providers in the position of the "financial responsibility" cop. **This recommendation needs to be deleted.** • Not a good idea as I doubt we would get the desired level of compliance.
5. Establish a Basic Benefit Plan	• Yes - Minimum standards are necessary and establish a plan that everyone can understand. • This is key and will take significant effort to define – basic preventative care, disease management, drug coverage, etc

	all need to be worked out and defined as part of the basic plan. • First and foremost, it isn't just private industry that has a stake in what a basic benefit package looks like. By excluding consumers, you immediate put all the decision-making in the hands of the insurance industry, which in all honesty, is going to make actuarially decisions on what a basic plan is and is not. Basic health care must include a comprehensive set of preventive, acute, and primary care as well as prescription drug coverage. Any exclusion of these aspects would create a product that falls far short of consumer needs. In addition, there is no mention of an affordability standard in the development of a basic plan. Affordability is a key component of ensuring coverage and a threshold should be stated that no basic plan developed will exceed 10 percent of net household pay with the expectation that the cost would hopefully be less than that. • If the financial responsibility standard is eliminated, there will be no need for a basic plan as envisioned under this recommendation. • I would also add variation on the plans, i.e. more options. • Not necessary if 4 is deleted. • Should use 2008 legislation to establish basic concepts and objective of basic plan for implementation in 2009. • Can succeed only if the out of pocket costs for clients is limited. • The establishment of a basic benefit plan is not needed if there is not an Insurance Financial Responsibility Standard. • Part of #4. • 5-1 Primary preventive care must be an integral part of any basic plan. Should include designation and reinforcement of the use of a medical home approach; urge that Community Health Centers be represented in the planning process. • Yes • Support this recommendation. Is it possible for the language introducing strategy 5-1 indicate it is important that the design of the basic plan include the mandated benefits as they have been established to address important health needs? An action step should be added to determine how the basic benefit plan will be offered. • Good (2) • Such a plan will need to represent <u>meaningful</u> health coverage, including coverage for behavioral health services. Stripped down plans may be affordable, but are worthless to the insured if/when they are needed. I oppose if this is simply a ploy to avoid insurance mandates. • Such a plan should be comprehensive and affordable, without insurance and pharmaceutical companies' excessive profits and inefficiencies. Such a plan should be

	available to *all*, not just the currently uninsured. Insurance costs have gone through the roof for all citizens currently insured. For example, a professional colleague currently pays $650 per month for the same basic services she had four years ago at half that cost. Insurance companies are likely to continue to gouge the public until they are removed from providing basic services. Basic services should be a universal right funded by the federal government, similar to Social Security. All other industrial nations have seen the value in providing a basic plan. Many have additionally offered those who can afford to have the option for "bells and whistles" insurance coverage. The Swiss and British models provide variations that the US should follow. Currently, Swiss costs, which are the second highest in the world, are about one-half the per-capita cost of the US, and Great Britain is about one-third the per-capita cost of the US. • The problem with this is that when left to legislators, it's too tempting to want to include everything. However, setting several standard benefit plans for employers to choose from is a good idea. • See recommendation #4 (I do not like this option). I still see some merit for a basic benefit plans but not sure how to sell if financial responsibility goes away? • This would be good provided it's truly Basic Benefit, meaning only those thing s that would seek to prevent problems from arising.
6. Increase Enrollment of Eligible Persons in Existing Govt. Program	• Yes – worth the effort – break down barriers and make it easy and motivate with force if needed. • Needs more definition of what this really is – examples need to be cited as to how this would be done. • Excellent recommendation. The only concern is that there are dates and deadlines in all of the recommendations for individual and business action steps. However, there are no such dates or deadlines for any of the recommendations that entail state government action such as program expansions or the development of waiver programs in recommendations 6 - 17. Why is that? The burden and urgency of health care reform must be shouldered equally between consumers, businesses, insurance, and government as has always been the case in our state and around the country. • Definitely need to make the most of existing programs. • The cost of doing associated with this type of program might be prohibitive. Can the citizens of SD afford this type of program? • Agree – low income folks are not choosing to not have health coverage. • I support. • 6.1 Will this be addressed in the 2008 Legislative Session?

	Important consideration for uninsured under 200-300 poverty. • Yes (2) • Support this recommendation. There is an obvious need to access federal participation to supplement state reforms. • Yes. Especially low income families. • Excellent • No comment. • This makes sense from a provider standpoint. Socially, it is the right thing to do. Such efforts need to be waged in a manner which considers the burden on taxpayers. • Yes. Make everyone eligible for an existing state pool. Federal SCHIP should be expanded as it is currently proposed in the US Senate and House. Ultimately, expansion of SCHIP, Medicaid, Medicare, VA, IHS and health care of the uninsured should lead to a single payer federal system for basic benefits. • The same comments as above apply here. If you like government health care, call Medicare sometime and see how responsive their customer service department is at handling complaints! Government-run health programs are already strapped. People should be covered by private health insurance. If public subsidies are necessary, provide that directly to the insurance plan chosen by the individual. The issue here will be "who pays". Again, individual and employer contributions should be required – as this is what makes our current system superior to government-run programs in other countries. • Yes – do it. • This is good but it again only represents cost shifting not cost reduction.
7. Expand Medicaid/SCHIP for Children and Pregnant Women	• Yes – worth the investment. • Some refining of the % poverty level is ok but also if it is increased too much it will deceive the kids for whom insurance is currently purchased into CHIP program. • Excellent recommendation. See comments in 6. • Excellent means to extend coverage at a low cost. • A great idea that has been dormant for too long. Hopefully, the necessary money can be found to expand both programs. It is an easy fix to some major health insurance coverage issues. • I support. • 7.1 Will this be addressed in the 2008 Legislative Session? Important consideration for uninsured under 200% - 300% of poverty. • High priority. • Yes • Support this recommendation. In recommendation 7-2, include private health providers as additional or alternate

	sources of high risk pregnancy case management services to improve birth outcomes. • Yes, as long as it does take them out of employer-sponsored programs. • This is a "must" to even attempt at lowering the uninsured rate. • No comment. • This makes sense from a provider standpoint. Socially, it is the right thing to do. Such efforts need to be waged in a manner which considers the burden on taxpayers. • Only for pregnant women if it covers family planning with no anti-women's reproductive choice exclusions. • Medicaid reimbursement must be addressed for existing enrollees prior to expanding the program. There are significant access problems developing in SD because physicians and other providers cannot afford to expand the number of Medicaid patients they see without putting their clinics in financial jeopardy and, therefore, limiting care for their current Medicaid patients. Expanding Medicaid would only exacerbate this already significant problem. • Yes, if we can afford. From all I have learned this will save the state money. • This could probably be included as being "Basic Health Care". I would rather see the public funds be funneled through the Medical Home.
8. Extend Access to Private Health Insurance Using Medicaid-Funded Premium Subsidies for Low Income Parents and Childless Adults	• Yes – if they will participate if this help makes it possible to take part. • Excellent recommendation. See comments in 6. • This may be very viable idea if used in combination with the Uninsurable Risk Pool and the current SD Risk Pool. However, I believe the cost would be out of reach of what would be considered reasonable and because of the cost I would not support moving forward with this idea. • Consider expansive of medical to all medically needy program. Is expansive program actually cheaper, more effective or cost effective? • I support if funding can be found. • 8.1 Will this be addressed in the 2008 Legislative Session? Important consideration for uninsured under 200 – 300% of poverty. • Government premium subsidies for private insurance may create an illusion of building on the strengths of private health insurance. There is danger that private insurers will want to pay only Medicaid rates for this population to make their plans more affordable and cost-shift onto providers. • Will this really save money vs. just covering these people under Medicaid? Private ins. coverage will allow providers to charge FFS rates instead of low Medicaid rates. • Absolutely.

	• Recommendation 8-1 should specifically mention using private insurance as the coverage vehicle. Insurance premiums in this income level (201% to 250%) can be split between the public program and the individual family on a sliding fee scale. Families in this income range have the ability for some level of premium contribution. Strategy 8-2 and 8-3 need to say what ESI stands for and reference income based premium subsidy. • Not for childless adults. • No comment. • This makes sense from a provider standpoint. Socially, it is the right thing to do. Such efforts need to be waged in a manner which considers the burden on taxpayers. • No. Tax dollars should not go to the already bloated private health insurance industry. Federal funds should be allocated only to a State or Regional sponsored single-payer system. • See comments above. (Medicaid reimbursement must be) • I like the trend of utilizing the private insurance market and asking eligibles to participate financially. Definitely on the right track. • I would prefer to address this care as a service provided by the concept of a "Medical Home."
9. Leverage Existing Funds and Public-Private Partnerships to Support Health Care for the Uninsured	• Yes – use incentives not force to motivate first then set minimum level of coverage. • What existing funds? Would like to see details of what this would look like – is this reality or simply sounds good? • Excellent recommendation. See comments in 6. • Again, this idea has a range of possibilities but the limiting factor will be costs. However, if federal dollar can be leveraged in a partnership with private health care providers it seems as if it might create a win-win situation. • Guarantee access to all regardless of income by 2010 rewrite state law. Remove county responsibility for indigent health care (except AB & funding partner). • Not sure I understand this one. • 9.2 Who or what State Agency will be taking the lead on this initiative? How will non HIS providers close to and on the reservations be included? Important consideration for uninsured under 200% to 300%of poverty. • The recommendation uses language that is code for "provide tax". Language needs to be included that makes it explicitly clear the report does not recommend pursuit of a provider tax or similar funding scheme, as has been assured by the Administration. • Yes – good opportunity to bring all players to the table. • Absolutely. • Support this recommendation. This recommendation accesses federal financial participation and can expand the

	number of counties and scope of covered services available. Should the 3rd bullet under Strategy 9-2 reference "Indian" health care services rather than "indigent" health care? • As long as it wasn't mandate, I support. • Good • Accessing additional federal funds and maximizing federal match should be explored. The use of public-private partnerships to leverage resources is a "win-win". • Yes, but see #8 above. Federal funds should be used to provide the public support to the partnerships and should not be a supplement to private insurance. • See comments above. (Medicaid reimbursement must be) • Yes • We spend too much time talking about the uninsured. We should recognize that self insuring is a legitimate option. Our health care system should be able to provide the level of health care the patient feels they can afford.
10. Use Health Information Technology to Promote Quality & Efficiency	• Yes – force institutions to work together to have systems that work together. • This is currently moving so fast that any organized gov't effort will be behind and stay behind. The private sector's very survival depends on this and I think ???? to lead the way. • Excellent recommendation. See comments in 6. • Great idea and relatively easy to begin a grass roots level effort with health care providers, insurance companies and the proper governmental agencies. • I support. • Consider developing incentive start-up programs to help rural and safety net health care provider organizations fund the deployment of HIT. • Yes – encourage further expansion and sharing of key information. • Of course. • Support this recommendation. Strategy 10-1 mentions a long range plan, but should also include a specific due date (such as 10-1-2-1-) to facilitate executive or legislative action if necessary. Strategy 10-2 should also have a specific due date to facilitate implementation of the recommendation. • Absolutely essential in the long term. But it is very expensive. • Long-term capital investment and private funding (cost/benefit) necessary. • Good • Generally support. Proper use of E-records can greatly enhance continuity/quality/safety of care. One caution: Keeping pace with changing technology can also add to costs.

	• Depends on who has access to personal information. It should be only in the public sector. There should be safeguards to prevent private sector manipulation of the information to reduce benefits and increase costs. • E-prescribing and electronic records are being developed currently. Simplified billing must be addressed as currently providers bill separately and to the patient directly. Consideration should be given to billing through third party payers. • Of course, makes sense. • This should definitely beginning to move and offers great opportunities for greater efficiency as more and more providers gain experience in the selection and use of the software.
11. Encourage Informed Consumer Choice	• Yes – take choices from employer and make give to consumers – they will have to learn. • Programs that steer people to personal responsibility should be highlighted. A formal health consumer education initiative is something that the state not insurance cost and med. & Hosp. associations should develop – it benefits all concerned and should be a high priority. • Excellent recommendation. See comments in 6. • Good idea and relatively easy to do. • I support. • 11.2 Consider the health disparities chronic care management model developed by the Institute of Health Improvement (IHI) and supported by the Health Resources Services Administration (HRSA) in Community Health Centers as one of the patient oriented practice guidelines. This model is currently used throughout community health centers nationwide. • What is meant by establishing a "neutral, credible" source for consumer access to comparative data? Could the source include one or more provider associations? • Yes (3) • Of course. • Support this recommendation. Is it possible to mention that the development of transparency resources in Strategy 11-1 be a collaborative effort by the provider community and the state? • Long-term capital investment and private funding (cost/benefit) necessary. • Good • I support increasing consumer involvement and empowering consumers to take the responsibility for their own health care. However, promoting price-based shopping of medical services has its limits. Who really wants the cheapest medical care available? When in medical crisis (and related care costs are greatest) no one is a "good consumer".

	• Definitely. However, every effort should be made to simplify and summarize options available. It's very complex for the average consumer, especially the elderly, to be able to wade through the various plans and benefits, as they are currently presented during open season in the federal and Medicare programs. • Consumer choice is limited due to the fact that employers pay the bill and there are too few providers in many areas of the state. What would be useful is if employers would offer variable coverage's and educate employees on selecting only the coverage they need – and saving for future medical costs. And, consumers should be educated about not asking for brand-name drugs, how to treat conditions with the lowest level of technology, etc. in terms of saving costs. • There should be a ???? between what the patient chooses for care and what the patient can afford.
12. Improve and Expand Chronic Disease Management	• Yes – Don't give people a choice or big incentive to participate. • These can all be done in the context of health consumer education and would be much more effective if part of an overall plan – again strategic partnerization with gov't/ insurance/ and professional organatzions is key. • Excellent recommendation. See comments in 6. • Strategy 12 -1: does this assume a "Mandate" for third party pymt of "coaching" services? • Explore opportunities utilizing the 70+ yearly Doctor of Pharmacy graduates from SDSU College of Pharmacy to Collaborate with physicians to assist in disease state management. Successful examples currently exist in Pierre & other communities. These pharmacists are not currently considered "providers" by Medicare, therefore cannot currently be reimbursed for such services. • Great idea. A number of SD companies currently have programs similar to the one outlined in this strategy. It has helped employees take additional ownership for their own health issues and it has provided invaluable information to help the companies manage their employee health plans. • I support. • 12.1 Consider the health disparities chronic care patient management model developed by the IHI and utilized by Community Health Centers as one of the pilot projects. 12.2 It is important to include the local primary care providers in local school/community programs. (partnership with Sioux Falls CHC and Sioux Falls School District. 12.3 Consider the health disparities chronic care management model developed by the IHI as one of the practice guidelines. This model is currently used throughout community health centers nationwide. • Yes

	• A minority of patients with serious illness, some of it preventable through lifestyle change, are responsible for a large portion of health care cost. Consider mandatory participation in counseling programs to change behavior and/or incentives for improved health for those participating in subsidized programs. • Of course. • Support this recommendation. Strategy 12-1 needs to be expanded to recognize that hospital based disease management program exist and should be used as an additional resource. • Disease management and wellness programs are very effective especially for children. • Good • I like the approach as described. The use of personal "coaches" to conserve health is infinitely preferable to merely managing utilization of services…which is how many plans now mange chronic diseases. • This is what every primary care physician should strive to do. Strong health management is the key to chronic disease, as well as all other conditions. • Existing programs should continue to be supported and allowed to demonstrate results. • This is an untapped opportunity. Hard to sell and implement and even harder to measure but we need to move forward. • This s another opportunity that could be provided by the "Medical Home."
13. Promote Lifelong Wellness	• Yes – Include schools and other public ????. • Excellent recommendation. See comments in 6. • 13 – 3 Strategy - - could be integrated with strategy 2-1. • Nice, but not essential. • Great idea. • I support. • 13.3 Explore "Best Practices" by employers. Include primary care medical home providers (i.e. community health centers) in the planning. • Yes (2) • Of course. • Support this recommendation. • Does not address health insurance (except in risk pool). • Good • This should be a top priority. Strategies should include promotion of mental/emotional wellness as well as physical wellness. • Definitely. The various wellness programs already implemented are proving themselves well worth the investment. As regards nutrition, we may well want to promote the eating of SD buffalo meat, organic and natural

	foods, which would benefit those SD agricultural producers. • SD has many successful efforts underway to promote wellness that should continue to be pursued and supported. • Long term planning – yes I like it. • This is a companion to improved medical literacy and could also be directed through the Medical Home philosophy similar to #12 above (This is another opportunity).
14. Support Access to Primary and Preventive Care	• Yes – establish limits and incentives to increase this usage. • Excellent recommendation. See comments in 6. • The State of SD needs to follow through on this idea. • I support. • 14.1 Explore additional new and innovation methods to incentivize South Dakota educational institutions to counsel and support students into appropriate fields as needed in the state (ex; medical students choosing primary care). 14.2 Explore strategies to increase access to c comprehensive primary care medical homes in all parts of the state, especially sparsely populated and for special populations. This comprehensive approach should include an effective a behavioral health component. 14.2B Form a stakeholders group of comprehensive primary care medical home providers to identify/develop essential criteria of a medical home for an incubator/replication program. • Yes • Crucial. • Support this recommendation. Suggest including “paraprofessionals” to the list of health care careers in the introductory language of Recommendation 14 • Disease management and wellness programs are very effective especially for children. • Good • Increasing access to this level of care optimizes healthfulness and saves money in the long haul. Disease prevention and health maintenance should also be assured in the areas of mental health and freedom from chemical addictions. • Definitely. Management of access to primary and preventive care is the key. The Canadians have had great success with rural health centers that use a triage approach to providing *all* primary and preventive care by having strong intake managers assigning patients to the appropriate level of care and prioritizing based on severity of the illness/injury. • SD should lead the nation in developing the “medical home” concept. The task force should consider recommending a demonstration program and funding assistance to pursue the design and implementation of this concept in various health care settings to use the primary

	care physician as "care manager". • This area is the sleeper. In the end we may find we have did more to preserve and create new access in SD than reducing the number of uninsured. This area is the silent champion of this process. • This is the area of access to Basic Health care similar to care offered by University to their students thought Student Health Service Clinic.
15. Promote Federal Policies to Improve the Health Status of American Indians	• Yes – Good luck. • This is an enormous problem and could be addressed initially be determining how the IHS clinic, hosp & docs could be brought into the overall health care system. Currently IHS is isolated, inefficient, and inadequate. An opportunity exists to strategically partners with the feds, state gov't/ insurances/ practicing docs & physicians in training. Will need to break down the barriers between IHS hosp/clinic/staff & the rest of the health care system. • Excellent recommendation. See comments in 6. • Good idea for SD's Native American population. • I support. • Yes • Sadly, yes. • Support this recommendation. South Dakota will continue to struggle with an uninsured population, access to care challenges, and poor health outcomes unless the needs of the state's Indian population are recognized and met by the federal government. • Let's stick with things we can do in South Dakota. • Good • Formation of tribal/state partnerships to leverage more favorable federal policies should be encouraged. Whether this combined effort could actually evolve the political impetus to influence positive change is questionable. Nonetheless, such a recommendation must be part of a conscionable plan of action for our state. • Definitely. (See #17 below. Support necessary funding) • We must engage ourselves as a state to help SD's American Indians.
16. Maximize Existing Resources for Access to Health Care for American Indians	• Yes (4) • Excellent recommendation. See comments in 6. • We as South Dakota citizens should be collaborating with tribal leaders and doing all we can to promote better health service accessibility on and off the reservations for the Native Americans. • I support. • Urge approaches that include local support and involvement from the tribal government. • Support this recommendation. It is incumbent on the state to do what it can within existing program structures, at the

	same time as the state presses federal government action. • Good • As this is a subset to recommendation #6, my comments are generally the same. Strongly support addressing critical gaps in primary/preventive health care. • Definitely. (See #17 below. Support necessary funding)
17. Seek Creative Solutions to Improve American Indian Health Care Outcomes	• Yes – great start – Don't drop let his discussion stop. • Excellent recommendation. See comments in 6. • This may require a different task force. • Good idea. • I support. • Urge approaches that include local support and involvement from the local tribal governments. • Yes (3) • Support this goal. Is it possible to include an action step to widely publicize these health disparities to promote national awareness and empathy in support of Recommendations 15, 16, and 17? • The Indian community needs to develop these solutions and present them to the state. They need to provide the impetus. • Good • I support the establishment of meaningful partnerships that proactively work to address health disparities in the American Indian population. In the past, such efforts have either never gotten out of the "discussion stage" or fizzled out before progress could be made. This would require (and deserves) long-term commitment. • Support necessary funding of IHS at a level to provide comprehensive care. Because of a long history of distrust between the State and the Tribes, it is critically important that the State work very closely with all of South Dakota's nine tribes in developing any of these solutions.
Additional Comments:	• Note: Propose change on page 21 instead of affordable quality insurance – change 1st sentence of 1st paragraph to say access……to affordable, quality health care. • The last paragraph on page 20 of the report regarding potential funding sources, should include the following language at the end. "Broad-based and innovative funding approaches can improve the acceptability of the report recommendations and improve the likelihood of successful implementation. Relying on funding mechanisms which are currently in place has the potential to and to the financial challenges faced by employers, insurers and providers and reduce the effectiveness of the recommendations." • Through-out the document a time frame should be added to each of the actions steps which do not have a time frame specified in the draft.