



Testimony on

**“Helping Families with Needed Care:
Medicaid’s Critical Role for Americans with Disabilities”**

by

**Aileen McCormick
CEO, Southwest Region, AMERIGROUP Corporation
Representing America’s Health Insurance Plans**

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I. Introduction

Mr. Chairman, Congressman Deal, and members of the subcommittee, I am Aileen McCormick, CEO of the Southwest Region of AMERIGROUP Corporation. My company provides health care coverage to 1.7 million people in 10 states and the District of Columbia, all of whom are enrolled in Medicaid and other publicly funded programs. We have been working for nine years to help Medicaid better serve people with disabilities through a nationally-recognized program in Texas called STAR+PLUS.

I am testifying today on behalf of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. AHIP's members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on the role Medicaid plays in meeting the health care needs of Americans with disabilities and, additionally, the innovative insurance products AHIP's members offer as financial protection for consumers against the high costs associated with long-term care and disability. We strongly support Medicaid's role as a health care safety net and we also are committed to ensuring that consumers have private sector options for meeting their future needs.

Our testimony today will focus on the leadership AHIP's members have demonstrated in three important areas: (1) providing high-quality health coverage to beneficiaries in state Medicaid programs; (2) offering long-term care insurance to provide Americans with financial protection against the risk of needing long-term care services; and (3) offering disability income insurance to help consumers replace lost income in the event that a disabling condition forces them to leave the workforce.

II. Health Plan Participation in Medicaid

Health insurance plans are making important contributions toward helping state Medicaid programs use their limited resources to expand access, improve quality, and better serve the health care needs of beneficiaries. In 2006, 19.8 million Medicaid beneficiaries – accounting for 43 percent of the Medicaid population – were enrolled in health plans providing comprehensive coverage. Nationwide, 314 health plans participate in state Medicaid programs.

Improved Care for Beneficiaries

Medicaid health plans have developed systems of coordinated care for ensuring that Medicaid beneficiaries receive health care services on a timely basis, while also emphasizing prevention and providing access to disease management services for those with chronic conditions. In general, each Medicaid beneficiary is encouraged to establish a relationship with a primary care physician who helps make arrangements for specialty visits, hospital care, home health care, or other care he or she may need. The primary care physician ensures that each patient receives the best available care in the most appropriate setting, and oversees all of a patient's treatments and medications.

Coordinated care systems provide for the seamless delivery of health care services across the continuum of care. In other words, physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, improve health status, and employ best practices to swiftly treat medical conditions that occur.

This approach is far superior to a system of uncoordinated care in which patients are forced to navigate a fragmented health care system on their own. Coordinated care provides the opportunity to reduce emergency room visits for routine care, and ensure prompt access to primary care physicians and specialists when care is needed. It also promotes communication between treating physicians about various treatments and medications a patient receives.

Innovative Programs

In a number of states, AHIP's members have partnered with Medicaid to create innovative programs for persons with disabilities and chronic conditions. These programs typically focus on decreasing the need for nursing home care, reducing hospitalizations, and increasing the number of elderly and persons with disabilities who can be better served in home and community settings. For beneficiaries, this means improved health outcomes and the opportunity to receive care in a familiar setting of their own choice.

The Texas STAR+PLUS program, for example, helps people live better, healthier lives and saves money at the same time. It does this by tailoring the health care system to fit the needs of individuals, instead of forcing individuals into institutions that do not offer the right care for them. This nationally recognized program currently serves 153,000 Medicaid beneficiaries.

From a budgetary standpoint, the Texas STAR+PLUS program reduced costs by 6.5 percent relative to FFS Medicaid¹. The program also reduced emergency room use by 40 percent and inpatient admissions by 28 percent². In addition, utilization of hospital services was reduced for beneficiaries with ambulatory care sensitive conditions (ACSC) – such as asthma, diabetes, and hypertension – that can be treated more effectively in an outpatient setting. Beneficiaries served by the Texas program include those who are dually eligible for both Medicare and Medicaid and beneficiaries eligible for Supplemental Security Income (SSI) benefits.

Another initiative, the Minnesota Senior Health Options program, combines health care and support services into a seamless package. According to the Centers for Medicare & Medicaid Services (CMS), dually eligible beneficiaries served by this program had fewer preventable emergency room visits and were more likely to receive preventive services after enrolling in a Medicaid health plan. The success of the Minnesota program is further evidenced by the fact that Medicaid enrollees reported a 94 percent satisfaction rate with their care coordinators.

¹ Presentation by the Texas Health and Human Services Commission to the House Select Committee on Health Care Expenditures, February 2003

² Texas Health and Human Services Commission, Financial Impact of Proposed Managed Care Expansion in Texas, February 2005

We encourage Congress to support the expansion of these types of innovative programs. We thank several subcommittee members who have cosponsored legislation, H.R. 1621, the Community Choice Act, that recognizes the important role of personal care services in enabling individuals with disabilities who require an institutional level of care to receive services under state Medicaid programs in a home or community setting.

Value Demonstrated by Research Findings

Numerous research findings demonstrate that Medicaid health plans – by coordinating care, by emphasizing prevention, by offering disease management services to the chronically ill, and by developing innovative programs – are improving health care for many of our nation’s most vulnerable citizens. For example:

- One study found that 77.5 percent of Medicaid health plans in northeastern states offered a registered dietician or certified nutritionist for obesity consultations, compared to 57.1 percent under Medicaid fee-for-service (FFS) programs. This study also showed that Medicaid health plans were almost four times more likely than FFS to offer obese patients other services such as discounted or free access to exercise facilities or weight loss centers³.
- Hospitalizations for people with chronic conditions such as asthma, diabetes, and hypertension often can be reduced with timely and effective treatment in an outpatient setting. Over a six-year period, the average number of hospitalizations for beneficiaries with these chronic conditions was one-third lower for California Medicaid health plan enrollees than for those in FFS Medicaid⁴.
- New York Medicaid health plan enrollees are much more likely to receive many critical preventive services than beneficiaries enrolled in FFS Medicaid. For example, 71 percent of

³ Tsai, et al, Availability of Nutrition Services for Medicaid Recipients in the Northeastern United States: Lack of Uniformity and the Positive Effect of Managed Care (Am J Managed Care 2003;9:817-821).

⁴ Bindman, et al, The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions (Health Serv Res. 2005 February; 40(1): 19-38).

women enrolled in Medicaid health plans were screened for cervical cancer within a three-year period, compared to 39 percent in FFS Medicaid⁵.

- One commonly used indicator to measure the effectiveness of the health care system in delivering prenatal care is the incidence of low-weight birth rates. During 2004 and 2005, women who received care from Medicaid health plans in Washington experienced lower rates of low-weight births than women who received their services through FFS Medicaid⁶.

Cost Savings for Medicaid

In addition to improving quality of care, Medicaid health plans help to ensure that the federal government and the states receive maximum value for the dollars they spend on Medicaid. Plans are advancing this goal through a variety of strategies, including encouraging preventive health care, managing prescription drug benefits, and providing disease management services that improve quality of life in a cost-effective manner. Several research studies have concluded that these strategies are generating savings for Medicaid:

- A 2004 synthesis of fourteen studies commissioned by AHIP found that savings of up to 19 percent are possible by effectively implementing Medicaid managed care programs. This study also found that these savings were achieved at the same time that Medicaid health plans demonstrated access and quality improvements.⁷
- A Lewin report found that the HealthChoices program in Pennsylvania saved the state more than \$2.7 billion over a five-year period. This report also found that Medicaid health plans have significantly enhanced access and quality for beneficiaries, including those with special needs.⁸

⁵ Roohan, et al, Quality Measurement in Medicaid Managed Care and Fee-for-Service. (American Journal of Medical Quality, 2006; 21:185-191).

⁶ Washington State Department of Social and Health Services, First Steps: Data Base Reports, 2004 and 2005.

⁷ AHIP Report: Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies, The Lewin Group, June 2004

⁸ Comparative Evaluation of Pennsylvania's Health Choices Program and Fee-for-Service Program, The Lewin Group, May 2005

- The U.S. Department of Health and Human Services (HHS) estimated that the New York Medicaid managed care program created savings of nearly \$6 billion over an eight-year period while expanding care to more than 400,000 people.⁹

AHIP/ADAPT Initiative

Recognizing that additional steps can be taken to meet the unique needs and circumstances of Medicaid beneficiaries with disabilities, AHIP has collaborated with ADAPT, a national disability rights organization, to develop principles for serving individuals with disabilities through Medicaid health plans. These principles address the following priorities:

- Training should be designed and conducted to ensure that community integration principles are advanced by the integration and delivery of acute and community long-term services.
- An ongoing dialogue with stakeholders, including individuals with disabilities, should be maintained in the development of Medicaid health plan contract requirements and in the design of Medicaid managed care programs.
- State Medicaid programs should include requirements and adequate funding to ensure that: (1) Medicaid health plans provide beneficiaries with the option for services to be delivered in the most integrated setting; and (2) services are based on a functional assessment outlined in a person-centered plan.
- An aggressive outreach and education strategy should be implemented to ensure that individuals with disabilities have the information they need to be knowledgeable about the programs and services available to them.
- Medicaid managed care programs that serve individuals with disabilities should offer home and community-based services as an option for beneficiaries regardless of their age or the extent of their disability.

⁹ HHS Secretary Leavitt and New York Governor Pataki Announce Important Step Toward Medicaid Reform, U.S. Department of Health and Human Services Press Release, March 16, 2005.

- Beneficiaries should have the option of developing, negotiating, and implementing plans to accept risk for and take control of their activities of daily living, instrumental activities of daily living, and health maintenance activities.
- Funding should be provided for Medicaid coverage that allows individuals access to appropriate medically or functionally necessary durable medical equipment (DME) and assistive technology that would enhance independent functioning and promote independent living.

Looking forward, these principles will serve as a foundation for our ongoing collaboration as health plans work with states and individuals with disabilities to address their interests and concerns.

III. Long-Term Care Insurance

Approximately 7 million Americans have purchased private long-term care insurance and are benefiting from the peace of mind and higher quality of life this coverage provides. This includes some 5 million policies purchased in the individual market and up to 2 million in the group market.

Value for Consumers and Taxpayers

Long-term care insurance offers significant value to policyholders, family caregivers, and taxpayers.

According to an AHIP study, consumers with long-term care insurance are 66 percent less likely to become impoverished to pay the costs of long-term care. For elderly people with disabilities, long-term care insurance reduces out-of-pocket expenses by an average of \$60,000 to \$75,000. Our study also found that those with private long-term care insurance receive an average of 14 more hours of personal care per week than those who have similar needs but lack private insurance. Another benefit of long-term care insurance is that it allows persons with chronic

illnesses and disabilities to remain in their homes. Approximately half of patients and family caregivers interviewed by trained nurses and social workers said that in the absence of their long-term care insurance benefits, the patients would not be able to remain in their homes and would have to seek institutional alternatives¹⁰. Another AHIP survey, conducted in 2007, found that 97 percent of claims are approved by long-term care insurers¹¹.

Long-term care insurance also can reduce state and federal Medicaid expenditures and federal Medicare home health expenditures. According to the AHIP study¹⁰ mentioned above, Medicaid savings are projected to total about \$5,000 for each policyholder with long-term care insurance and Medicare savings are estimated to exceed \$1,600 per policyholder. Aggregate savings to Medicare and Medicaid are estimated at about \$30 billion. These savings will grow as more people acquire policies and the average age of purchasers continues to decline.

Long-term care insurance policies contain a wide range of benefit options at moderately priced premiums. For example:

- Long-term care insurance plans offer coverage of nursing home, assisted living facility, home health care, and hospice care. On a case-by-case basis, plans also provide certain alternate care services not listed in the policy (e.g., covering a stay in a special Alzheimer's facility or building a wheelchair ramp to allow the individual to remain in his or her home), subject to the policy's benefit limits.
- Other common benefits include care coordination or case management services, support with activities of daily living, medical equipment coverage, home-delivered meals, spousal discounts, and survivorship benefits. Plans also commonly cover caregiver training to ensure that caregivers learn basic techniques for safely caring for patients in their homes (e.g., transferring patients from their bed to a chair). In addition, virtually all plans cover respite care, designed to pay for brief periods of formal care to provide relief to caregivers.

¹⁰ AHIP, *Benefits of Long-Term Care Insurance: Enhanced Care for Disabled Elders, Improved Quality of Life for Caregivers and Savings to Medicare & Medicaid*, September 2002

¹¹ AHIP, *Long-Term Care Insurance Claims and Rescissions*, July 2007

The value of this coverage is particularly clear when costs are examined on an individual level. Genworth Financial, an AHIP member, has commissioned annual cost of care studies since 2001. The most recent study¹², based on information gathered in January and February 2007, includes the following findings:

- The average annual cost for a private nursing home room (single occupant) is \$74,806 (a daily rate of \$204.95).
- The average annual cost for a semi-private room (double occupancy) is \$65,985 (a daily rate of \$180.78).
- The average annual cost for a private one-bedroom unit in an assisted living facility is \$32,572 (a daily rate of \$89.24).
- The average hourly rate for certified home health aides is \$32.37, while the average hourly rate for homemaker services is \$17.46.

Many families do not have the resources to meet these high costs. However, for millions of Americans who purchase private long-term care insurance, these costs can be covered without depleting the patients' assets while providing them peace of mind in knowing that their families will not be burdened by unbearable financial obligations.

Who Buys Long-Term Care Insurance

AHIP recently commissioned a study¹³, conducted by LifePlans, Inc., to identify who buys long-term care insurance in the individual market and understand what motivates them to do so. Ten insurance companies participated in this study, representing more than 80 percent of total sales of long-term care insurance policies in 2005. This study builds upon similar work completed in 1990, 1995, and 2000.

¹² Genworth Financial, 2007 Cost of Care Survey, March 2007

¹³ LifePlans, Inc., Who Buys Long-Term Care Insurance? April 2007

The study's key findings include the following:

- The average age of individual purchasers of long-term care insurance declined from 67 years to 61 years between 2000 and 2005. Two-thirds of all individual long-term care policies sold are now purchased by people younger than 65. The major demographic differences between buyers and nonbuyers are that the latter tend to be somewhat older, less likely to be employed, and have lower incomes than buyers of long-term care insurance. In 2005, 71 percent of buyers had incomes exceeding \$50,000, 13 percent had incomes between \$35,000 and \$50,000, and another 13 percent had incomes between \$20,000 and \$35,000.
- Buyers are twice as likely as nonbuyers to strongly agree that “it is important to plan now for the possibility of needing long-term care services.” On another key statement, nonbuyers are twice as likely as buyers to agree that “the government will pay for most of the costs of long-term care if services are ever needed.” Nonbuyers also were much more likely than buyers – 70 percent versus 14 percent – to underestimate the cost of nursing homes in their area.
- In examining the coverage offered by long-term care insurance policies, the study found a trend toward the purchase of comprehensive coverage. In 2005, 90 percent of policies sold were comprehensive (i.e., covering both institutional care and home care) – compared to 77 percent in 2000 and 37 percent in 1990. In addition, more than three-quarters of buyers chose some form of inflation protection in 2005, up from 41 percent in 2000.
- A highly significant finding from the 2005 study is that more than 80 percent of current nonbuyers would be more interested in buying a policy if they could deduct premiums from their taxes.

LTC Partnerships

AHIP strongly supports the expansion of public-private long-term care partnerships that Congress enacted under the Deficit Reduction Act of 2005 (DRA). The partnerships authorized by the DRA are allowing many Americans to receive the financial protection provided by long-

term care insurance while also ensuring that Medicaid will play a role in meeting the needs of those who require extended long-term care stays.

Building upon the innovative partnerships that originally were implemented in New York, California, Connecticut, and Indiana, the DRA creates powerful new incentives for more Americans all across the nation to prepare for the future by purchasing private long-term care insurance that coordinates with Medicaid. Specifically, in states adopting the partnership approach, individuals can purchase private long-term care insurance policies with the assurance that Medicaid will cover long-term care costs incurred beyond the terms of their private coverage. In these states, under the terms of the partnership, people with private insurance are not required to “spend down” their remaining assets to qualify for Medicaid.

At the end of 2007, nine states (Idaho, North Dakota, South Dakota, Minnesota, Nebraska, Ohio, Florida, Kansas and Virginia) had established operational partnership programs. All of these states modeled their partnership implementation rules after the *AHIP Qualified LTCI Partnership Proposed Implementation Guidelines*. Rollouts of additional partnership programs are expected in other states throughout 2008.

AHIP has been working closely with the states to assist in implementation of the partnership programs. We also worked with CMS to develop a uniform data set for state reporting on long-term care partnership programs and standards for reciprocity. Additionally, AHIP collaborated with the Robert Wood Johnson Foundation on a project that provided grants to the states to help with their implementation of partnerships.

In January 2007, AHIP released a study¹⁴ projecting that the expanded long-term care partnerships could lead to federal budget savings of \$6 billion annually (using constant 2005 dollars) in the Medicaid program by 2050. This is equivalent to \$60 billion in federal savings over ten years in today’s terms – and \$100 billion if state budget savings are included.

¹⁴ AHIP, Long-Term Care Insurance Partnerships: New Choices for Consumers – Potential Savings for Federal and State Government, January 2007

This study is based on assumptions that translate into the enrollment of approximately 35 million people in long-term care insurance by 2050 – compared to a baseline of fewer than 20 million that would be enrolled without the expansion of partnership programs. This increased sales of long-term care insurance is projected to reduce Medicaid costs because private long-term care insurance will be covering much of the care that otherwise would be paid by Medicaid.

Outreach and Education

In November 2007, AHIP released new survey findings showing that many Baby Boomers have misconceptions about who pays for long-term care services and have not thought about long-term care insurance. The survey, conducted for AHIP by StrategyOne, includes the following findings:

- Most Baby Boomers have not focused on planning for long-term care expenses. The survey data show that even among Baby Boomers nearing or at the age of 60, only one in four say they are “very familiar” with long-term care insurance. In addition, 41 percent say they have not had any discussions about long-term care in the past twelve months.
- Many Baby Boomers erroneously believe they have coverage for long-term care expenses. The survey found that 30 percent of Baby Boomers think they have long-term care coverage. However, even if all current long-term care insurance policyholders were Baby Boomers – which they are not – that would only account for less than 10 percent of the Baby Boomer population, suggesting that many Baby Boomers have misconceptions about their coverage.
- Fifty-four percent of Baby Boomers think Medicare will pay for long-term care services, and 44 percent believe “other health insurance” will pay. These findings show that many people are unaware that Medicare does not cover long-term care indefinitely and that Medicaid will cover these services only after requiring individuals to spend down nearly all of their assets to qualify for assistance.

Recognizing the challenges raised by these survey findings, AHIP and our members are strongly committed to educating consumers about the importance of long-term care coverage. In addition

to developing a consumer's guide to long-term care insurance, we work on an ongoing basis to highlight our survey and research findings in our communications with the media, policymakers, and others.

AHIP also is an enthusiastic supporter of the "Own Your Future" Long-Term Care Awareness Campaign, which is working to increase awareness among the American public about the importance of planning for future long-term care needs. As of March 2007, 15 states have participated in this joint federal-state campaign through mailings to households with family members between the ages of 45 to 70. Other elements of this awareness campaign include the development of state-based information, such as long-term care websites, and dissemination of other resources.

IV. Disability Income Insurance

Private disability income insurance provides tens of millions of Americans with protection that complements the safety net provided by the Social Security Disability Insurance (SSDI) program.

Approximately 38 million U.S. workers are covered by employer-sponsored group long-term disability coverage¹⁵. Some three million American workers have individual disability income coverage. In addition to extending benefits to many persons who are not eligible for SSDI, this coverage provides a level of benefits that spares many Americans from financial hardship.

Value for Consumers

In 2006, more than 650,000 individuals received long-term disability payments from private insurers totaling more than \$9 billion. One-third of these individuals did not qualify for SSDI. Moreover, 95 percent of reported disabilities were not work-related and therefore not eligible for coverage under workers compensation¹⁶.

¹⁵ JHA, 2006 U.S. Group Disability Market Survey

¹⁶ 2006 Council for Disability Awareness Claims Review

Private disability insurers resolve claims within 30 days or less for approximately 75-80 percent of claimants, thus ensuring that benefits can be paid promptly to replace an eligible claimant's lost wages. Our members' track record exceeds the requirements set by federal regulations, which establish a 45-day timeframe for the initial resolution of private disability claims and allow an extension – of up to a total of 105 days – if, for reasons beyond the control of the insurer, more time is required to gather information.

In addition to replacing lost income for claimants in a timely fashion, private disability insurers play a key role in restoring disabled workers to financial self-sufficiency and maintaining productivity for America's businesses. By investing in rehabilitation and return-to-work programs, private disability insurers are actively engaged in helping workers with disabilities return to the workforce. In fact, a survey by Milliman, Inc. found that private disability insurers spent an average of \$3,200 in 2005 on each disabled employee receiving rehabilitation and return-to-work services¹⁷.

These innovative programs include a wide range of strategies in recognition of the fact that persons with disabilities are highly diverse and face varying circumstances. Services offered by rehabilitation and return-to-work programs include medical case management, vocational and employment assessment, worksite modification, purchase of adaptive equipment, business and financial planning, retraining for a new occupation, and education expenses. The Milliman survey found that annual budgets for these programs, which vary by company, range from \$450,000 to more than \$10 million.

Additionally, private disability insurers have been very proactive in designing policies that help claimants return to work. As a result, persons receiving private disability payments often have access to work incentive benefits, rehabilitation benefits, workplace accommodation benefits, and child or dependent care benefits during rehabilitation. These innovative benefits reflect our members' strong commitment to promoting employment and self-sufficiency among persons with disabilities.

¹⁷ Survey of Rehabilitation and Return-to-Work Practices Among U.S. Disability Carriers, Milliman, Inc., May 2007

National Education Campaign

AHIP has launched a national education campaign to promote awareness about the importance of disability income protection and to highlight the value disability insurance provides for workers, employers, and taxpayers.

Recognizing that more than 100 million Americans lack private disability income protection, our campaign has created a website – www.yourincomeatrisk.org – focused on educating consumers about a wide range of disability-related issues. The need for such education is highlighted by survey findings showing that many American workers have misunderstandings about their likelihood of experiencing a disability and the resources that would be available if they become disabled.

In 2004, AHIP released a survey by Ayres, McHenry and Associates which found that 58 percent of working adults believe they are covered by disability insurance, even though only one-third of workers nationwide are covered. The survey also found that workers overestimate the proportion of disabilities that are covered by workers' compensation insurance. Although only 10 percent of disabilities are covered by workers' compensation insurance, 59 percent of those surveyed believe that the proportion is higher. Additionally, 47 percent of respondents to the AHIP survey said they were not concerned about a potential disability or illness that could keep them out of work for an extended period of time. However, data compiled by AHIP and the Society of Actuaries show that one in three workers over the age of thirty will become disabled for at least three months at some point during their careers.

Over the coming year, AHIP will be taking additional steps to continue our national education campaign. These steps include a retooling of our "Your Income At Risk" website, an updated consumer guide on disability income insurance, a new publication for policymakers and the media, a survey of key disability claims information, and additional research on key disability issues.

Partnering With the SSA

Finally, our members also are demonstrating leadership, on behalf of persons with disabilities, by engaging the Social Security Administration (SSA) in a dialogue about advancing a public-private partnership to employ the tools and techniques of private disability insurers in improving the administration of the SSDI program.

There is a great deal of common ground joining the SSDI program and the private disability insurance industry. Both face the same daunting demographic and morbidity trends and both must deal with a highly complex claims adjudication process addressing both functionality and medical factors. Additionally, both public and private disability income programs must carefully strike a balance between the entitlement of individuals and the overall costs of providing disability income security.

We believe this common ground makes private disability insurers and the SSA natural partners and, additionally, that there may be core competencies and tools that private disability insurers can bring to bear to help the SSA further improve the efficiency and effectiveness of the SSDI program. Accordingly, we are interested in advancing private-public partnerships to:

- speed and improve SSDI claim adjudication through new processes/systems for providing the SSA with key claims information regarding the medical condition and functionality of private claimants who apply for SSDI benefits; and
- ensure the timely, accurate, and fair coordination of private and public disability income benefits by modernizing the process for providing private insurers with the necessary SSDI benefit status information.

AHIP and our members are committed to working with Congress and the SSA to design initiatives addressing both of these priorities.

V. Conclusion

Thank you for this opportunity to testify on these important issues. We look forward to working with the subcommittee to continue to address the health care and other needs of individuals with disabilities. AHIP's members are strongly committed to serving this population through their participation in Medicaid and by offering innovative insurance products.