Exhibit F

COVERAGE OPTIONS FOR NEVADA

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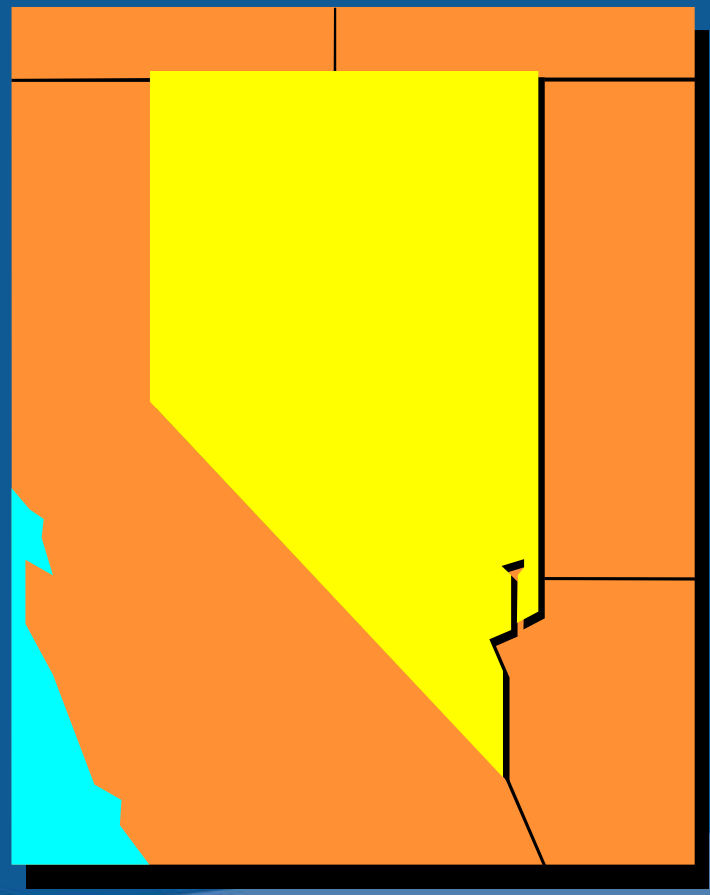
THAT'S LIFE *By* MIKE TWOHY

Presentation Overview

- Who we are
- Environmental Scan
- Coverage Options
- State Innovations



STATE COVERAGE INITIATIVES

Who We Are: State Coverage Initiatives (SCI)

- Funded by The Robert Wood Johnson Foundation
- Direct technical assistance to states
  - Onsite presentations and retreats
  - Meetings for state officials
    - January 2004 conference
    - Small-group consultations
  - Web site: http://statecoverage.net
  - Publications
- Grant funding

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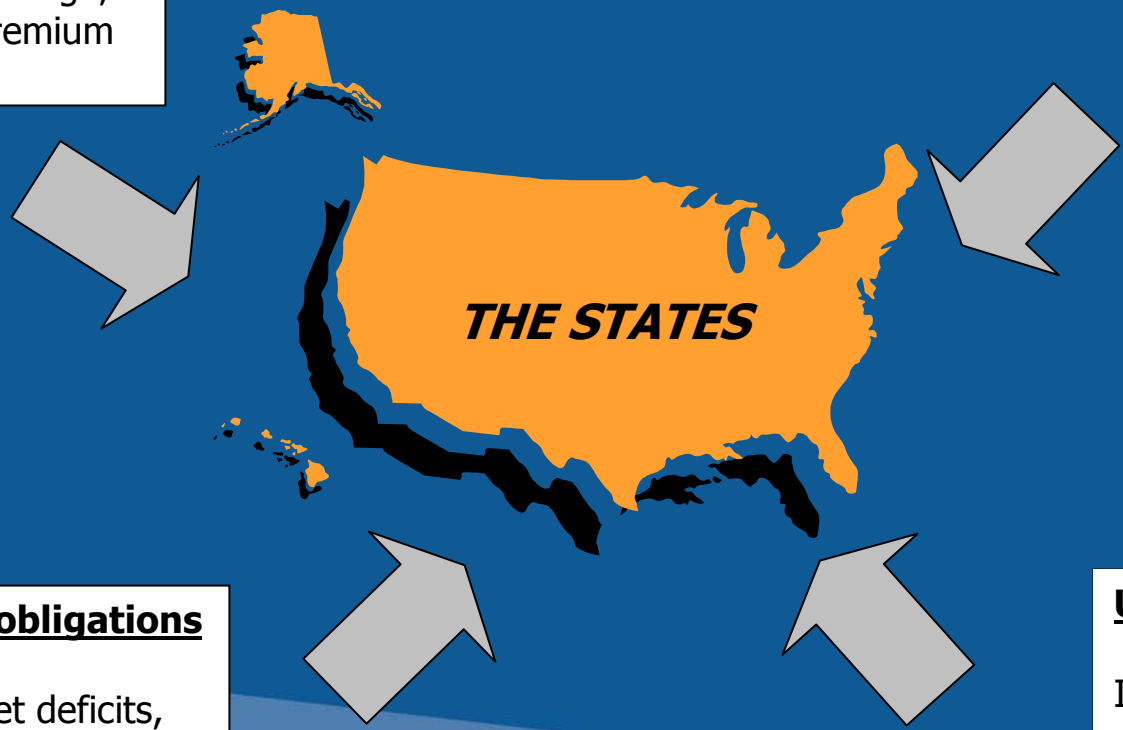
Challenges From All Sides

Private market

Drop in small employer coverage, continuing premium increases

State/Federal Partnership

Who pays, who dictates key parameters? E.g., long-term care, dual eligibles.



Other state obligations

Massive budget deficits, mounting security/public health commitments, K-12 education, etc.

US health care system

Increasing cost of health care (rising hospital costs, technology, aging, Rx, etc.); serious quality issues; growing uninsured

State Environmental Scan

- Massive budget deficits
  - States have had to contend with $200b in deficits over last 3 years
  - $70b in FY 2002
    - $62b due to revenue shortfalls
    - $7b from Medicaid/SCHIP spending growth

Sources: Rockefeller Institute of Government for Kaiser Family Foundation and NCSL

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Private Trends Affect States

- Declining private market coverage
  - Decreases in all sizes of firms, especially in smallest (<10 workers): 55% in 2003 from 58% in 2002
  - Employers struggling with 14% premium growth in 2003
  - Inability to sustain these increases forces difficult decisions
- 2001 CPS: 41.2m uninsured
- 2002 CPS: 43.6m uninsured (5.7% increase)
  - Driven by 1.3% drop in employer-sponsored insurance

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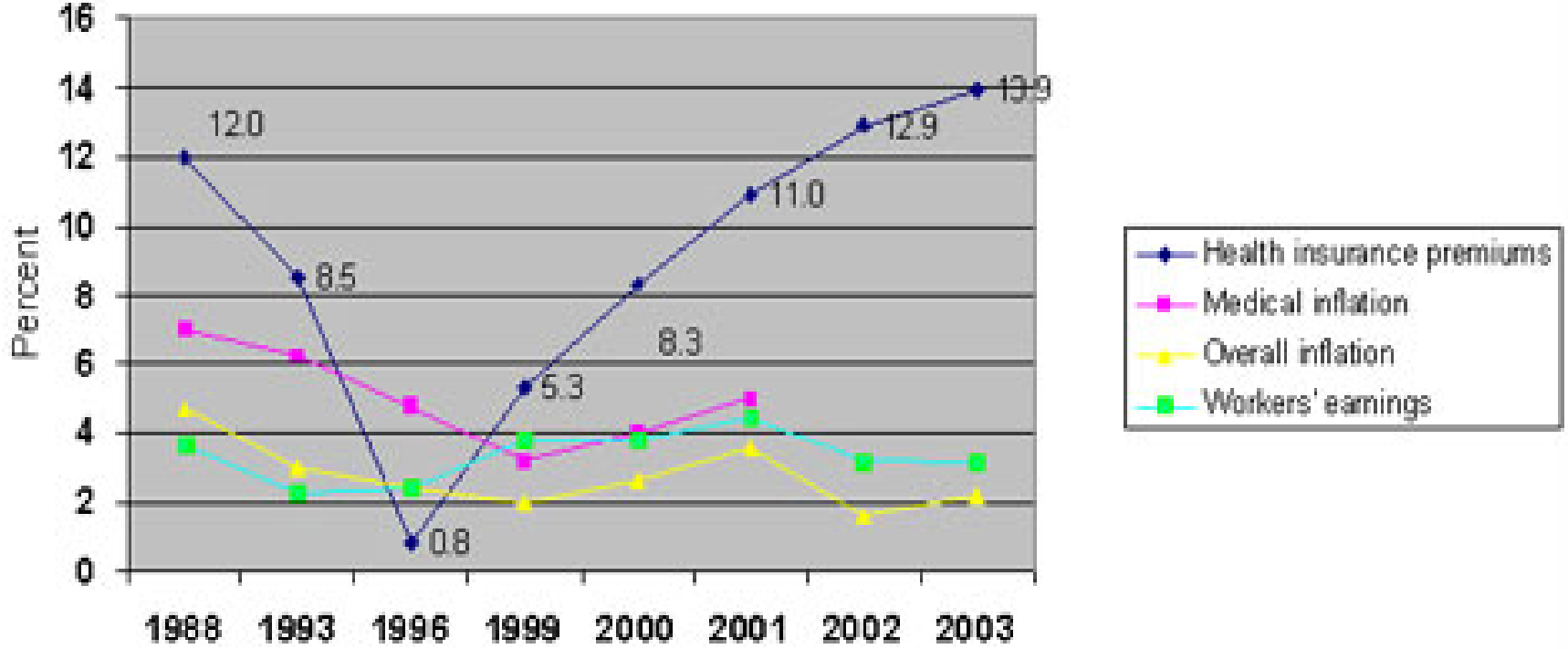
Sources: Kaiser/HRET 2003 Employer Health Benefits Survey, Current Population Survey

Rising Premiums an Anomaly



Sources: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003; KPMG Survey of Employer-Sponsored Health

What's Driving Premium Growth?

- Loosening of managed care
- Provider consolidation and push-back
- Rx demand increases
- Long-run cost growth (technology)

Source: Center for Studying Health System Change

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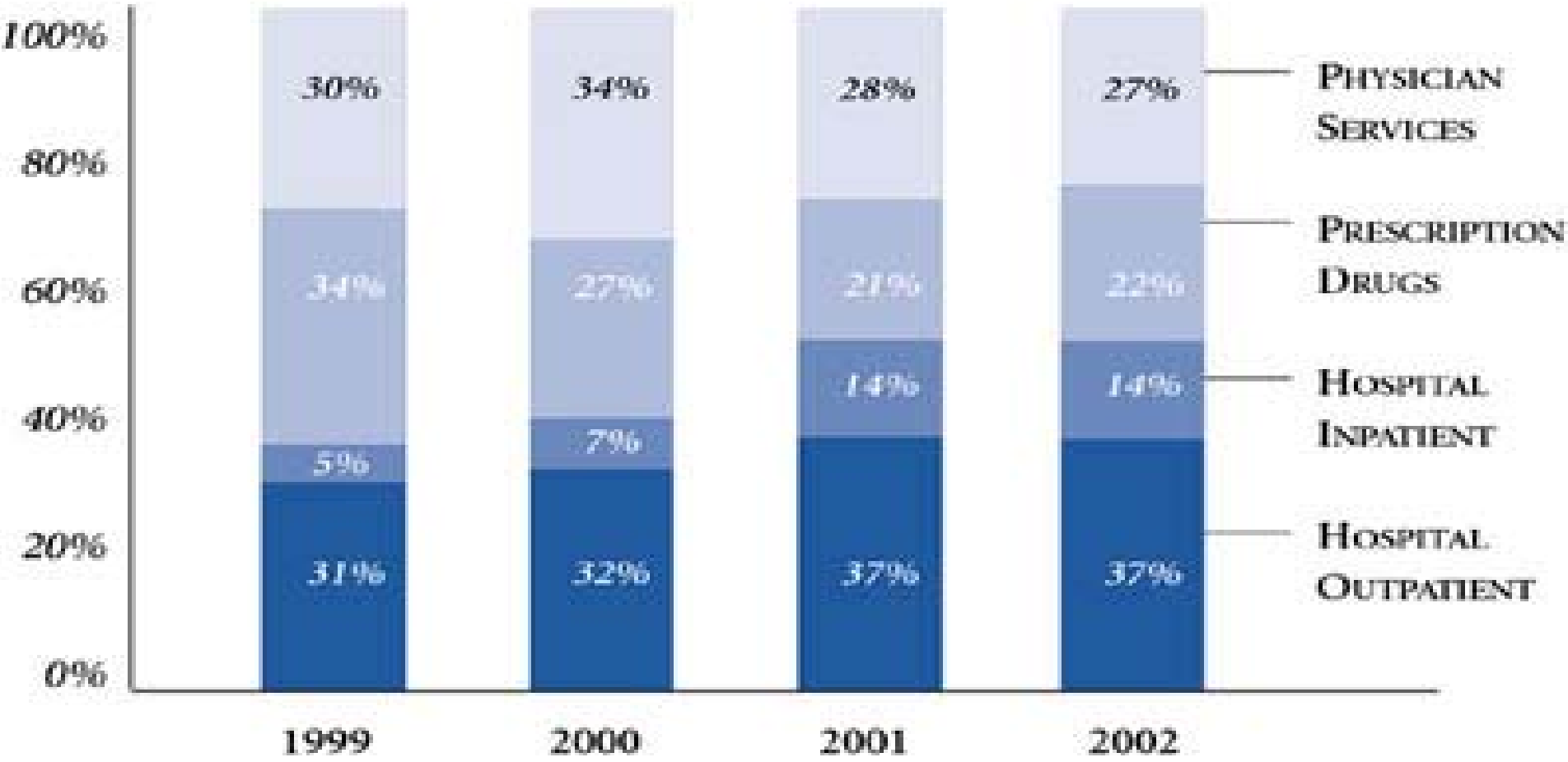
Hospitals Driving Premium Increases



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Source: Center for studying Health Systems Change

Market Concentration

- In most states, and on average:
  - Fewer insurers
  - Larger insurers
  - Fast-growing Blues
- But:
  - 20 states gained group or individual insurers
  - In some states, the largest insurer lost market share
    - 16 state group markets
    - 17 state individual markets

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Source: *Mapping State Health insurance Markets, 2001: Structure and Change*

What Causes Markets to Concentrate, Or…Why Do Insurers Leave?

- For business reasons:
  - Markets are crowded (many insurers per population)
  - Greater HMO penetration (economies of scale)
  - Fail to compete (low market share, high loss ratio)
  - No diversification to the group market
- No evidence that regulation affects insurers' decisions to exit (or enter)

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Key Themes in the New Environment

- Emphasis on cost containment
  - DM and Rx strategies
- Shift from coverage expansion to maintenance
- Low-cost/no-cost expansion options
- Program restructuring/new federal flexibility
- Trade-offs in benefit structure
- Partnerships: seeking to combine funding sources (federal, state, local, employer, employee)
- Short term and long term strategies

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Options for Expanding Coverage

- Medicaid
  - Section 1115 research and demonstration waivers
  - Section 1931 income disregards
- SCHIP
- State – Only Programs

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Options for Expanding Coverage

- Low Cost/No Cost
  - Reaching out to niche populations
  - Administrative simplification
  - Small employer, consumer education
- Bolstering the Safety Net
  - Creating “medical home” for uninsured
  - Access over insurance

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Federal Flexibility: HIFA

- Helps states control costs while expanding coverage
- Funding mechanisms:
  - Unused SCHIP allotments to cover adults
  - Unspent DSH funds
- Increased flexibility in benefits and cost sharing
- Emphasis on developing models building off ESI
- Cap enrollment (non-entitlement)
- Status:
  - Approved : AZ, CA, CO, IL, ME, NM, NJ, OR
  - Pending: AR, MI

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First Approved HIFA Waiver: Arizona

- Ballot measure to expand coverage
- Expansion Groups:
  - Phase 1: adults to 100% FPL
  - Phase 2: parents of Medicaid/SCHIP children between 100% and 200% FPL
- Budget: unspent SCHIP allotment
- No cap, priority for funding SCHIP kids, SCHIP and Medicaid parents, childless adults
- Cost-sharing: existing Medicaid and SCHIP levels
- Study feasibility of ESI pilot program

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HIFA: New Mexico Model

- Targeted implementation date: Spring 2004
- Expansion Group: Adults up to 200% FPL
- "Secretary approved" standardized benefit package ($210 pm/pm)
- Premium contributions from employers ($75/mo), employees ($0-$35), state and federal government
- Crowd-out prevention features

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HIFA: Illinois Premium Assistance Program

- Expansion Group: Parents of Medicaid and SCHIP children with incomes up to 185% FPL (phased-in)
- Premium assistance now available to children 133% - 185% FPL
- Uses HIFA flexibility to reduce state administrative obligations
- Informed consumer choice model

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HIFA: Oregon Health Plan 2

- Expansion Group: Adults from 170% to 185% FPL
  - Childless adults (commercial package)
  - Medicaid/SCHIP parents (commercial package)
  - State-only Family Health insurance Assistance Program (FHIAP) benchmark package
- Focus on ESI through FHIAP not Medicaid
  - Sliding scale subsidies
- Informed choice

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HIFA: Factors to Consider

- Last waiver approved over a year ago
- States' ability to pursue HIFA under current budget circumstances
- Uncertainty in Administration's overall waiver strategy
- Impact of GAO's recommendations on use of SCHIP funds

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Utah's 1115 waiver: Primary Care Network (PCN)

- HIFA look-alike
- Expansion Group: Adults (19-64) without coverage for 6 months, with income <150% FPL
- Capped at 25,000 enrollees
- Benefit package: primary and preventive care
- $50 annual enrollment fee (with $1,000 cap)
- HB 122 - allows private sector to purchase the primary care package

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Utah's 1115 waiver: Primary Care Network

- Funding
- Specialty physician & hospital coverage through community donated care alliances
- Other "Invisible" features
- Covered at Work program

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State Innovations in 2003

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California's "Pay or Play" Law

- SB2 passed in September, signed in October
  - Workers in firms with 200+ from 2006
  - Workers in firms with 50-199 from 2007
  - Workers in firms with 20-49 only if state passes 20% tax credit for employers
- Firm pays into State Health Purchasing Fund for each worker and receives credit for providing acceptable coverage
- Employers must cover >80% of premium
- Will cover up to 1.1 m uninsured (25% of total)
- Multiple challenges expected

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Idaho's Voucher Program

Idaho Health Insurance Access Card Act (April 2003)

- Kids: SCHIP expansion from 150 to 185% FPL
  - Parents with children between 133 and 185% FPL could choose between Access Card ($100/month for ESI coverage) and traditional SCHIP
- Adults: $100 a month to purchase private health insurance for up to 1,000 uninsured Idaho adults (~185 percent FPL) who work for small employers (2~50 employees)
- Financing: Federally funded at enhanced rate

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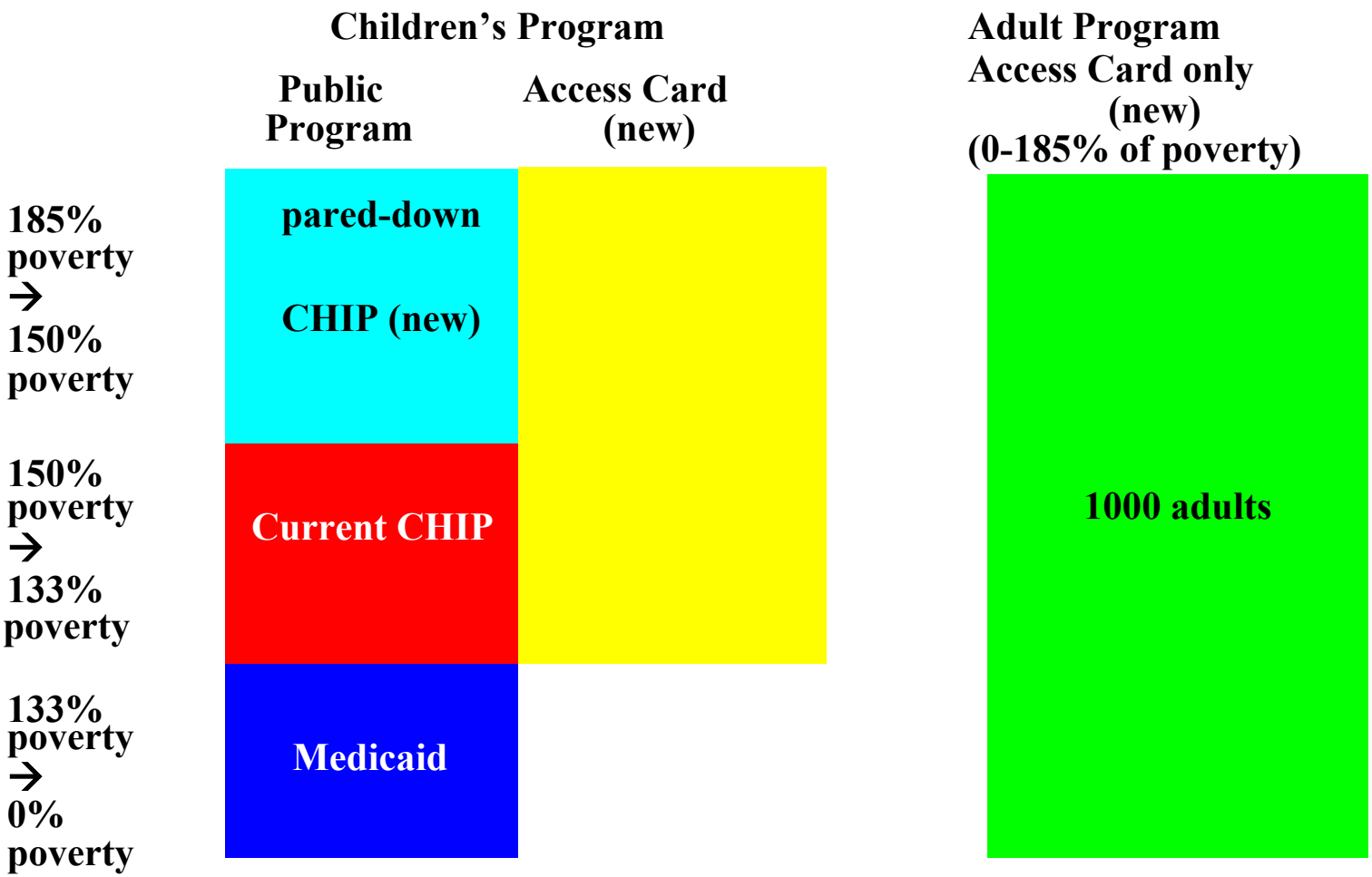
Idaho's Access Card



Maine's Dirigo Health

- Voluntary program addressing cost, quality and access
- Focus
  - small business,
  - self-employed,
  - workers without offered coverage,
  - low-income in large firms
- MaineCare (Medicaid) expansion to 200% FPL for parents, 125% FPL for childless adults
  - sliding scale subsidies to 300% FPL

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Maine's Dirigo Health (cont.)

- Cost containment
  - CON moratorium
  - Voluntary limits on operating margins
  - Required electronic claims submission by 2005
  - Price disclosure
- "Savings offset payment" on carriers from UC savings (capped at 4%)
- Maine Quality Forum created

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Other Recent Expansions/Actions

- Wyoming: SCHIP expansion from 133-200% FPL (8,000 children)
- Montana: Legislation to allow a demonstration project for insurers to offer limited benefit plan to uninsured
- Texas: Held 9 health insurance fairs across state to educate small employers
  - Rate guide developed www.tdi.state.tx.us/consumer/serg01.html

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Expansions: How To Get It Done In Difficult Times

- Leadership and commitment from the top
- Stakeholder willingness to sacrifice at the table
- Employer pressure to solve "cost-shift"
- Employer willingness to partner with public sector
- Federal flexibility and money
- Infrastructure: Solid data and policy analysis
- New benefit designs
- Setting priorities for smaller coverage gains as part of a bigger plan

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Final Thoughts

You got to be very careful if you don't know where you're going because you might not get there.

-Yogi Berra, Health Care Expert

If you go through life convinced that your way is best, all the new ideas in the world will pass you by.

-Akio Morita, Sony

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