Adequate Health Care Task Force
Special Meeting
Meeting Minutes
Friday, November 4, 2005
2:00 PM – 4:30 PM

Civic Opera Building
20 North Wacker Drive, Tower Club
Chicago, Illinois

Illinois Public Act 93-0973, formerly House Bill 2268, creates the Health Care Justice Act and encourages the State of Illinois to implement a health care plan that provides access to a full range of preventive, acute, and long-term health care services; maintains and improves the quality of health care services offered to Illinois residents, and meets other criteria. The Illinois Department of Public Health (IDPH) is required, subject to an appropriation or availability of other funds, to enter into a contract with an "independent research entity" experienced in assessing health care reforms, financing, and care delivery models. The provisions of this legislation establish an "Adequate Health Care Task Force" with 29 voting members: five to be appointed by the Governor, and six appointments made by each of the four leaders of the General assembly (the Speaker of the House and the House Minority Leader, and the President of the Senate and the Senate Minority Leader). The Directors of the Departments of Public Health, Public Aid, Aging, and Insurance, along with the Secretary of the Department of Human Services, are to be invited to meetings of the "Adequate Health Care Task Force," but are not included in the Task Force's membership. The Department of Public Health is required to be "the primary agency in providing administrative support" to the Task Force.

This legislation provides for public hearings in each Illinois Congressional District, and a website detailing the work of the Task Force, accessible through the Governor's internet home page, is to be established and maintained. Printed copies of Task Force information are to be made available for persons who lack access to the Internet website. A Task Force report, detailing recommendations for a health care access plan as specified within the legislation, is to be submitted to the General Assembly by March 15, 2006. The bill encourages the General Assembly to consider legislation enacting the Task Force recommendations by December 31, 2006. The Act took effect July 1, 2004.

Task Force Members in Attendance: Jim Duffett; Colleen Kannaday; David Koehler; Dr. Wayne Lerner, Chair; Dr. Niva Lubin-Johnson; Pamela Mitroff; James Moore; Kenneth Robbins; Ruth Rothstein

Task Force Members Absent: Dr. Craig Backs; Dr. Anthony Barbato; Kenneth Boyd; Catherine Bresler; Timothy Carrigan; Rep. Elizabeth Coulson; Jan Daker; Margaret Davis; Dr. Arthur Jones; Sen. Iris Y. Martinez; Mike Murphy; Dr. Joseph Orthoefer; Tracey Printen; Joseph Roberts; Gregory Smith; Sen. Donne E. Trotter; Dr. Quentin Young

Illinois Department of Public Health Staff: David Carvalho; Randy Hall; Mike Jones; Danielle Powers; Ashley Walter

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I. Welcome and Purpose of Session

Dr. Wayne Lerner, Chair, called the Adequate Health Care Task Force special meeting to order at approximately 2:00PM. Dr. Lerner thanked the Michael Reese Health Trust and the Health and Disability Advocates for underwriting

and organizing the meeting. Dr. Lerner then introduced the session's three presenters – Dr. Len Nichols, Alan Weil, and Cindy Mann.

II. Dr. Len Nichols, New America Foundation

Dr. Len Nichols presented "Health System Reform as a Moral & Economic Imperative". In his presentation, Dr. Nichols highlighted the linked problems of our health care system, explained why incremental reforms can't work, and suggested pathways to comprehensive reform. Dr. Nichols proposed that the linked problems are low value for the dollar (how much health care we get for each dollar spent on health), uneven quality, and inequitable access to care. He argued that incremental reforms do not work because they lack a sense of urgency, key incentives remain unchanged and perverse, excessive individualism persists, and problems are linked. Dr. Nichols also stated that two myths impede progress in expanding access to health care: (1) the uninsured get all the care they need; and (2) America is rich and can afford unfettered medical technology growth. He proposed that in order to expand access to health care there needs to be a moral case, and economic case, a delivery system centered on the "culture of value", and credible policy design.

Dr. Nichols cited a biblical story regarding gleaning to set the stage for the moral case for ensuring access to quality and affordable health care. He argued that health care has joined food as an indispensable commodity. He also noted that information will play a key role in any proposal. He later proposed a sequence of policy steps required to achieve access to quality and affordable health care for all: (1) creating a political space in which you articulate the moral case and explain economic facts and risks; (2) instituting cost growth containment policies; (3) creating purchasing requirements, venues, and subsidies; and (4) linking dedicated tax revenue appropriation to evidence-based coverage decisions over time.

III. Alan Weil, National Academy for State Health Policy

Alan Weil presented "Lessons Learned on the Path to Covering the Uninsured". Weil began his presentation by describing two experiences he had had relating to expanding access to health care. The first involved his work in Colorado under Governor Romer that included developing an ambitious plan for universal health care named ColoradoCare. He used this story to highlight the importance of federal/state partnerships when looking to expand access to health care. His second experience involved the drafting of three proposals in Massachusetts to expand access to health care. The highlights of these proposals are as follows:

(1) Individual Mandate, Employer Mandate (All Employers)
(2) Individual Mandate, Employer Mandate (Large Employers)
(3) Individual Mandate

More information on these proposals can be found at www.roadmaptocoverage.org. Weil stressed that an individual mandate should be used as a backstop, not a solution. He argued that before an individual mandate be implemented insurance needs to be made available and affordable. Thus, other policies that likely should be implemented prior to (or in conjunction with) an individual mandate include reinsurance, purchasing pools, Medicaid expansions, and/or subsidies.

Weil then presented the five lessons he has learned regarding expanding access to health care:

(1) Principles never gave anyone health insurance or health care.
    - He urged the Task Force to take the principles outlined in the law and run with them.
(2) Move into the details but talk like the man on the street who doesn't deal with health care issues every day.

- Weil argued that most people don't talk about health insurance – they talk about health care.
- He stressed that the important questions are, "What are the benefits? Access to what?" He added that an insurance card alone doesn't always cut it if there is no access.

(3) No proposal can eliminate all inequities, but good plans can reduce them.
- Weil argued that if the Task Force's expectation is to eliminate all inequities it will be immobilized.
- He challenged the Task Force to consider its limits with regards to benefits, access, cost, and quality.

(4) Successful reform efforts must expand the pot of money.
- Weil admitted that there is waste in the current system, but argued that the ability to redistribute resources is lacking in the American polity – it just isn't going to happen.
- He argued that one grand bargain won't work –
    a. If you don't put extra money into the pot, the most likely move given political realities is to take it from the poor (those on Medicaid) to give it to the middle class.
    b. Providers may be the Task Force's biggest allies – doctors need to associate expanding access with increasing income.

(5) You need your Federal partner.
- No state has expanded coverage without a Federal partnership (i.e., the Medicaid program).

Weil closed his presentation by bestowing three pieces of advice to the Task Force:

(1) You are not alone – the eyes of the nation are watching you (with respect to health policy).
- Illinois has expanded Medicaid in a time of recession.
- Illinois has recently passed legislation to provide universal health insurance coverage to all children.
- He added that the eyes of the advocates and foundations are also watching and that the Task Force should leverage resources they may be able to provide.

(2) This will be a long-term effort.
- Weil stressed the importance of having both short-term and long-term goals - while the long-term goal may be universality, it will require incremental steps.
- He added that sustaining progress will be crucial to this endeavor.

(3) It is important to engage locally.
- Weil implored the Task Force to use simple terms to reach and engage everyone.
- This will play a key role in building something sustainable.

IV. Cindy Mann, Center for Children and Family Studies at Georgetown University Health Policy Institute

Cindy Mann presented "The Role of Medicaid in a Restructured Health Care System". Mann began her presentation by showing the Task Force the extensive role Medicaid plays in Illinois. She also presented information to the Task Force that shows that the elderly and people with disabilities account for 70% of Medicaid expenditures in Illinois, which demonstrates that Medicaid is used to fill gaps in Medicare (such as long term care). Throughout her presentation Mann also stressed that Medicaid supplements financing for other systems, including special education and early intervention services for children and the child welfare system. Mann then proceeded to show how key issues could be addressed by Medicaid by seamlessly integrating it with new or existing programs. She concluded by presenting the limitations of Medicaid, in particular with respect to childless adults and budget neutrality constraints. In response to questions from the Task Force, Mann stressed the importance of paying attention to provider payments (putting insufficient funding into the system causes cross-subsidization) and creating a broader prospective to include prevention, not just acute care.

V. Questions and Answers

Dr. Art Jones asked the panelists how payments for providers should be structured. Dr. Len Nichols responded that payment should be based on outcomes, not procedures. However, Dr. Nichols admitted that we do not currently have the ability to risk adjust as would be required for such a structure, but that process measures are available. He argued that a "Capitation Plus" structure should be implemented using information that should be made available through the use of electronic medical records.

Kenneth Smithmier asked the panelists where it should look for money to add to the "pot". Mr. Smithmier specifically inquired about the write-off employers receive on premium assistance. Dr. Nichols suggested that a tax cap be put into place because people fear that employers will flee the system if it is taken away, but that they may be willing to stay for a trade. Dr. Nichols suggested dedicating "x" amount of revenue for programs to ensure access to health care and to have a special discussion/process when special issues arise (new technologies, special populations).

Dr. Niva Lubin-Johnson asked the panelists why the Institute of Medicine report, "Unequal Treatment" has not been mentioned as part of the cost/quality discussion. She added that different populations and their particular needs must be considered when discussing cost and quality. Dr. Wayne Lerner added that population-based outcomes also need to be considered.

Kenneth Robbins noted that all proposals keep multiple sources of coverage. He asked the panelists how crowd out should be addressed, as 70% of people now covered by Dirigo (Maine) were previously covered by employer sponsored insurance. Mann responded that the crowd out in Maine was expected because of the large proportion of small businesses in Maine. She added that it is impossible to know which businesses would have dropped coverage even if Dirigo was not implemented. Mann also explained that under Dirigo, Medicaid rates were brought up to commercial rates. She concluded that at some point the Task Force will need to make peace with the fact that there will be shifting. It is important for the Task Force to calculate it and understand it, but it shouldn't tear its hair out over it. Weil added that the small group market in Maine is difficult and added that remembering the context is important. He noted that crowd out is an unfortunate term because every time an employee loses employer sponsored insurance and enrolls in Medicaid, he considers it a good thing. He pointed out that most people who have private coverage have little coverage. For example, middle income kids have worse access than low and high income kids. Weil stressed the importance of comprehensiveness and argued that crowd out deals with a broader set of issues and should not be a deal breaker. Dr. Nichols added that in California, as many as 1.5 million children with private coverage are eligible for public coverage. They could stay privately covered, but they are supposedly eligible. His point was that equity costs money.

David Koehler noted that he sees adding money to the pot as the potential deal breaker, because it is an issue of allocation. Mr. Koehler suggested that this is where expanding access to health care becomes politically difficult. Dr. Nichols suggested that it is not a static picture and that the situation needs to be thought of as a trajectory. That is, if cost growth is not curtailed, we are looking at 20-30% of a family's income being spent on health insurance premiums. He added that such cost containment cannot be achieved without new money because the money that is currently being "wasted" cannot be drawn out of the system to be used in the short run. Mann agreed with Dr. Nichols. She added that this is why cost, quality, and access must be considered together. Dr. Lerner asked to add two more factors into the cost-quality-access triangle: (1) some temporal variable, and (2) co-obligation (personal responsibility). Dr. Nichols agreed with Dr. Lerner. He added that any proposal must include incentives that are income-related.

Pamela Mitroff asked the panelists how Task Force members could coalesce around a benefit plan. Dr. Nichols suggested that the benefit plan should reflect the values of the community but be based on science. He added that consumers should be more aware of the marginal costs of higher cost utilization (although not through a large deductible). He suggested that actuaries could present the Task Force with a multitude of options, as well as academia.

David Carvalho wrapped up the question and answer session by once again thanking the panelists, the Michael Reese Health Trust, and the Health and Disability Advocates.

VII. Adjournment

Dr. Lerner adjourned the meeting at approximately 4:30 PM.