PRIVATE SECTOR OPTIONS FOR

INCREASING ACCESS TO CARE

SPECIAL MEETING OF THE ADEQUATE

HEALTH CARE TASK FORCE

April 21, 2006

9:15 a.m.

Blue Cross Blue Shield of Illinois

300 East Randolph Street

Chicago, Illinois 60601

MR. LERNER: I would like to start the Adequate Health Task Force Special Meeting today on Private Sector Options for Increasing Access to Health Care. Can everybody hear me okay? Good.

My name is Wayne Lerner. I am the President of the Rehabilitation Institute of Chicago. I'm pleased to be Chairman of the Adequate Health Care Task Force. I would like to call the meeting to order as we are apt to do at every one of our meetings.

Two things to start out. Number one, I would ask everybody who is carrying phones, pagers, PDA's, or other various electronic devices to either turn them off or turn them on vibrate so that we can provide the respect to our speakers today and really get into our discussion.

Second, I would like to go around the table and have everybody introduce themselves. Please remember that we are videotaping this conference and we have a court reporter. So we have to talk clearly and articulately so that she can get down all of

this important information.

Ken, will you start out.

MR. SMITHMIER: My name is Ken Smithmier from Decatur Memorial Hospital, Decatur, Illinois.

MR. MITCHELL: My name is Marty Mitchell. I am with American Health Insurance Plans based out of Washington D.C.

MR. BACHMAN: Ron Bachman, senior fellow with Center for Health Transformation.

MR. BRADGON: Tarren Bragdon from the Maine Heritage Policy Center.

MR. WIESKE: JP Wieske with the Council for Affordable Health Insurance.

MR. DOOLING: Terry Dooling with Schosser & Company, LLC.

MR. JONES: Art Jones from Lawndale Churches.

MS. JOHNSON: Niva Lubin-Johnson from Prairie State Medical Society of the National Medical Association.

MR. CARVAHLO: Dave Carvahlo from the Illinois Department of Public Health.

MR. KOHLER: David Kohler from Peoria

Area Labor Management Counsel.

MS. PRINTEN: Tracey Printen from the Illinois State Medical Society.

MS. MITROFF: Pam Mitroff from Pamela D. Mitroff Consulting.

MS. BRESLER: Catherine Bresler from Trustmark Insurance Company.

MR. SMITH: Greg Smith from Group Marketing Services in Lincoln, Illinois.

MR. MURPHY: Mike Murphy with Well Point.

MR. ROBBINS: Ken Robbins from Illinois Hospital Association.

MR. JONES: Mike Jones from the Illinois Department of Public Health.

MR. LERNER: We can go to our guests with us and the other folks with us. Why don't you go ahead and introduce yourself.

We can't hear you.

MS. GOLDSTEIN: Sarah Goldstein with the Illinois Public Health Institute.

MR. BULIHAM: Dan Buliham, Blue Cross.

MS. DARBY: Janice Darby representing individually insured with Ameris Group.

MS. WALTER: Ashley Walter with Well Point.

MS. MACKER: Natalie Macker with the Catholic Preventive Health Care.

MR. JORDAN: Jim Jordan with the Illinois Division of Insurance.

MR. AGUSTON: Alan Aguston with the Illinois Chamber of Commerce.

MR. CHAMBERS: Chris Chambers.

MR. ALGER: Patrick Alger with the Illinois State Medical Society.

MR. FITZPATRICK: Jerry Fitzpatrick with Trust Life Insurance.

MS. LYNN: Judith Lynn, Blue Cross Blue Shield.

MR. LERNER: Thank you. Did I miss anybody?

Okay. I would like to really thank several people for helping us put together a very special day, Mike Murphy and Joe Roberts, who took the lead on this and set up the schedule so that we were able to intensively look at the options for private sector involvement in covering the uninsured and

underinsured, and we really want to thank Mike and Joe for their great work. Thank you very much.

We also absolutely want to thank Blue Cross Blue Shield of Illinois for hosting us today and for providing us with wonderful refreshments, meeting facilities, and a great accommodation. So if you can pass on the word to the folks at Blue Cross, we would really appreciate that.

With that, are there any announcements or housekeeping business? Let's get started. We are going to move through the agenda. Our first presenter today is Mr. Phil O'Connor. Mr. O'Connor is the former Illinois Insurance Commissioner. He will give us a historical background on the health insurance market in Illinois.

Mr. O'Connor.

MR. O'CONNOR: First of all, good morning. Thank you. My day job is really in the energy business. I am formerly the Director of Insurance here in Illinois, and since leaving the insurance company quite a long time ago in

the early '80's, I after that served as Chairman of the Illinois Commerce Commission and spent a lot of time for the past 25 years looking at questions of regulation in competition in industries that are either network industries or industries that are characterized by a considerable degree of regulation, and therefore the challenge is to figure out what the role of competition that might be in those industries.

Mike Murphy asked if I would come here this morning and provide a few observations. There are three topics that I would like to touch on. The first is some observations about health care funding and health care markets and primarily with a kind of a quick look back on the past 40 years or so, not necessarily an Illinois emphasis, but with some implications for Illinois.

The second topic really has to do with the framework in the tradition of insurance regulation in Illinois. I'm referring primarily to the regulation of what we might think of as the private insurance market, third party insurers.

Finally, some observations based on really three or more decades of experience and research that's been done in the relative merits of price competition versus price regulation in the insurance arena. So let me figure out if I'm doing the right thing here.

In looking at the health insurance markets, I think one way of thinking about it is that the history of it certainly in the past 40 years has been one of changing market shares. One thing we can say about the health insurance market or the health care funding market, I don't know what you would like to call it, is that there has been an enormous amount of change in terms of who pays what, how it's paid, what it is we're paying for; and there are -- of course, there are a large number of factors that go into driving the dynamics involved, whether it's changing demographics.

Just look now at the aging Baby Boomers, in which I am one, economic growth. We may have a lot more to spend on things that we want to spend it on, perhaps feeling better, managing chronic conditions, and so forth,

enormous technology changes. Obviously in medicine that's apparent to any one of us.

Just think about going to the dentist. If you go to the dentist every four months or six months or whatever, at least I am amazed that every time I walk in there it seems to be entirely new equipment or some new technique that is being used for diagnostics or for whatever.

Then of course the financial markets are dramatically more complexed today, and that effects health care insurance and health care funding simply because we are always looking for more efficient ways of financing things or moving money around within the economy.

The other thing I have already touched on is it may well be that with respect to insurance, health insurance, and health care that the products we're purchasing today are really dramatically different in both kind and quality than what we were purchasing back in 1965. By the way, I chose 1965 because it's the advent of Medicare, a major public policy decision; and, of course, it has dramatic

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implications.

A few comparative statistics between 1965 and 2005. My caveat on these numbers is first they are all drawn from federal resources, and I'm happy to give the resources to anybody who is interested. The other thing is that I had to do a little bit of internalization to stay with my 6505 theme, but I haven't done any violence to the basics.

We obviously always talk a lot about how much gross domestic product we spend on health care, and we can see that has almost tripled during that 40 year period. That, of course, doesn't mean that we're spending three times as much for the same thing. It's no different than we have different expenditures on electronic equipment in our home, entertainment equipment in our homes, but we're buying something quite different today than we were in 1965 which was, you know, generally speaking black and white television or the color T.V.'s where everybody's face was green.

What were the sources of funds? This is really where we see some dramatic

change. Out of pocket payments, you know, were less than half in 1965, but almost three times the proportion of today, falling from about 43 percent of all expenditures and to about 15 percent today, and commensurately there has been a change in third party payment.

It's similarly in the share between private and public, but particularly the share between different sources of public expenditures have changed. So we have gone from about a three-fourths, one-fourths private, public to something approaching about even Steven.

Again, these numbers are subject to all kinds of interpretation as to what really fits where, you know, how are we counting health care expenditures from auto insurance, as an example, or exactly how are we counting self-insured employers, how are we counting health care insurance for Federal employees and State employees, things of that nature, but I think it's really directionality that's important here, and it's really been flipping over all of this that is important. Obviously the really interesting thing to me was the share

of State versus Federal.

Now, what was that? Well, back in '65, you know, county hospitals around the country are accounted for an enormous amount of what we would think of as being the public share of health care expenditures. Also, Federal employees would have had a much larger share relative to public expenditure in total because the federal government of course was not financing nearly as much of the health care system as it does today. So we've seen this go from rough parity between Federal and State in '65 to nearly, you know, 2 and a half, almost 3 to 1 Federal share of the public piece of the pie.

The other thing is you fool around with the numbers a little bit. What we see is we just look at private health insurance, and then we look at public funding and think of that as insurance. In '65 it roughly was equal shares, about one-fourth or a little more of the health care system, health care funding system. That of course has changed a little bit. They still -- they are still in rough parity, 40

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percent for private, 45 percent for public; but each has grown dramatically in its overall share taking that away from out-of-pocket spending.

Again, part of the question is what's going on here. One of the things that is going on in much what we would think of as being routine medical care, even though the scope of routine medical care has increased significantly, is that was generally paid more out of pocket and health insurance was reserved for those unexpected type of events. We have now come to adjust our thinking significantly about what it is health insurance pays for and that it is paying not just for things that are unexpected events, accidents, sudden illness or whatever it might be that I think most of us would argue ought to be routine. Therefore, not unexpected, but we are looking to third party financing schemes to pay for most of that. It's neither bad nor good but it's important -- it has to be an important element in our thinking about what it is that we are doing and what it is that we recall about things.

Also there is a question of what

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we're buying. Now, these data here are really for the 20 year period of '80 to 2000. So speculate on your own as to what it was in 15 years leading up to 1980 and five years since. I think it's directionality that is interesting here.

Some of this is intuitively obvious. If we just watch, we know that inpatient care hospitalization share of the market has fallen from just shy of being half to a little over one-third of the health care dollar today. Interestingly, if you look down the list at nursing home care, it occupies about the same relevant position today as it did in 1980.

Again, we may be buying different things or we may be calling some things different things than we are today, but you can see the tripling in home health care. Even though it has gone from one percent to three percent, that nonetheless is important in terms of direction, and prescription drugs of course is a standout with roughly speaking doubling of the market share for financing.

Again, that sort of is intuitively

obvious, and it's not so much that I think we can say drugs are more expensive. We are actually buying different things today. We are buying a whole lot more than we did in 1980. I mean, there are probably a number of people in this room, myself among them, who have high blood pressure. Mine doesn't derive from speaking events like this. It's just hereditary.

You take drugs for that that weren't even around in 1980, so we pay for that. It's probably more of a -- you think of it as a quality of life issue that we classify as health care spending today that wasn't even an option in 1980. These, I think, are relatively interesting data. I can't claim to know what's underneath all of these where all the implications are, but it's certainly worthy of a closer look.

Now, I started off with a notion that the history here of health care insurance and funding for the past 40 years is a story of market share change. So in thinking about market share, market share has changed because

there is competition, and competition comes in a variety of forms. Competition by its very nature is tension.

Now, what I'm trying to do here is to suggest what some of the tensions are in the health care market where you have different places on continuum fighting for market share. These are not meant to be dialect, one is in direct opposition to the other. In fact, the meaning of these things has changed over time. For instance, the notion -- the phrase managed care was something that developed well after 1965 and means something really different today than it did in let's say in the late '70's.

But what do we have? We have that fee for service versus capitation tension. Managed care -- I think that managed care now has a lot more to do with contracting of prices as opposed to noncontract prices where you find out what the price is at the point of service.

Health insurance was a much more risk indemnity situation in the past and therefore much more deserving in terms of insurance perhaps than most of what we call

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insurance today because today we see more in the way of self-insurance. I don't mean by that out of pocket, but within groups what we see is that the assessment on the group for health care premiums is designed to be roughly approximate to that group's experience, not to some larger community.

Guarantee issue versus underwriting. We had the Federal legislation a few years ago quoting the notion that an insurer must take certain risks other than perhaps a relatively small number than is thought to be uninsurable. That has -- that was intended to displace underwriting, but in all markets there is a reaction. Insurance companies are not in the business of losing money. You know, they started health care with insurance companies for the purpose of depleting your surplus and your capital. So you're going to underwrite in one way or another. That's simply in the nature.

Obviously the hospitalization versus outpatient continuum which has evolved in sort of the full service versus specialized setting continuum where increasingly within the hospital

business, the facility's business, we see this tension in which certain sorts of care are seeking lower cost settings and perhaps higher margin settings.

I had breakfast the other day with a young fella, a lawyer here in town, and learned that his corporate law business that he has often deals with helping hospitals devise commercial arrangements with physician practice groups within a hospital in order to dissuade them from leaving and going off into, you know, pancreas specialized settings or something and to keep them operating out of the hospital, but to do it in a fashion that recognizes the compensation issues and so forth that arise. This is a constant sort of tension. All of these are.

Compensation versus employee benefit. Well, you don't have to look any farther than the newspapers every day to see that a large portion of the labor management tension or conflict or debate in this country revolves around the question of cash compensation versus health insurance, per dollar

college insurance versus copayment coinsurance and so forth, something again that the market is driving that we see come out in all sorts of ways, some of which are necessary and pleasant.

Then I kind of come full circle here on full service versus catastrophic. For a long period of time health insurance was migrating from the direction of full coverage, mandated benefits, full scope of services. There is now a recognition that particularly for young people a lot of them simply don't want to buy a lot of coverage that they don't think that they need, and they have a preference, if they buy at all, for participating in some kind of catastrophic coverage, which is more than insurance in the traditional sense. All these tensions are at play. I'm sure that if we came back here in three or four years we can look at this same list. We would look at it differently and we might add or eliminate certain things from the list.

What about Illinois? There are any number of ways of looking at what we've done policy wise in Illinois and thinking about its

implications and whether it's been piecemeal or comprehensive or whatever, but there are, I think, some important milestones that have implications for where we are today.

In the late '70's and '80's when I look back on it with the Illinois Insurance Department, we undertook to actually promote managed care. One reason was that the market seemed to be crying out for capitation arrangements and in some way of guess what, containing cost.

Because I was insurance director I had a little something to say about it at the time. I sort of looked at it from my own frame of reference. I had grown up in California and only came to Illinois to finish my senior year in college and go to grad school. You know, I was a member of the kaiser permini system from, I don't, know probably when I was two years old. My father worked in a Naval ship yard in Northern California and kaiser permini grew up in World War II to the service shipyard members. It was a natural part of lifehood.

To be honest with you, I came and

went to the insurance department and later became director, and I was surprised. I had thought that's the way everything worked. I didn't realize that actually the Maine way of operating was fee for service. It never occurred to me, and I thought that everyone just rushed in the middle of the night for that shot of adrenaline, you would pay two bucks, and that was the beginning of the start.

We began to promote it and began to work with health insurers like Blue Cross Blue Shield being an example. We were realizing that the classic indemnity system just was not going to serve the full market and that there were other needs to be served.

Another milestone that has to do with Blue Cross Blue Shield -- it was in '83 when the State got out of the business of trying to regulate the prices of individual policies at Blue Cross Blue Shield, small group community rated policies and of Medicare supplement. This had become a major political controversy, and it's hard to remember looking at this building today that in 1981, '82 Blue Cross Blue Shield

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of Illinois was to the point where they had maybe six weeks of available cash for payment to clinics.

Today it is a much healthier company obviously, and one of the elements of that was getting them out of the business of, first of all, being different, being the largest provider by far but being different in that they were considered kind of a nonprofit having to respond to regulators about pricing and always having pricing changes becoming political events. That has changed significantly. Part of it was having Blue Cross Blue Shield become a mutual insurance company. One wouldn't think that small of a change would be that important, but it was. It changed from one corporate form to another.

Cost control regimes. Again, if we go back 25 years most of the cost control regimes employed today by third party administrators, by insurance companies, and even by Federal and State providers of health coverage were not even on the horizon. Now, much of our ability to do that of course is a

function of increasing computerization and the ability to manage databases, but a lot of it had to do with the logic of how you were looking at prices that were coming from providers, how it was that nonphysicians, for instance, were evaluating what it was that was going on in terms of utilization. So say what we will about whether it's been successful. This has been one of the big changes and actually was in great part an initiative on the part of state government.

Another area has been mandated benefits. I happen to be very skeptical about mandated benefits. What I'm talking about are specific conditions or specific treatments or diagnostic techniques would become mandated from State government to a modest segment of insurers because third party State regulated insurance companies, you know, represent only a modest portion of all insurance coverage. In my view, putting those kind of mandates tends to restore the market. It makes everybody feel good about mandating them, but it isn't necessarily, I think, the most effective way of getting them.

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That's my opinion.

1987 comprehensive health insurance plan here in Illinois will take care of high risk coverage. It's actually been quite a successful program, a God sent to those people and a very good thing to the health insurance industry because it does relieve political and other pressure dealing with people who in many ways are uninsurable.

In the '90's we had the portability pre-existing condition legislation, two different versions of it. That was a product of the prior health care reformed task force that was established. It was a modest sort of result. It may have had some good consequences. I am not in a position to evaluate it, but what it was was a targeted effort to deal with a very specific issue, basically a job lock of people, otherwise competitive economy, and competitive labor market feeling that they needed to stay in a job, particularly in a smaller business or whether they were going to a smaller business because they had coverage and couldn't risk having a lapse of coverage or some kind of gap

in care for say a chronically ill spouse or child. Then of course we had these periodic reviews.

The other thing is a very conscious policy choice in Illinois staying with competition as the price regulator rather than trying to be in business and have the government regulate the price of third party health insurance. Let me focus on that for just a moment. It's not a topic that most normal people should want to be familiar with. I will give you the quick rundown of it.

By the way, I should have really brought it, but I had this little show and tell I take around. It says reproduction of the front page of the extra addition of the New York Times, June 6, 1994. Everyone knows about June 6th of 1994, D Day. So the New York Times was big headlines about the landing in France, other stories about the liberation of Rome, which had taken place the day before. The one little nonwar story was that the Supreme Court had ruled that insurance was indeed interstate commerce. Up until 1994 insurance was not

considered to be in interstate commerce based on the old Supreme Court decisions from the 1890's. So all of a sudden insurance was subject to antitrust laws. So the insurance could not occlude or have common pricing or so forth. There was a lot of merit to some of the activities that underlay that pricing in Congress.

So Congress within the year acted with the Karen Ferguson Act to essentially reestablish the status quo and leave insurance regulation with the states but in so doing prescribe that insurance companies would be free of most of the provisions in the antitrust laws to the extent that the states regulated some function, so pricing being the most obvious example. If a state oversaw pricing in some fashion, then insurance companies in that state were relieved from exposure under the antitrust laws with respect to pricing in common because it was being regulated by the states.

In Illinois we basically opted out of that. It's kind of call reversed preemption. What we've decided in Illinois is not to

regulate insurance prices and instead to rely on an antitrust law, and we actually among all 50 of the states are the farthest off to the end of the bell shape curve on that because with respect to property casualty insurance, for instance, we have no law whatsoever. We operate strictly on the antitrust basis.

This was sort of an accidental policy that developed over time in the early '70's, but it's really become a part in parcel of Illinois insurance regulation. So that's kind of a core element. It doesn't mean it couldn't change. On the other hand, we've had 35 years or so of a pretty strong commitment in Illinois to alliance of pricing competition to control insurance rates rather than thinking that by somehow regulating the prices of insurance we will have some sort of beneficial effect, whether on the prices themselves or on the underlying cost.

Now, I'm going to get a little bit more into my opinions on the matter at this stage of the game. I was the research director of the Illinois Insurance Department in the late

'70's. We started a program of comparative analysis looking at all of the states and a variety of dimensions to look at performance in those states that were sort of prior approval regulation and those that relied more on competition similar to the situation in Illinois.

Now, much of this research -- this is the big caveat is in the property and casualty business. I would maintain however that because of the principals of insurance that the findings -- you would expect to have pretty much the same findings if one were to look at health insurance using the same sorts of methodologies.

One of the sort of basic results -- and this is not just my research or that of the Illinois department. This is pretty much what you find from looking at the full body of academic and regulatory based research around the country, again primarily in the property and casualty industry and specifically in the auto business. Remember auto cases have a fair amount of catastrophic coverage in this country.

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If we compare the competitive states versus the regulation states, we find these sort of results -- I'm not going to go through all of them. The states are relying on rate regulation. The rates tend to be no lower than the average. We tend to see lessen entry into the market by new insurers and more exit from the market.

So as an example, in Illinois because we have -- I think it's because we have the most competitive pricing regime in auto insurance, we actually have licensed in Illinois a greater share of all companies licensed anywhere in America to do business here in auto insurance. So if you're not clear what I mean by that is if you list all of the countries in the company licensed anywhere in the country in the state to do auto insurance business, a greater portion of those companies are licensed as well in Illinois compared to any other state. There is something about competition that attracts providers.

One of the other things is the residual market pools tend to be -- have a much

larger population. Those are the pools that are set up to provide insurance for people who cannot otherwise be insured out in the marketplace. So if we look at places like New Jersey and Massachusetts, they have very heavy handed regulatory schemes or previously in South Carolina we would see that 25, 30, 40 percent of the auto insurance market is in a high risk pool, whereas in Illinois considerably less than one percent. Now, again, it has a lot to do with competitive pricing and ability to charge so that all those who are insurable can really find a place in the market. Anyway, there is a variety of consequences. Again, these are most directly applicable to the auto market supported by the body of research, and I think you would find pretty much the same thing.

But with respect to health insurance, and again looking only at the insurance department, the first is that all policy forms for health insurance need to be prior approved. That's not the medical coverage under auto because property and casualty policy forms can be filed with the insurance

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department. They are stamped as received. The company can then go ahead and use them subject to the agreement that if they are disapproved at a later time those policies have to be withdrawn and the disputed provisions have to be interpreted in the most favorable light to the policyholder.

With health insurance we do it up front, but what's important in the Illinois department is because a lot of resources are not being expended on prior approval of property casualty forms and prior approval of rates, there are greater regulatory resources to devote to the timely consideration of health insurance policy forms so that they can get into the market more quickly than perhaps in a lot of other places. So it allows for innervation.

This prior approval is really designed to see that the policy forms are meeting minimum statutory and regulatory standards so they are not unfair. They are not unfairly discriminatorily. The provisions meet all of the various standards for when a claim has to be resolved. You know, a variety of

things like that include the mandate and benefits and so forth. Apart from that, quite a bit of innovation is both permitted and to a large part encouraged, and this has created an environment in the Illinois department and has not been a partisan question of openness to change.

So where has the emphasis been? The emphasis has tended to be more on consumer protection than price regulation. So market conduct exams. The insurance department has a team that goes into insurance companies, look at the files, look at the practices to see that the underwriting is being done in accord with the company's own standards in their manuals, claims are being handled in a timely way, all that sort of thing. Again, more resources because other resources are not being spent on price regulation in my view.

The other thing is that complaint ratios are put out so that the insurance department receives complaints, a very good system for handling those complaints. The department does not try to evaluate for purposes

of the complaint ratios whether the complaint was justified. This is sort of a standard of where there is smoke there is probably fire. So the greater the proportion of complaints that come relative to the population insured, the higher the ratio that's publicized that's available on websites. Those consumers who shop or who are interested in a relatively small portion can have a bigger fact, but can look at that and figure out, you know, how the consumer who is already doing business with the company believe they are fairing.

The other area -- and this is, I think, of paramount importance is the resources that can be devoted to financial regulation. You know, insurance is a case of selling a promise. If you give me money today, I will take care of a problem that you have tomorrow. Of course, one of the essential elements of that is that I am around tomorrow and that I have the money to take care of it properly, and this is where financial regulation comes in. I think the people who have worked in the Illinois insurance department are in a position to say

really without much fear of contradiction that if we look at all of the important innovations in advances in financial regulations, solvency regulation in the insurance business for the past 30 years or so, virtually all of them have originated in Illinois and started out as an initiative or project within the Illinois insurance department and eventually spread to other states and then became matters of really being adopted by the organization of insurance commissioners who help set standards for regulation around the country. That's a very important feature of the sort of professionalism, at least I believe, that has been a hallmark of the Illinois department.

I think this is my last slide. Again, this is my opinion, but I think it comports with economic theory. So at least I don't have to get up here and tell you that I have some opinions that contradict prevailing economic theory. There are a very large number of people just in this town alone who won Nobel prizes talking about these kinds of things, and I would like to think that I am -- the views

that I have based on experience and research in the insurance business comport with these general views.

First is that Illinois if we look at our prices for various kinds of insurance coverage, including health insurance, not only is it available but it's available at a price that is favorable in relative national terms. Again, you have got to look at the underlying cost, do you live in a big city, by big teaching hospitals, you will tend to have somewhat higher, called a table, than if you might be in some other place.

Another thing is that hard markets correct quickly. By hard markets it means a lack of availability. The insurance business runs its cycles. You tend to have long periods of I'll call it overcapitalization and therefore gradual overpricing relative to the risk and then relatively short periods of shortages and of high prices, during which insurers replenish their capital base and the cycle begins over again. This is something that is really almost like a law of nature when you look at the

insurance business. It's true in a lot of other businesses as well that are capital intensive.

The other thing is that if we have price competition it's going to do a better job of accurately conveying messages about risk. Whether it's in health insurance or it is in auto insurance or fire insurance or whatever, if the price that's charged for the coverage is less than what that particular risk characteristics would suggest the price should be, you're going to have to distortions in the market. It's an economic phenomena. There will be less in the way of prevention. Those who have less risk will pay more and so forth.

Now, we often say, well, insurance is a case of sharing risks, and that's true. It's also a case of like risks sharing a risk, not necessarily of trying to put unlike or dissimilar risks into the same pot because one way or the other, the bad risks will either be sorted out or somebody will find a more efficient way of covering the better risks.

I've already talked about entering and exit risks. I think there has been a lot of

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evidence that the competitive system takes to track those who are prepared to risk their capital whether it's in health insurance or other areas.

I think again from a policy standpoint we have largely adhered to these principals that accurate pricing is better than inaccurate pricing. The competition tends to provide a better promise of accurate pricing than the price regulation does, and then in the end those accurate pricing signals provide for a more efficient and economical market for whatever type of insurance it is that we're considering.

So let me stop there and, Mr. Chairman, I don't know if you want me to respond to questions or what would you like me to do.

MR. LERNER: Yes. We have got a few minutes for questions before we break. Actually, if you could put that last slide up there for me.

The last bullet, just to start up the questioning, State policymakers have sent a

signal of politics will not distort economics of the insurance market. I can follow all the other bullets that relate to all forms of insurance, including health care until I got to the last one. Because with there being this high emphasis on public and private funding on health insurance and with some states subsidies and some states no subsidies for the uninsured and underinsured, I don't know how that one plays itself out. Can you pick up on that because our task force is directly related to that issue?

MR. O'CONNOR: That comment may -- again, if it's -- I was trying to keep within the context of health insurance. It's a state regulated health insurance. That would be the coverage provided by any company chartered as an insurer and state regulated by the State Department of Insurance. In that respect you know in 30 -- well, since the 1970's there has been very little that's been done to inject regulation of prices into that arena and a fair amount to get us out of price regulation in that arena. One of the things that I have learned,

both as a utility regulator and insurance regulator, is that you usually end up with the same overall dollar figure for regulation and competition, although probably less in competition and you spend more in regulation.

Let's assume you spend the exact same amount and that the aggregate price level that results from regulation is the same as the aggregate result level that results from competition. The same price changes are nonevents when you don't regulate it and become political events and news worthy when they are regulated. What it's about is the public decision, not the actual economic event.

I saw this most pointedly a number of years ago where it was a utility regulator. Of course, it was at the last cycle of rising energy prices, and we had a phase of a new power plan for utility that serves the northwest quadrant of the state, at the time Illinois Gas and Electric. It was about a five percent increase, and we were facing it in a power plant. It would be about three or four years with five percent increases. They would take

place automatically. The first five percent increase was both blaring headlines in the quad cities area newspapers.

A year later when the second five percent clicked in, it was literally on the open page, and that's because it was not an event that you can send the cameras and the reporters to, and I think that's a big part of it. We had this with a vengeance with Blue Cross Blue Shield rates in the late '70's, late '80's.

MR. LERNER: That's a very important clarification point. Because as you think about the models that we choose to look at, there are some subsidies that may be included and how the subsidies may or may not effect the current insurance market plays out in this regard.

We have a few minutes for some questions. Go ahead.

MS. JOHNSON: Thank you. Thank you for your presentation. It was very informative from a historical perspective. Two questions, and the second is somewhat related to the first.

I would like you to comment on the success or nonsuccess of HMO's and controlling

costs. I am a provider. I am a physician. I represent an organization of predominantly African American physicians and the patients we serve, and I don't see where HMO's have been successful in controlling cost. They control how much I receive. They control how much providers receive, other providers receive, including hospitals to the point that Northwestern and the University of Chicago don't contract with HMO's anymore, and so I would like you to comment on that.

Then the second question is somewhat related. You stated that Illinois got out of the business of regulating insurance premiums, but the insurance company's government, including State and Feds, got into the business of regulating how much providers are paid.

MR. O'CONNOR: Those are very apt questions and comments. You know, the problem with answering the first, of course, is that we don't really know what things would be absent managed care. So it's kind of a but for question.

MS. JOHNSON: Can I add a caveat to

that? We've seen those companies that have HMO products have CEO's who are making seven and eight digit compensation packets also.

MR. O'CONNOR: I missed the vote on that one, but I think your point is well taken on the question of have they been successful. I guess I really have only two responses. One would be that I'm not sure that we have the proper expectations about what managed care HMO's would or could do when we were embarking on it. That's the first thing. We may have had notions about what their purpose was that turned out to be incorrect. They may have had other purposes altogether.

And related to that is a second point, which is that I kind of go back to my central theme that the history here is one of changing market shares, and we don't really know what the results would have been if for the past 25 years or so in this state we hadn't had as a share of the market the capitation managed care phenomena in competition with another model or fee for services and so forth.

So for me the bottom line would not

be so much whether I can pinpoint cost savings or whatever that come out of HMO's but to be confident that the existence of the tension between fee for service and capitation or managed care contract payments and noncontract should be sufficient to or be expected to squeeze efficiencies out of the system because of the competition itself and that other -- that people are going to seek lower costs, more efficient ways of doing it if they don't find one to their satisfaction.

Now, that may be polyanish on my part. You don't have to nod so vigorously.

MS. JOHNSON: Because it's not happening. It hasn't happened in my opinion. I am working harder to make the same or less, and hospitals are getting out of the business of contracting with HMO's because they are getting paid less.

MR. O'CONNOR: Now, that's your second point, which is the role of insurers and others, government in particular, of setting price -- trying to preserve price control on the provider. Yes, that's true. However, you just

pointed out that there are health providers who are opting out. There are health providers who are saying I will not deal with managed care providers. I am going to charge what I charge and I will charge prices that I think meet my cost and for those who want to contract with me upfront for a price forget about it. They are opting out, and they are free to do so.

That's my point about the tendency system. If we go back, we will say if we had in 1965 imposed a single model that we were going to enforce and get everybody into, my guess is we probably would have a far less satisfying result than we have today, not that the result that we have today is completely satisfying. That's because we operate on a competitive basis that forces one person to be better than the next.

MR. LERNER: Other questions? Yes.

UNIDENTIFIED PERSON: In the line of the last bullet point Representative Mary Flowers had a hearing in the last legislation session, and it was on the notion of price regulation of insurance. Business people and individuals came

up and testified that unlike auto insurance their rates were going up even though they did not have any adverse events for the past two or three years, and they were calling for a price regulation for the State. I just was wondering why you thought that Illinois having brought consumer attention versus price regulation was a good thing when there is so much suffering as a result of that.

MR. O'CONNOR: Well, I don't know about suffering, but let's take two things I think you touched on. I will take the second one first.

25 years ago price regulation in a health insurance business was largely confined to Blue Cross Blue Shield and only to a segment of its business. That process was destroying the company. So it was the major health insurance care provider in the state. It was on the brink of insolvency, and it was largely the price regulatory process that was driving that, and I could see it because I was the regulator at the time; and the only way that I saw for that institution -- again, the largest provider in the state -- was to get out and become

financially healthy again so it could do what it was suppose to do to provide coverage could survive. I think in the end that proved to be exactly the right choice.

Let's remember what health insurance is from -- again, let's just talk only about those regulated by the state insurance department. They have capital, risk capital that they are putting up to insure policyholders against some event. They cannot survive very long if the premiums that they take in are less than what they pay out supplemented by investment income.

So given the choice between price regulation of insurers, price competition of insurers if the goal is to have health insurers prepare to risk their capital, I would take the latter because price competition in the insurance business has been pretty well demonstrated to do a very good job of tracking the at risk capital as opposed to driving it away. I would opt to attract the capital as opposed to driving it away.

The problem of a policyholder who

says my rates are going up but, you know, I haven't had a loss -- now, I can take the most extreme example of course, which is if you have life insurance, you can't say, well, as I've gotten older my premiums have gone up but I haven't died. It's kind of a ludicrous example, but the point is the risk is there that I am going to die. The risk increases as I get older, and therefore in that risk grouping justifies higher premiums.

Why would premiums go up in the health insurance business? Well, even though I may not have, you know, had a heart attack in the past several years, there is still a known risk that among, you know, 20,000 Phils there will be X number of heart attacks, and the insurer has to cover that group, not any particular individual because if it were a question of just your individual losses determining what your premiums were then we would go back to the 43 percent out-of-pocket or more figure that we had in '65 where basically you were paying out-of-pocket your own losses.

Along the line here we decided to do

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more a way of grouping people so that these events can be shared. What's really going on is this number here of going from 6 to 16 percent of GPD, you think about your own personal GPD, gross personal product, if it's gone from 6 percent to 16 percent, you're going to see that in your health insurance premiums. That's because if you want an MRI now, you go get an MRI. In 1965 it wasn't even in anybody's wildest dream that there was such a contraption. We're paying for that now. So, you know, you've got to take the good with the bad I suppose.

MR. LERNER: We are a couple of minutes into our break, and I would like to have everybody take a stretch break.

Are you going to stick around for the day?

MR. O'CONNOR: I will be here through about lunchtime.

MR. LERNER: So grab you -- I think what has been pointed out is the inner section among social policy and the values that underlie social policy and economic policy and how the models that we choose will be very complexed as

a result of that.

Thank you very much, Mr. O'Connor.

(Whereupon, a recess was taken.)

MR. LERNER: I want to thank, Mr. O'Connor, for setting a wonderful stage.

Now I would like to call Dr. Michael McRaith, Director of the Illinois Division of Insurance to the podium.

UNIDENTIFIED PERSON: (Inaudible.)

MR. LERNER: What about Mr. Bradley? Would you be willing to resituate yourself and soon as Mr. McRaith gets here we will go forth?

While you're moving to the podium, let me make an announcement that I was ask to make before. There may be some confusion about lunch. Unfortunately, the lunch will only be provided for the presenters, State agency representatives, and the Task Force members. We realize that there may be some confusion. In the spirit of price competition however, any of us who have lunch and wish to sell it --

Mr. Bragdon, we really appreciate you coming today. He is the director of Health

Reform Initiatives for the Maine Heritage Policy Center. He is going to talk to us about a plan that all of us have been reading about, the Dirigo Plan and its effect on the private insurance market in Maine. Thank you very much, Mr. Bragdon.

MR. BRAGDON: Thank you very much for having me here. My name is Tarren Bragdon. I served four years in the Maine legislature with our current governor. When he came into office he set up a health reform task force called the Health Action Team or the HAT. I was a member of that task force. So I have been following and providing analysis on the Dirigo health initiative in Maine since it began in its early stages in 2003. I write a series of reports all focus on health care and health care policy within Maine. I really appreciate the opportunity to talk to you about Maine's Dirigo health initiative.

First of all, Dirigo is Latin. It's the state motto, and it means I lead. So no one has accused Maine of modesty, I guess, but that's why it's called Dirigo Health. What I

want to talk to you about is not just tell you what Dirigo Health is, which I think it's important to understand, but also to let you know what results we have seen. One of the things that I think is all too coming a problem is people describe a program that's going on in the state but they don't talk about what the results have been, and I really want to do both for you.

First of all, Dirigo Health has three parts. I think it's really important because typically only the middle one gets a lot of attention. First of all, it had a significant Medicaid expansion. Maine has a very large Medicaid program. In fact, Maine is the state with the highest percent of its population under 65 on Medicaid. We just surpassed Tennessee. Dirigo Health has a significant Medicaid expansion that was part of it.

The second part of Dirigo Health and the one that gets the most attention is this insurance product, and it was called just to confuse Dirigo Choice. It's an insurance

product that's targeted at small businesses, as well as individuals who are purchasing insurance not through their employer.

Then thirdly Dirigo Health had a whole host of regulations on the health insurance market within Maine and then also on the health care industry within Maine, and I will gloss over those, but I know in similar proposals in Illinois you have different elements that are all part of Maine's Dirigo Health Initiative. So I want to spend a little bit of time talking about them.

One of the things -- like I said, I had the opportunity to serve four years in the Maine legislature, and I view myself now as a recovering politician, if you will; and one of the things that I try to do as a recovering politician is remind current politicians of their promises because I think it's very important. Oftentimes these initiatives come in with much fan fair and then after a year or two we don't read much about them.

So when Dirigo came in and was signed into law in June of 2003 it promised

three things. One, it was going to eliminate all 135,000 uninsured people in Maine. Just to put it in perspective, Maine has 1.3 million people. About 12 percent of our population under 65 is uninsured. Two, it was suppose to be self-supporting with no new taxes and, three, it was suppose to be stabilized rather health insurance premiums and health care costs. So if you think of Dirigo Health as an infomercial, it slices, it dices, it peels. It really promised to do everything and be a comprehensive kind of silver bullet solution that state legislatures really liked.

First, I want to talk more about the Dirigo Choice insurance product because this is probably of the most interest. I apologize for the small type on the printout in front of you, but again it's targeted at small businesses, individuals, or sole proprietors. It began -- it began being sold January 1, 2005. It requires employers to pay 60 percent of the premium for employee only coverage, but they don't have to pay any of the premium for dependent coverage.

There are two products, with either at the high end, and this will make more sense in just a moment. Either $1,250 deductible or $1,750 for deductible twice that for dependent coverage. Then it has a series of premium subsidies for those people who are earning less than 300 percent of the federal poverty limit, which is about $30,000 for an individual, 60,000 for a family of four roughly.

Another interesting feature is not only does it have premium subsidies but it has reduced deductibles and out-of-pocket maximums for people who are earning less. Because of that, it's a very complicated insurance product. As you know, typically an insurance plan has four different coverage options, employee only, employee and spouse or partner, employee and child or family coverage.

Well, Dirigo within each of those coverage levels has six different plans. So depending on how much you make, you have a different deductible, a different net premium cost, and a different sort of subsidy that's being provided to you.

To understand this you really need to look at all the different plans. I think part of the challenge with Dirigo is this really introduced a level of complexity into health insurance that wasn't there for small employers. It sort of may be good social policy, but I think it's a challenge to administer. It's a challenge for certain dynamics that sets up in the workplace, and I want to talk about that.

If you look at this chart, it's actually suppose to help you understand and not be confused. So let me explain it. The black part on the bottom is the amount that the employer must pay. This is a single person who is getting employee only coverage. The red part is how much the taxpayer is paying or how much the premium subsidy is, and the white part is the net cost to the employee. So you can see there is income levels down at the bottom. I think this is really probably too small for you to decipher on your printout, but I believe these will be posted on-line and you can look at it later should you desire.

As an employee moves up the income

scale, they pay more for a higher deductible plan. So if an employee is earning say $12,000 a year working full-time at just about minimum wage, say $13,000 a year, they are going to pay $300 a year for an insurance plan with a $250 deductible. If that employee goes to making $7 an hour, they are going to pay $600 a year for a plan that has a $500 deductible. So the more you make, the more you pay, and the higher your deductible.

What this does is it kind of sets up some dynamics within the workplace. They're apparent with this kind of coverage, but it becomes even more apparent when you start to talk about dependent coverage. As your income moves up, a very small variation in income or ECOLA, a cost of living increase, can cause you to bump into the next income category. So you can go from 650 to 675 to $7 an hour. You make roughly $500 or more a year, and you can have your net health insurance cost go from 300 to 600 and your deductible go up $250.

What's even more interesting is what this means for family coverage. It's all based

on the poverty level, which is adjusted for how many people are within your household and also rather than looking at the employee's income, it looks at household income, which sets up another dynamic.

So if you have two employees who are sitting side by side and one is married, that person's spouse income is included in their total income calculation. If you have another employee who is living with somebody, that person's income is not included in the income calculation. So you have this very odd marriage penalty in Dirigo.

The other thing is health insurance in Maine and in most other states, whether you cover one child or many children, it's the same net cost for family coverage. Well, because this is based on the poverty limit, the more children you have the higher or better coverage you can get for a reduced cost. This is what I call the Dirigo Choice fertility bonus.

If somebody has one child, they may pay more -- I'm sorry. If somebody has one child, they will pay less and have a lower

deductible than somebody who makes 10 or $15,000 more than them who has three or four children. So you can make more if you have more kids, even though the underlying insurance product that you're buying has the exact same cost.

As you can see, as you move through each income category when you start talking about dependent coverage, the white portion, which is the employee's net cost, you have these dramatic clips. So you have heard about the Medicaid clip where you are either eligible or not. Well, Dirigo has three or four different clips you can fall off of depending on the income level that you are at. Again, it's one of these ideas that make sense on paper, but when you put it into practice you can have some odd dynamics.

This is for a family of four, but as that family goes from earning $28,000 a year to making $29,000 a year, the amount they are paying out of pocket for their health insurance benefits goes from 1,800 to almost 3,600, and their deductible goes up by $500. So you set up this very odd dynamic. At the same time you

have this dynamic -- and, again, I don't think when this was designed this was really intended, but you set up this dynamic where the employees' subsidies are based on what their total portion of the premium is.

So what is the incentive for the employer? The incentive for the employer is to bottom out their level of participation and how much they pay of the employee's presume because they want to maximize the subsidy to their employee. So if you're in the second income category from the left, if my employer pays $1 more than they have to or the bare minimum for my health insurance benefit, my subsidy is reduced 80 cents. So my employee -- my employer rather pays a $1 more. I as the employee save 20 cents. So why would an employer do that? The problem with that is you set up this very perverse dynamic where you incentivise employers to pay less not pay more.

Well, how is Dirigo Choice done? Dirigo Choice went on the market in October of 2004 with coverage beginning January 1, 2005. The blue line is how many people were projected

to sign up. Now, I just again want to put this in perspective for you. Maine's small group market is about 120,000 people. Our individual insurance market is 40,000 people. We are a really small state and we have some challenges with our health insurance that I will talk about later.

To reach the goal of covering all the uninsured within five years, the projection was to sign up 31,000 people by the end of the first year, last December, and by a year from now, July, 2007, to have almost 60,000 people signed up. Well, Dirigo Choice, I think, is probably the only item in the Maine budget that's under projection.

The red line is how many people have actually bought Dirigo Choice. At the end of last year just under 7500 had bought Dirigo Choice. Now that number is just over 9,000, but an even more interesting dynamic is the green line, which is a flattening line and in fact reducing. That's the number of covered lives for small businesses. So the number of covered lives for small businesses that provide this

product to their employees is actually reducing. It was 3,700 at the end of last year. Now it's gone down by about 100.

So what's happening? Dirigo Choice that was targeted as an affordable benefit for small employers instead has turned into a subsidized product in the individual insurance market. Why is that important to understand? Because Maine's individual insurance market is very costly. Maine has guaranteed issue in its individual insurance market. We are one of just a handful of states that does that. We also have a modified community rating. So regardless of how old or how sick you are, essentially you pay almost the same premium. So what does that mean?

Well, I actually buy my insurance in the individual market. I am part of 40,000 people, like I said, in Maine who do. Before we put these regulations in we had $90,000 people who bought insurance in the individual market. That was in 1993. We now have 40,000. My wife and I -- we don't have any kids. It's just my wife and I. We pay $400 a month for a $10,000

deductible policy. So we're both healthy. We have no pre-existing conditions. That's the only product available to us that's affordable. Anything with a lower deductible we pay more in premium than we buy down in the deductible. So we're paying almost $5,000 a year for a health benefit that we really probably have a three or four percent chance of using in any one year.

So what are people doing? Essentially in Maine we have set up this kind of mean choice for people where you have either costly private insurance or you have this taxpayer subsidized lower deductible private Dirigo Choice public private health insurance. So really if you want a deductible below $5,000 per person, your only affordable option is Dirigo Choice.

In a way rather than Maine taking a look at its individual insurance market and seeing how they could regulate that more affordably, what they did is just subsidized sort of an overregulated, expensive insurance market. In fact, if I moved next door to New Hampshire I could buy a plan because I have

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priced this out -- I can buy a plan that has a $1,500 deductible for $120 a month. So you can see it sets up this very perverse incentive when you make the individual insurance market, which is sort of your private health insurance safety net, the market when you make it too expensive.

Well, how many people who are uninsured are actually buying Dirigo Choice? The state did a survey and determined that 22 percent of people who bought this insurance product were uninsured at the time they bought it. Typically what state programs do is they target their products for the uninsured to the uninsured, but Dirigo Choice doesn't require that you be uninsured to buy it. So the vast majority of people switched from private insurance to subsidized private insurance.

Why would they do that? Well, it's in their economic best interest to do this. If there is no prevention of that, then you're going to have kind of that crowd out where people can buy a subsidized product where before they were paying whatever they were paying so that this Dirigo Choice product has not proven

attractive to the people that it was targeted to, the uninsured.

In fact, if you look at Dirigo Choice's impact on the uninsured, we had 135,000 of them. After the first year we have reached just over one percent of them. I think this is something really to consider. If you're going to target the uninsured, you need to make sure that people are actually uninsured who are signing up.

Well, how is Dirigo Choice funded? Glad you asked. It's funded to keep with the no new taxes pledge of our governor. They came up with this very elaborate scheme that really only a politician could love, so I think it's great. Just kidding, but what they did is they said we are not going to do a straight premium tax. Maine already has a two percent premium tax on all non-HMO insurance products. Instead, we are going to calculate how much this new state program has saved this state and then we are going to tax you based on those savings. So we are going to -- the state regulation is going to save you money and then we are going to tax you

to recoup that savings to fund this program. So whether we have this program or not, in theory you will be paying no more because we saved you money by having this program and now we are going to recoup those savings. Those savings are capped at no more than four percent of premiums.

I already told you how poor the sales record in the first year and also how few uninsured people actually bought the product. The challenge is how do you calculate savings when you're not reaching your target audience. Well, you start calculating savings in other ways.

Dirigo Help Initiative had a voluntary price cap on hospitals that they would increase cost by no more than three percent. Maine has 39 hospitals. They are all nonprofit hospitals. We have no for profit hospitals, and they would say they worked really hard and they stayed under this cap. The state said, well, we projected you would have increased cost at more than three percent. Since you only raised cost three percent, we projected that this new

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voluntary cap saved the state -- saved everyone within the state 34 million dollars.

Well, this kind of clever math leaves out a very important fact that in this exact same year the state cut Medicaid payments to hospitals by 60 million dollars, but when you only sort of do the kind of math you want to do you can come up with these savings.

The other interesting thing is they looked at how much did we save in charity care, and this I think gets a lot of attention when we start talking about the uninsured, but I think in many ways it can be a real red herring. Maine has about 190 million dollars in charity care and bad debt. There was a lot of conversation when Dirigo Help came in that this is money we all are paying. We can just better design the health care system if we can save this money, reinvest it, and provide care to the uninsured.

Well, the uninsured aren't buying this product and also subsequently if you look at studies you realize that only about half of all charity care and bad debt are for people who

are chronically uninsured. So since the uninsured weren't buying this product and the -- there weren't significant bad debt and charity care cost, the state determined that bad debt and charity care still grew but it grew less than what they thought it would grow. So they projected they saved $3,000,000 and reduced bad debt and charity care cost.

Why is that important? Because we spent 27 million dollars on the program in premium subsidies to save 2.7 million dollars. So, again, if you look at our return on investment, it's about negative 90 percent.

My favorite category of savings though is the third one. I'm sorry to give you all this information, but I think you may hear that Dirigo Choice has saved the state money, and I think you need to look at sort of math is all in the eye of the beholder.

The last category is the state said we haven't raised physician Medicaid reimbursement in 20 years, so they raised it. Then Maine has for every dollar of Medicaid cost the taxpayer finances a third of that. So the

Medicaid budget went up to about $7,000,000 to fund this increase for physicians.

Well, the state when they calculated the savings said we increased Medicaid patients to the physicians for the first time in 20 years. Therefore, we saved all of you money. Therefore, we are going to count that as savings. So the taxpayers paid for that once in the Medicaid budget, and now we count it as savings, and they paid for it again in this Dirigo Choice savings offset payment.

What is even more interesting is all of these other regulations that the state determined saved no money. We had expanded the certificate of need now in Maine. We are one of the only states that cover certificate of needs out to the individual physician's office. We have a state health plan because the idea was if we better planned health care resources, we could maybe, you know, spend money more wisely.

We now have a capital investment fund where the state arbitrarily decides how much money they will approve and certificate of need proposals. That's set at $6,000,000 a

year. So the state will approve no more capital investments in Maine's health care system if it adds more in the aggregate $6,000,000 in costs, and they calculate that based on third year operating costs.

What's scary to me is the impact of some of these measures 10, 15 years down the line when you make a very poor world state even more unattractive to physicians because they have to get approval to set up an office or an ambulatory surgical suite. What does that do to the quality of care over time? And when you limit investments in equipment and other kinds of technologies, what does that do over time?

Well, let's look at Dirigo Choice by the numbers. In the first year the state spent about $4,200 -- I'm sorry. The cost of each person with Dirigo Choice was about $4,200. The part paid by the employer and the employee was just over half that. The taxpayer subsidized the other half of that. So for each person who bought Dirigo Choice, it cost the Maine taxpayer almost $1,900 per person per year.

Well, since there was no target to

the uninsured, when you look at the marginal cost for each uninsured person reached, you will see that's over $8,000. Again, this is all state money. We don't have any magic federal money coming in for this particular program. It's a very expensive program. It's not reaching its target group.

At its current burn rate, if you will, it will take Dirigo 81 years, not 5 to reach all the uninsured, and it will cost more than 1.1 billion dollars, which just to put it in perspective is more -- is about the same of our total income tax collection in Maine.

Unfortunately, I think for a lot of people who were excited about Dirigo, Dirigo has become almost this cult where people think if they believe hard enough it will work. What's tragic about that is that that kind of bunker mentality doesn't cause people to step back and say how can we redesign this to make it more effective. Instead, it just says let's keep doing this because maybe it will start working.

So we have arguments in Maine now on maybe changing Dirigo Choice from being fully

insured to having the state self-insure, self-administrate, which again doesn't fundamentally change the structure of the program or a product that people just aren't buying.

So what are the lessons learned? What unsolicited advice -- I guess I should say solicited because you asked me to come here -- would you give to people in Illinois who are looking at this? I think there are many lessons learned from the Dirigo health experiment in Maine. You know, I think when you looked back to 2004 and 2005, Dirigo Health was very much sort of the flavor of the year health insurance reform effort. It got a lot of attention nationally. People were looking at it closely.

Now when I read news stories about it I see where it's like disappointing, more expensive, but unfortunately it seems like -- and, again, because we are going into an election year, sort of all bets are off. It seems like there is less interest in reforming this and making it more effective and learning from the Dirigo health experiment and more

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interest in just sort of believing that the current system will work if we just give it enough time.

What were the big lessons learned? One I think is health individuals directly don't help certain insurance plans purchased by individuals working for certain businesses. I think there is this idea in Maine and in other states that all the uninsured look exactly the same. So if I as a removed bureaucrat or politician can design an insurance product in my own mind that I think would be attractive to them, they will buy it, but instead they are all very different; and what is attractive to me right now is not attractive to me maybe when I have children, when I got older, when I am near retirement. People, just like insurance products, are very dynamic.

The other thing is I think in some ways Maine thought that all the uninsured work at one small business and if we can just convince that small business to start offering health insurance we will get people to sign up. I think now we are realizing that they just

don't work for companies that don't offer insurance, they work for big companies, for small companies. They are very dynamic. Maybe they are changing jobs or at that moment in time they don't have access to a health insurance benefit. It's a very dynamic population. You can't have this silver bullet one size fits all approach.

The other thing is getting a business to move from not providing health insurance to providing health insurance is a big change, and you don't get a business to do that by requiring that they pay $2,200 for every employee that they now provide insurance to. If you're going to have somebody go from zero to some number, you can't make that number a significant part of their payroll or it's just not financially possible for them to start providing health insurance benefits. So I think you have to be reasonable. Again, you can be reasonable if you target to businesses that don't provide a health insurance benefit. Don't make it complex and difficult to administer. If it takes me five paragraphs to explain how this

plan works, that's a problem.

The other thing that I think was very intriguing is that even with very generous premium subsidies, we learn that premiums do really matter. In fact, given the very generous premium subsidies, 85 percent of all people choose the higher deductible option, and this was surprising to me. I think we have this notion that people want comprehensive coverages, but what we don't think about is the cost benefit that people go through in their own individual budgets even with a highly subsidized plan on what they can afford, what they will use, and how much they are willing to pay for it.

I think the last point is really a critical one. Don't fund a program to reach the uninsured by punishing everyone who buys private health insurance. Dirigo Choice this year is targeted to reach 10,000 people. The new tax will effect up to 760,000 people. So you're taxing 760,000 people to reach 10,000 people, and out of that 760,000 almost a quarter of a million, 260,000 of them earn less than the

maximum income eligibility for Dirigo Choice.

So you have people who will be paying taxes to provide subsidies to individuals who are making more than they do but who simply buy a particular insurance product. So I think you need to look at that kind of equity as well.

I'm happy to answer questions.

MR. LERNER: What a great presentation. Thank you very much.

We have time for a couple of questions. Ken.

MR. SMITHMIER: To the degree that you are familiar with it, you haven't commented on the plan recently passed in Massachusetts and how you think it compares for better or worse with your lessons learned in Maine.

MR. BRAGDON: Well, I think a couple of different things. One, Massachusetts has some similar challenges in Maine on how it regulates insurance on the individual market, and some of those regulations weren't really addressed in the Massachusetts plan, so I think that's a challenge that they are going to have.

Massachusetts as part of its plan,

as most people know, mandates that people buy health insurance. I think it's 40 percent of the uninsured in Massachusetts earn more than 300 percent of the poverty level. That's not true of most states. So whereas that mandate approach may or may not be attractive in Massachusetts, I think it will be even more unattractive in other states, particularly in a state like Maine. If you mandate that somebody buy health insurance but you regulated it in a way that it's so expensive, that's not helpful. That's really just mean. You're mandating that they buy something that you know they can't afford.

What's good about what Massachusetts did is they do have premium assistance or premium subsidies that are tied to individuals where they work. So individuals can buy into their employer's plan. You can maximize employer dollar without just choosing one particular plan from the statement. I think that's important because when you take the approach of Dirigo Health, you will say we will help if you buy this one plan. We won't help

you if you do anything else. That's not helpful because small businesses may already have a health insurance product but they have uninsured people working for them with little financial help that can buy into that plan. I think Massachusetts did that. That's a more beneficial approach.

MR. LERNER: One more question.

UNIDENTIFIED PERSON: I can't resist why you decided not to change anything about the employer based insurance. The percent of employer based insurance keeps going down every year, and it's just a wonderful experiment. Maine is small enough to do away with the idea perhaps, perhaps not with employer based insurance. Can you address that? Did you not address that issue or --

MR. BRADGON: There was actually a whole single payers study a couple of years before this in Maine, but the cost of moving to that system was politically unpalpable at that time even by people who wanted to go to that.

Maine already, we have the highest state and local income tax burden in the

country. Our top income tax bracket is 8 and a half percent. It kicks in after you earn 17,000 a year. So we have the highest property taxes in the country per capita. I think that given that -- we have the 39th in income. Given that there is not a lot of wiggle room for people to pay more even if they are looking at getting something that they kind of pay for directly now, they will start paying indirectly for it through increased taxes and then sort of a single payer health care system. So I think that was looked at, but it was just not politically palpable for people who already sort of feel like they are paying as much as they can to the state and to their towns.

What I think should have been looked at even more is how can we in Maine do a better job. You know, when I give these talks, I remind people that Dirigo again is Latin and it means I will lead. Well, there is another Latin word disco, and it means I learn. So I think not to be tickey, I think Maine needs less Dirigo and more disco. We need to learn from states who do a better job than we do and copy

what they are doing.

47 states have a higher percent of their low income people buying private health insurance. Why is that true and how can we learn from how they regulate private health insurance to make private health insurance an affordable option for people in Maine, not just have a social program or sort of an outreach private health insurance? I think that whole introspection and that analysis hasn't been done in Maine yet, which is unfortunate.

MR. LERNER: I want to thank you for your presentation. If I had time, one of the things that I would be very interested in other than the public, private issue is if it's complex to administer and understand for the professionals, I can't imagine what the general public goes through. So whatever we talk about as a model has to be something that's easily understandable to everybody. Thank you very much.

Michael McRaith is the Director of the Illinois Division of Insurance, and he will discuss some of the health insurance issues here

in Illinois, which will take us right up to lunchtime.

MR. MCRAITH: Good morning. I don't have a power point. I work for the State. We don't have these resources at our fingertips.

Is Joe Roberts here?

MR. ROBERTS: I am.

MR. MCRAITH: I met Joe by telephone about two weeks ago, and he called and asked me to call him and was very concerned about what I was going to say and how long I was going to talk. Joe, I am pleased to report I have condensed my comments. It shouldn't take more than 45 minutes.

As an initial matter I want to recognize and thank each of you serving on the Task Force and those of you who have participated so extensively on the Task Force traveling around the state. You have spent time and energy in public service and devoted your creative and constructive efforts to address this vast, enormous public policy issue. For some of you this has taken you away from your revenue generating and your bill paying

professions, and your commitment to this process is one for which I personally thank you and I commend you.

Needless to say, all of you know that health care delivery and health care insurance simply are our single biggest domestic issue as a nation, not five years from now, not in some abstract innocuous sense, but today health care delivery and insurance is the biggest issue we confront.

At the NEIC with Superintendent Iupa from Maine issues of health care and health care insurance consistently dominate the discussions that I have with other lead insurance regulators. As with most of our national policy decisions, economics will be the driving force behind any change in our current system. When do most American begin to feel in their pockets the increased premiums for fewer benefits? At what point will deductibles be so high that too many working Americans simply assume too much personal, financial risk? Joe asked me not to get into statistics. He said you guys have heard about those at nauseam, but let me just

point out a couple that I think is interesting, if not important to note.

In 1987 health care costs for the average American family were 7.7 percent of the annual household income. By 2004 that percentage increased to 18 percent. Today health care costs amount to 16.2 percent of our gross domestic product. Within the next 5 to 10 years, as most of you know, that will increase to 20 percent. By comparison the manufacturing sector of our economy currently totals 20 percent of the USGP. The Cook County Hospital emergency room receives approximately 150,000 visits per year, and if my calculator is correct that's more than 410 visits per day to the Cook County Hospital emergency room.

So our priority must be the shared priority provided in the greatest -- providing the best health care for the greatest number of people, and how we do this in five years, as I said, may be worlds away from how we did it now.

The delivery systems must prove beyond true. We cannot have so many Americans introduced to health care through an emergency

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room. The recent changes in bankruptcy laws, changes that make personal bankruptcy more difficult and ironically more expensive for the individual will directly impact health care insurance providers.

In the second week of October of 2005, one week proceeding the enactment of the so-called bankruptcy reform, in Illinois alone more than 10,000 individuals filed for personal bankruptcy. The line stretched around the block at the Dirksen building. In most reports -- although some dispute this, but most reports that I've seen estimate that between 60 to 65 percent of those public bankruptcies were the result of medical expenses.

So while many attempt or desire to place health care and economics into different political different silos for political reasons, that desire will soon face -- ultimately face an unsettling reality, and I am encouraging -- I encourage you as a Task Force to accept -- not to accept that insurance is in a silo that is separate from the underlying cost of health care.

In the wake of the recent pension fiascoes, the pension burdens that some of our major corporations confront, fewer and fewer employers will offer post retirement health care insurance. Some estimate that that will impose an additional burden of approximately $200,000 per individual in some cases.

So while the discussion and analysis continues nationally, many have presented arguments that return us to the nonproductive and what I consider divisive plea for tort reform. I am not going to burden you with a long story, but I know at least one of our attendees today, one of our Task Force members was present when I attended a meeting of the NEIC at the quarterly meeting that was held in our fair city in early December. I sat in on a health insurance committee meeting.

Around the top and sides of the U shape table, not entirely dissimilar from the way you guys are sitting today, were some of the U.S. -- the countries leading insurance regulators and some of the greatest health insurance regulatory minds in the country, and I

don't include myself in that; but I did opt to sit in because I wanted to learn more about this issue, and the executive director had a very well regard and well respected and well informed executive from D.C. to present what was to me a very informative presentation about the very pie slices of health care cost. It was very interesting and very helpful and informative to me, but unfortunately she made a comment about tort reform in her presentation, and that brought us to the inevitable downward spiral about whether trial lawyers and verdicts cause the demise of our health care system in our generating the health care cost that appears in some ways to be out of control.

The increase cost of medical malpractice insurance around the country is not a cause for increased health care costs in general. While I won't bore you with the details, I will simply say that the percentage increase in verdicts and settlement has been exceeded significantly by the increased premium costs for doctors.

So as an industry -- as an insurance

industry, as a state and country if we don't focus on constructive resolutions of the health care issues, then we will see more and more Americans with less and less access to quality health care.

Along these lines Senators Engi and Nelson are sponsoring and have introduced the Health Insurance Marketplace Modernization and Affordability Act of 2006, otherwise known as HEMA. I understand that this bill will be discussed on the Senate floor shortly after the Senators return from their current recess.

While that effort should be commended, HEMA as presently drafted will eliminate State mandates, eliminate community rating bands, and preempt State based consumer protections, including solvency and market conduct.

Senators Engi and Nelson informed the other insurance commissioners and I by video conference that there would be health care legislation coming out of Congress this summer. We are hopeful it's not HEMA. For small group health plans in Illinois, as you know, has

adopted rating bands consistent with the NEIC prescribed regulations and therefore has a modified somewhat derivative form of regulations for insurance offered to small groups. Some states have community rating bands, which is the practice, of course, of implementing rating bands based on the region or the insured's industry. It sounds like Maine has a modified rating band practice.

With HEMA states such as these would lose the opportunity to legislate whether to have community rating bands. If the state presently has community rating bands, under HEMA those states would lose the authority to determine the scope of those bands independently of the federal guidelines.

As we know, the purpose and function of rating bands is to spread risk among those within certain communities or within certain industries, driving cost ability, eliminating the desk file for some small group plans.

For state legislative health coverage and mandates HEMA will allow a quote, eligible insurer, an insurer determined to be

eligible by the federal government to offer in any state a basic strip down health care policy. The only requirement is that the eligible insurer also offer a policy to employers that includes the mandated benefits of an employee program for one of the five most popular states.

It is noteworthy that the legislation in its current form allows an eligible insurer to sell in any state regardless of whether certified, licensed, or authorized by that state, but HEMA does not identify who will regulate that insurer for solvency for market conduct.

Also, much to my personal chagrin, the statute amazingly, explicitly authorized lawsuits against state insurance regulators. In my entire life as an attorney in private practice, I use to appreciate the prospects of a good lawsuit, but it's rather sombering now to read that U.S. Senators wants to explicitly authorize eligible insurers to sue a state regulator, including providing those insurers with a right to expedite and review in the

federal courts of appeals.

I am not sure whether the health insurance industry supports this bill, but it seems to me that the bill invites competition from nonconventional insurers to enroll, as quote, federally eligible insurers, perhaps opening the market place to the insurance world equivalent to Sam's Club or Target. This is a real prospect, a real possibility if this legislation was to be passed.

How this bill was revised in light of Massachusetts' Governor Rami's recent signing of that state's health insurance reform remains unclear. The Massachusetts initiative creatively attempts to insure that every Massachusetts resident has health insurance and mandates that every resident has some form of health insurance. I expect that you have seen and read articles regarding this initiative. I thought I would offer a few facets comparing Illinois and Massachusetts. Needless to say, the double is in the details on these things. I have not seen the details and don't believe they are worked out yet, but the bill was passed and

signed.

Illinois is the fifth most popular state with 12.7 million residents. Massachusetts is the 13th most popular state with approximately 6.4 million. In Illinois approximately 16 percent of the population is uninsured or approximately 1.8 million residents and in Massachusetts 12.3 percent of the population is uninsured or approximately less than Illinois. I mistyped that number. Forgive me much. The national per state average is 17.6 percent of the population is uninsured, as I think you know.

Illinois has 58 companies offering individual policies. Massachusetts has 16. Illinois has 50 companies offering small group policies. Massachusetts has 25. Illinois has 76 companies offering large group policies, and Massachusetts has 28, which unlike Illinois that total includes those policies offering student accident and sickness claims. Illinois has 27 companies offering HMO products, and Massachusetts has 10. In Illinois for a 29 year old nonsmoking male living in the City of

Chicago purchasing a PPO with a $1,000 deductible and standard benefits, the cost is $133.12 per month. For that same life and the same coverage in Boston the cost is $282.14 per month.

Massachusetts does not approve group rates but must follow the statutorily defined methodology for establishing small group rates. Massachusetts does review and preapprove nongroup rates annually and the carrier cannot offer a rate more than 10 percent higher than the average rate.

A few comments on the initiative. The mandate will not be enforced until what will be known as the Commonwealth health insurance connector or Chick or Chick determines that the plans that are offered are in fact affordable.

The plan combines several components for which different constituents are defined. There are tax incentives so that businesses with fewer than 50 employees will be allowed to buy insurance with pretaxed dollars, and not to be cynical but I wonder how many companies with 80 employees are now going to split into two

separate related corporations.

The plan incentivises insurers to offer low cost stripped down insurance plans for the unemployed but the young and the -- for the employed but young and invincible, a sliding scale of subsidies for individuals with incomes at or below 300 percent of the federal poverty guidelines and expands Medicaid availability for children and imposes individual penalties upon individuals who ignore the mandate. These individuals will lose their personal exemption on their state income taxes.

As has been publicized, Massachusetts Governor Rami struck the provision of the bill that imposed a $295 per employee penalty on employers with 11 or more employees who do not offer health insurance to those employees. As all of us know, even at $295 that penalty would not have covered the cost of the program for most employees.

Once fully implemented in it's present form current conservative estimates are that the program will cost 1.2 billion dollars for three years. Nevertheless, these two recent

legislative initiatives with Congress, with HEMA, and the Massachusetts initiative indicates a direction for the country that should not surprise us. The end result will be -- will not be at one end of the partisan political spectrum or the other. The end result will likely be the creative and constructive collaboration in the public and private sectors.

In Illinois the Governor's All Kids insurance program will begin enrollment in the next few months. All Kids will provide affordable health insurance for the estimated quarter of a million uninsured children in the state. It's designed to provide insurance for children from working or middle class families who are caught in that gap between public program thresholds and other affordable private insurance.

Premium payments will be based on income only and will not factor in pre-existing conditions. This allows for children to receive regular exam, check-ups, and receive treatment before becoming hospitalized for what might have been a preventable disease.

As you well know, over 40 percent of the hospital costs for uninsureds are passed on as higher premiums for people with insurance. So the All Kids program has an additional benefit for saving the cost of expense of treatments for uninsured children. Health insurance helps children learn. Uninsured children are 25 percent more likely to miss school. The studies have shown that the school performance with children enrolled in health care improved by 68 percent and their reading scores more than doubled.

As with many other programs throughout the U.S., all Kids intends to introduce children to health care through a venue other than a hospital emergency room. All Kids is a bold, unprecedented, and in some places an unwelcomed step for a state as large and diverse as Illinois, but it reflects a willingness to address the real issues of health care delivery and insurance.

Some interested parties expressed concerned about the program and whether it signals a trend towards a single payer system.

It is clear that the uninsured children of Illinois will benefit. It's hard to argue that health insurance does not make a positive difference because if that were true, we wouldn't be here. Just as headstart and early preschool programs have an impact on a child's academic performance, so too can early health insurance have a positive impact on a child's well being.

As a country needless to say, we need to improve the quality, affordability, and accessibility of health care. As an industry -- as insurance industry participants though we cannot accept that insurance is the sole cause of the increased cost. We must continue to actively learn about and understand the cost of defensive medicine, the value of nutritional counseling, and wellness care for children and young adults.

Many of you, I am sure, have read the interesting articles and those of you who are the medical professionals know far better than me but read articles about the value of dental care, for example, and how effective

regular dental care can reduce other health care costs. In this way insurance functions as the metaphor for currency, in my opinion, that can bring health care professionals and insurance to a place of personal responsibility and awareness. Insurance provides a ticket through which meaningful health care can be delivered, but in and of itself insurance obviously does not deliver the care. It doesn't prescribe the drugs or deliver the physical therapy.

As an industry though insurers and agents can collaborate with other sectors of the health care economy with hospitals, physicians, and insurance consumer groups and public agencies to collectively lead this country and lead this state as we are doing.

If nothing else, regardless of what we think about or how we evaluate the merits of the Massachusetts program, that effort demonstrates that people from different political and policy perspectives can work together to remedy that which is not presently working.

Indeed, Governor Rami is a

Republican, and Massachusetts is a famously Democratic state in many parts. At some point as a country though that bill and HEMA and the others need to integrate the underlying costs of health care. Those costs more than any other factor increases the roles of the uninsured and the underinsured. Insurance companies are a comfortable target, but insurance companies are not driving double digit health care cost increases.

As we examine private market solutions to the health care and health care insurance challenge, we are of necessity excluding a significant percentage of the insurance programs that are governed by the existing dictates of the federal government through ARISA.

So as the Task Force moves forward, I again commend you for your commitment to service, but I also urge you not to shy away from discussing the true underlying cost drivers that force many individuals in small businesses off of the roads of the insured.

As the Task Force enters the latest

stages of its endeavor and begins to prepare its much anticipated report, I urge each of you to question to what extent the insurance should be the focus of health care reform. Access to quality and affordable health care requires a comprehensive examination of the whole health care equation, the increasing costs of prescription drugs, for example, or the cost savings that I mentioned earlier for the entire health care system if more people have preventive care, wellness care, and counseling.

Finally, the Illinois Comprehensive Health Insurance Program, the CHIP program, offers a tremendous option and benefit to those Illinois residents who are not Medicaid eligible but who are or have been profoundly ill. Not every state has a high risk pool. For example, Massachusetts is known as a guaranteed issue state. Every applicant for health insurance must be given a price quote within the constraints of that state's rate regulation. States like Wisconsin and Minnesota have tens of thousands of enrollees in those high risk areas.

In this regard as an insurance regulator, I am hopeful that the Task Force will provide insight into whether the Illinois health insurance market should be regulated differently or better and whether some of the best practices in other states lead to regulatory systems or environments more conducive to accessible and affordable health care insurance.

While we may not always agree on the conclusion, I can assure you that we are open. The Division of Insurance is open to hear and learn from you from the diverse perspectives that you offer and to ultimately assist the Task Force, assisting in implementing the conclusions of the Task Force.

Thank you very much.

MR. LERNER: Before we break now for the very highly priced lunches, are there any question for Mr. McRaith?

MS. DAVIS: I asked this question to our lead speaker this morning. Mary Flowers -- Mary Flowers just had a hearing, and her conclusion of the testimony is that the health insurance industry is increasing expeditiously greater

than auto insurance without a recognition of loss. Businesses and individuals are saying that their insurance have jumped even 300 percent, but there is no basis that they can determine for this great increase. The previous speaker talked about Illinois opting out of price regulation. What is your thoughts as you have indicated that you would be amenable to discussions regarding this?

MR. MCRAITH: As I mentioned, we are -- I am particularly interested in learning about the best practices in other states, and by that I mean those practices that lead to real results, real benefits for residents, for those people who need to purchase insurance.

The subject of great regulation is a subject I could talk about for the rest of the day, but suffice it to say I have not seen either empirically or anecdotally any evidence that rate regulation, meaning approving the rate before it's charged to a consumer, has any benefit to the consumer, as I could recite stories about Massachusetts and its automobile insurance market or New Jersey and its

automobile insurance market, as well as other stories, and I am happy to have that conversation with you at your convenience.

MR. LERNER: I want to thank our morning speakers. They have done a great job of establishing the accommodations. We are now going to adjourn for lunch. We will be called back to order at 12:30. Thank you very much.

(Whereupon, a recess was taken.)

MR. LERNER: Our first speaker is Mr. Ron Bachman, who is with the Center for Health Transformation. He will be speaking to us on consumerism in health care.

Mr. Bachman, thank you very much for being here.

MR. BACHMAN: Thank you.

I am going to try to step out in front so I can get a little closer to some of the folks. When questions start, I may back up a little behind the podium. There is a lot of material to cover. I think I have a handout. I know I have the slides. I have a bigger version of the slides and some of the details. We are

not going to be able to go through all of those slides. I thought it would be helpful for the Task Force to have the information there, and maybe some of my comments would give some background on the slides we don't go over today. It will probably make a little sense.

I want to start off by asking you to get yourself into a little bit of a different frame of mind because I want to take you outside of your comfort zone. I want to put some thoughts in your head about where health care might be going. As we talk about it, I want you to try to have an attitude that is what I would call a yes if attitude as opposed to a no because.

A no because attitude shuts down the discussion. That won't work because. We can all think of those things any time we are talking about something new. It cuts down the creative juices about solving the problem because you have a predetermined attitude that is not going to work.

If you take a yes if attitude, you might have some concerns about an approach or a

model but you start to think about if that's a concern how do I solve it. It's a fundamental difference I would really ask you to take as a mindset as we walk through this. I am going to tell you about some things and share with you where I see the future of health care is going that might not be a natural feeling for you.

So with that sort of a beginning, what you're talking about is whatever recommendations the Task Force comes up with. It's about change. As an actuality I like formulas. Here is a formula I stoled from a Columbia professor. I forgot the name, so I apologize to whoever it is that actually developed this. I think it's a nice little formula to keep in mind and it kind of frames where we are.

In order to change, three things have to be in alignment. You have to have a desire to change, and clearly with health care striving with a national debate is the heightened desire for change, whether it's at a state level or federal level, employer level, Medicaid cost, Medicare cost, whatever. I think

we have reached the threshold where there is a growing acceptance that we need to change, but if you don't have a common vision people can tell you processes, here is how you get there, and then you make a lot of expensive false starts and you don't integrate with each other in a common sort of strategy.

So what I'm going to try to do is paint a vision, that missing link. If we have a common vision, which is what I think the Task Force may ultimately be struggling with, how do you get together all these different presentations to a common vision? But when you reach some sort of a consensus or a common vision, then can you actually move forward? Until then there is a lot of frustration, a lot of political debate, and maybe even a lot of expensive false starts with people trying different things without really understanding where the market is going and what the dynamics might be.

Another dimension I will touch on briefly -- I am not going to go through a lot of the problems. You have heard some of the

problems. You all know the problems. I want to try to get to the solution. The rapid nature -- I want to get to some of the proposed solutions of where I see the marketplace going. I don't want to diminish the problems, so I am going to touch on a couple of the problems that I think are major issues but rapidly get the solutions.

One of the real issues I think you have to face at the beginning and as I talk about health care reform is it's really who you trust. People have different attitudes about where we might ought to go based upon who do you trust or maybe who do you distrust, and the two sort of extremes are the governmental solution or private sector solution.

So if you trust the government more than the private sector, you tend to think that maybe these are extremes, but I am trying to paint the picture with a stereo type. You have got a bunch of greedy health care companies. You tend to trust the government more because you distrust the market place. So there is a natural advocacy toward government controlled solutions or whether they are a single payer or

its the family Medicare system or government Canadian style systems. It really goes back to who do you really trust I think.

If you trust the market place, you might think of government in terms of as a great inhibition, it's politically motivated, lobbyists are going to be demanding things with all these regulations. So you distrust government and the ways that comes from that program and you tend to trust the competitive marketplace. So the solution comes up of individual ownership, personal responsibility, lower taxes, and tax credits.

Now, whichever side of that you may be on today, what I'm asking you to do is sort of step back from that a little bit and open yourself up to some other ideas. The charge that I was actually given is to sort of present to you the private sector solutions. So if your natural inclination is to think more of the trust of the government and the profit orientation of greedy insurance companies is part of the problem and the regulations will overcome that, I am asking you to step back and

think about some of the things we will throw out with a yes if attitude.

I am going to skip through these, but what we also are going to talk about is not just health care change or insurance change or private sector change that delivers care in the same system we have today. The system is really what I refer to as a 21st century intelligent health system. We don't have an intelligent health system today. This outlines some of the conditions of what an intelligent health system is. It's basically a more transparent marketplace with more choices, more information, and more knowledge on the individual side.

Some more definitions of what a health care consumer would be, and I want to talk about that as the real core here is the health care consumers. Why are we able to talk about this new concept? You read everyday -- and I am sure you keep coming across consumer driven health care listings. What happened to allow us to even have that discussion? Does anyone know the magic date when all of this actually started? June 26, 2002, less than four

years ago.

What happened on June 26, 2002? On June 26, 2002, the Internal Revenue Service created out of whole cloth an entirely new approach to health care, which is now gaining ahold. They created something called a health reimbursement arrangement called HRA. Prior to June 26, 2002 the type of account that would allow you to have ownership that would accumulate from year to year was illegal. Many of you are familiar with it. You have in your own health programs FSA, flexible spending account.

What's the problem with flexible spending accounts? Use it or lose it. What a dumb thing to have. The government designed program says that when you get to this you better use it or lose it. So you increase utilization when we are trying to decrease utilization. You go out and buy unnecessary things like eyeglasses. That's kind of dumb. That's an IRS interpretation of the law. There is no law that requires you to use it or lose it. That's how powerful IRS interpretations

are.

Well, I worked very close with the White House with the intrigue of my political connections and the involvement I had with the development of the health reimbursement arrangements. For 20 years the IRS help -- Sections 105 and 106 of the IRS code could not be interpreted to allow for this accumulation. They wouldn't even do a private letter ruling. They just said we are not going to rule on it at all. So we didn't have this ability to accumulate.

On June 26, 2002 the IRS reinterpreted or interpreted for the first time and said you can accumulate funds now from year to year, and if they are not used you don't have to lose them. It dramatically changed health care because insurance ought to have three pieces to it, and we only had two prior to it.

The three pieces are the first piece is the budgeting process. You pay your monthly premiums rather than annual premiums. The second piece is risk sharing. I am sick this year. You help pay for me. You're sick next

year, so I pay for you. You have a risk sharing process. What we never had in health care before was an ability to accumulate savings. You have that life insurance. You have that universal life or cash value life insurance policies, but we never could accumulate savings on health before. We can now. That's a new tool that we never had available until June 26, 2002.

We now actually have two different accounts available. We have something called the health savings account, which is part of the Modernization Act, which has nothing to do with the Medicare population. It's one of those things in Washington where you attach a piece of legislation to something else that's going to pass in order to get it through.

So we now have something called a health savings account. It sounds a lot like the health predestined arrangement. They are very different. One has no law behind it. It was purely a regulatory reinterpretation. It was enormously flexible. I will give you some indication of how flexible it is and how it

might be used.

We have another piece of legislation that has very specific requirements to tap into a great and wonderful tax advantage. HSH has a triple tax advantage, not taxed on the front end, not taxed when you use it, not taxed on the back end. You go to cash it out after you retire or use it for health care expenses. There is no other tax advantage vehicle that has those three items. Usually it's not taxed on the front end or not taxed on the back end.

We are going to have more, and we are only talking about consumers of other markets like the Medicaid market. If you look at the recent Medicaid legislation, there is something called health opportunity account. We are going to see a lot of different accounts. That's good. It shows a diversity of opportunity is to use a savings vehicle to accumulate for health care.

Let's touch on another question a little bit earlier that I heard over here. I think if you step back and take a look at health care, again, in a very simplified way in order

to get through a quick presentation there are two options I see developing in the future of health care. One is a supply and control model, and one is a demand and control method. I am not an economist, but I will use their terminology.

What we have had so far and what managed care has actually been in my opinion is a supply and control model. They control cost by controlling supply. You assume demand for health care is unlimited. How do you control cost if demand is unlimited? You have to control supply. It's not medically necessary. It's not appropriate. It's not covered. You're not sick enough. We are not going to give that to you. So you have limitations on what you can access, and that was sort of the question that you were raising earlier.

I think that system has now failed. We tried it and it had some value. It lowered for a while. It squeezed out hospitalizations and pushed more into outpatient settings, but that system has failed because somebody else is controlling your health care. Somebody else is

saying what those limitations are, what those restrictions are.

The second approach that's developing out there is this consumerism approach. That's where the individual has more choices where it's not a third party who is restricting, and in fact it is a very fundamental difference. I think it's so fundamental we have lost site of how fundamentally different this developing system is because in the managed care model we assumed demand is unlimited. The consumers model says, no, that's totally wrong. We are going to control demand, not assume that's unlimited. There is a very fundamental difference in the model concepts.

How do you control demand in a new system when in the old system you said it was unlimited? Well, the proposal on the table, if you will, around health care consumerism is you have to empower the individual. How do you control demand in any other part of your life? You have an economic stake in the gain. You don't waste services. You don't go and use

services that you don't need because you have an economic stake in the game. When somebody else is paying the bill, you go and use whatever you want. If somebody else was paying for your groceries, you probably would buy different groceries. That's the whole idea.

So consumerism is about empowering the individual and about changing the demand for services and changing the behaviors giving them more education. Consumerism -- I want to be sure before the end of this that our words are taken in the right context. Consumerism is not about putting all of the burden of this new health care system on the consumer. Everybody has got a stake in this, whether its the hospitals, the doctors, the insurance carriers, the vendors that are out there and the individual consumer.

You will hear a lot about the empowerment. What it sounds like in the description that you might hear is that it's all about forcing more responsibility on the individual and they are the only ones involved. That's not the case as I see it.

Supply and control are failing. I said that. The real reason we need to change, and I will get to the solutions and show you the crystal ball of where I see the health care going and how you may be able to tap into the power of those trends that are going on.

It's a moral issue. It's not just a cost issue. If you take a look at the Institute of Medicine, there are between 46 and $98,000 deaths a year in the hospital for medical errors. People are dying out there. They are not just getting bad care. They are dying out there. So it's a moral issue.

You can go through this whole list here of how it's effecting us. So the current system is not working. There is another phrase out there that says every system is perfectly designed to the outcome achieved. We have got a system designed to do this. We have got to change. It's not just reforming the system. You can't tinker at the edges because health care is like a big blob. If you make a little change over here, the system -- so if you think you're going to make a cost adjusting change or

you're going to effect the system, it's too big. You can't do that. You really have to fundamentally change the system. That sounds pretty ominous.

How in the world can you change something as big as health care? The reality is it's changing. It's changing towards consumers. We are about three years into what I think is a ten year evolution. It's pretty tough sometimes when you are in a middle of a transformation to really understand it and even see it. I don't think people back in the middle ages understood when the renaissance started. I don't think we really understood when communism began to fail. So it's really tough when major transformations are occurring to actually see what is happening around us. We are actually blinded. You can't see the forest from the trees kind of thing.

Tragedy of the uninsureds. You have heard that 18,000 excess deaths -- not deaths, excess deaths a year die of people who are uninsured. All these people are dying because they don't have insurance. They are 25 percent more likely to die than people who have

insurance. 37 percent more likely to die from injuries from a trauma, let alone all the other aspects of the uninsured. The bottom line on all of this is regardless of how you view the issue, the cost of society is high. It's probably higher than any of us want to really admit or understand. It's got to be something that we work on.

Private sector solution is not a single payer system. The private sector is a 300 million payer system. You want to get everybody involved in health care. You have got to get them financially involved. You have got to get them educated about it. It's a whole new system. People are not too stupid to understand health care. We assume they are. They are not. If you want to learn how to budget your money, ask somebody who makes $18,000 a year.

These are the mega trends that I think are going through society and are now only coming to health care. This is not really an issue of trying to argue for one system or not. I believe this is happening. I think it's going to happen regardless of which political party is

involved. Now, the timing may be different because elections do matter in terms of regulation and legislation goes on, but it doesn't matter which party is empowered.

In the long run I think we are moving towards a consumer system because we are making personal responsibility, self-help, self-care, individual ownership, portability, transparency, and consumers in general. You know, you go to the ATM's these days. You don't go inside of the bank. People are buying stocks on-line. You check out the price of cars on-line. You do everything with much more personal involvement.

The definition of health care consumers, and I'll share the model in a minute. Health care consumers is about transforming the health and benefit plan into one that puts economic purchasing power and decisionmaking in the hands of participants. Notice it doesn't say anything about high deductible plan. Too often when we are talking about consumers, we are talking about high deductible health plans. Health care consumerism, it has nothing to do

with plan design.

Now, the first generation of health savings accounts require that by law. I don't think the second generation is. I don't want my comments taking out of context in terms of health savings accounts. It is a great vehicle. It is a great start. It is a great yes, yes situation. I believe we need to rapidly move to a second generation health savings account to make them truly effective. So any creative systems about health savings accounts, don't take that out of context and say, oh, he said something negative about health savings accounts that it is only for the young and healthy and wealthy. No, that's not the case. They are a great start. They have not been perfected. They are going to grow and expand, and we are going to get additional legislation, I believe, that will make them more effective in the market place to drive health care down to the consumer level.

Notice it's not just about plan design. It's about the right information so people are more educated on health care issues.

It's rewarding to do the right thing. The term I like to use is a shared savings model. If someone is doing the right thing -- if a diabetic is taking care of themselves, they are saving the employer a lot of money, if a diabetic on Medicaid is taking care of themself, changing their lifestyles, taking their medication, they are saving the State a ton of money. That person should be rewarded with part of that savings. You can do that by putting it into an account that's now allowed.

Now, Medicaid it's going to take some legislation, but the account I talked about earlier is not a bad start. I would change it a little bit to make it more effective. An employer can do that by putting rewards and incentives into an account that's a shared savings model.

Everybody knows this slide here. Everybody has got a piece of it. It's not just about the consumer. It's about each individual policy state holder making a change. It's all about behavioral change. There are two basic principals. If it doesn't work for our sickest

member of the group or society, it fails. If you have antiselection and it's not working for the sickest employees and if it's only for the young, healthy, and wealthy, it will fail. It will give temporary relief in some ways, but it will ultimately fail.

The system has to work for the sickest employees. It has to work for those who are interested in getting involved in their health care and those who have no interest in getting involved in the health care. Sometimes health care while it may be important, our family issues are more important, our job responsibilities are important. We don't have time to get on the internet to find out what the health care costs are of this drug or that drug. It has to work for all of us.

Here is a model. I see four generations of health care developing out there. This is not just a theoretical model. It's where I see the market moving. I think the reality is the market is moving. You see lots of evidence in what's happening in the real world, but where I see the vision is that we are

only between the first and second generation. There are four generations.

The first generation is a focus on discretionary expenses, the high deductible plans you hear about. What good is a high deductible plan with an account to a diabetic. They are not going to have a chance to accumulate funds because they are going to go through that account. It's a good start. We've got something to focus on discretionary expenses, which is prescription drugs, office visits, emergency room, maybe some diagnostic x-ray, lab, those things. Those are really 80 percent of the population but only 20 percent of the claims. It's a good start. It's the foundation. We are rapidly moving in the market place in the second generation, which is the focus is on real behavioral change.

Real behavioral change says if you're a diabetic, let's say I have got a $2,000 account, $2,000 deductible health plan and I have got a thousand dollar account that I control. If I blow through that, I have got a thousand dollars out of my pocket. What if I am

a diabetic, I am taking care of myself, and I am doing a lot of things. I am saving my employer a lot of money by stabilizing my condition. I am listening to my doctor. The employer under these new programs can share some of that savings back. So they give me $100 a month into my account because I am compliant with care. Guess what? I now have my whole deductible covered. I have zero out of pocket because my employer now is sharing the savings back to me.

As a diabetic do I like this program? It's a whole heck of a lot better than my HMO or even my PPO. A shared savings model allows us to move rapidly into the second generation. It's going to take more computer systems and more touch points. We are moving rapidly into the second generation model at the national level for the commercial marketplace where the employer pays.

The whole idea is to start to be developed and being involved in consumer eccentric Medicare, consumer eccentric Medicaid. If consumers is a new system, not a tweaking of the old system, but is truly a new system, it

has to work on all of our problems. It has to be a consumer eccentric Medicaid. It has to be a consumer eccentric Medicare, and it has to deal with the uninsured. Each one of those is a different presentation, which I can't get into. The same concepts will apply.

Let me touch on third generation and fourth generation. Third generation is about integrated health and performance. It's about how health care effects employers bottom line. Because if you have employees who are taking care of themself or stabilizing their condition, if you have got a diabetic or an asthmatic or a congestive heart failure patient who is doing better because they are involved in their own health care and they are being rewarded for it even, they are going to be on the job so you have more productivity, fewer absences, fewer unscheduled sick days, fewer turnovers, et cetera, et cetera, et cetera.

The third generation is about how does health care when you take it out of the silo of health care effect the overall organization. It definitely has those impacts.

The fourth generation is where I think we are ultimately moving. The fourth generation is about you and it's about me and our own individual health care, very personalized one-on-one health care. So the tools and resources available are very specific to you, whether you're using push technology about issues that you're interested in or we're using predictive modeling or we're using culturally sensitive disease management programs.

I will give you a quick example of how we are not that far away from fourth generation. Do you know that there is a diabetic telephone that's available? The diabetic telephone could actually test your blood sugar. You don't even have to prick your finger. They actually have a laser that's 98 percent accurate just lasering your skin on what your blood sugar is. The results go through the phone mechanism, go out to the lab, and you get a call back on your results. If you forgot to do your test, which you're suppose to do three times a day, it calls you and reminds you. It's

very personalized, very individualized health care.

There are four or five building blocks. I will mention these five building blocks. There are actually five or six. The sixth one is null, but I will mention these five. It's interaction of these building blocks that are important. Personal care accounts, I mention health savings accounts, health reimbursement accounts, there is flexible savings accounts, and there will be others.

Wellness, early intervention, prevention, disease management, that's the 20 percent of the population with 80 percent claim. If you can deal with disease management perhaps and people with chronic and persistent cases, asthmatics, diabetics, congestive heart failure, probably hypertension, depression and those sort of issues, you will have a big impact on health care.

I will give you a little later if I remember -- if someone wants to ask me, there are four very simple conditions that if you control them in any environment you would have a

dramatic impact, in my opinion, on health care costs, very simple things to do, the decision information, decision support tools, and incentive rewards on how to change and give up behavioral change.

You can access the crystal ball right here. If there is one slide you want to take out of my whole presentation, it would be this one. This is the crystal ball in my opinion of where health care is going and how you can take each of these building blocks and see how it would translate as we move along into the future and how the different generations would work.

Let me just take as an example the first generation as to where we are and what you might think of as consumerism before this discussion. Now, you may argue it's just the start. It's not the end game. It's a very beginning stage of where health care is moving.

You get a personal care account. You get an initial balance only, $2,000 deductible described. You get a thousand

dollars. You get some balance, initial balance, and you get those doctors. If you use them, then you're in your own pocket. That's first generation.

Almost all first generation products have a wellness piece to it. They do cover 100 percent preventative care services. Each employer can define it under HSA legislature and restrictions. We don't want you to not go get your health care because you're going to come out of your account. So that's good that those -- that evolution has occurred.

Disease management. A lot of times you have information available on prescription drug cost or maybe you have a coach that you can call, but it's pretty passive on information and disease management, which is why a lot of the earlier studies on disease management said there wasn't a whole lot of savings there because it was a beginning stage, and it evolved quite rapidly over the last couple of years.

The decision support information, again this is sort of an Internet check of what prescription drug prices were. You don't have

hospital prices or doctor's fees or that sort of thing. There was no incentive or rewards. If you did anything, you gave out theatre tickets or American Express cards or something like that.

We are moving rapidly -- if anybody is doing anything, you almost have to jump into a second generation model. A second generation model says I just don't get an initial balance. I get rewards.

There is an activity for compliance, what I call pay for compliance. In the world of health care you may hear a lot about pay for performance. That's rewarding a physician or provider who is doing the right things in health care and you're giving them extra money for doing the right kind of medicine. Pay for compliance is the flip side of that coin. It's paying the individual who is compliant with the care to be doing the right things, and they get the shared savings and rewards.

Going all the way down to the bottom of there, notice the incentives. I use another term called a health incentive account. Think

about this. Take your state employee program and do not change a single benefit, except add without taking away anything else, add a health incentive account with no money in it. Now, if you have got a first generation mindset, you say that's stupid. There is nothing in there. There is no value. There is no benefit, why would do I that, but in a second generation mindset it makes a lot of sense because now I have a vessel where I can share savings so that diabetic or whatever the condition is, I can put money into there. I can also put money in there for wellness, people who are doing the right things in terms of nonsmoking or going to exercise clubs or going through a corporate run or whatever you want to do for wellness. You can put money in there for shared wellness activities so you're not just putting money in there for people who are sick but for people who are well and maintaining a healthy lifestyle.

So it has nothing to do with high deductible claims. It has something to do with rewards and incentives without changing behaviors. I will leave it there. The savings

are pretty enormous.

The paradigm shift here about moving to cover the uninsured, I think HSA's and the subsidies to the low income can be very helpful in moving that marketplace. One of my passions -- I retired last year actually to help solve the uninsured problems. I am not here selling any services. I'm on a mission, and I think it's really important that we change the market place so we can actually reach the uninsured.

And the Massachusetts plan, I have looked at that a little bit. I don't consider myself an expert in it at all. I think one of the real important parts of what has come out of what Dr. Rami and the state of Massachusetts has done is to create a focus not on the uninsured but on the low income uninsured. That's a big difference.

In Massachusetts the uninsured are 500,000 roughly. 200,000 are eligible for Medicaid. So he puts it in a program to bring them to Medicaid. 100,000 are making enough money that they should be able to afford health

insurance. In fact, the fastest growing part of the uninsured is people making more than 75,000 a year. They made two decisions, one they are not going to get sick; and, two, if they do get sick, somebody else is going to pay the bill. That's not a good neighbor to have that's going to rely on your goodwill to cover the cost. So in Massachusetts only 200,000 of the 500,000 uninsured are low income uninsured that require the subsidies that are involved.

I think that's unique to that state that was mentioned earlier, but I think it changes the debate on what you ought to look at when talking about the uninsured so that the main experiment doesn't happen where you are not addressing the low income uninsured and you start to address all the uninsured.

Let me stop there because I have run up against my time, and if there are any questions I will be glad to answer them now or later.

MR. LERNER: Yes, let's thank Mr. Bachman for a great presentation.

Craig.

UNIDENTIFIED PERSON: Pretty consistently for your presentation you seem to continue the tying of insurance to employer, at least for many people. Is that an unnecessary assumption in any of this?

MR. BACHMAN: No, not at all. In fact, look at those mega trans. The big issue is around affordability. The only way you can have true affordability is individual insurance, and I think the disconnect though is that while many people promoting the health care consumers approach are very much in favor of the individual marketplace, the reality is that we have 50 different states with 50 different insurance and commissioners and 50 different sets of mandates, 50 different sets of premium taxes, filing requirements, et cetera. We have a disfunctional state insurance regulatory marketplace. We can't reform it. It has to be eliminated. We have to eliminate state reform.

There are some easy ways to do that actually. I would point you to Representative Shad of Arizona's bill last year, the Health Care Choice Act in Washington. That basically

said -- and I will recommend that you all think about this as part of what you can do voluntarily. The Shad bill said that if a policy was approved under the laws and regulations of any state in this country, it's automatically approved in every other state.

Now, state insurance commissioners have model regulations for reciprocity in many others, disability and life insurance as I understand. They have no reciprocity modeled around health care. Thinking about creating competition, if you believe competition is a real key of the marketplace, why don't you create competition in this state than you really have, although it sounds like you're at the high end of the competition; but if you will allow other states to come in here with policies that you approve that you could recognize, you would have more companies coming in here. Bank of America with HSA's or Wachovia International if they get approval in one state you will have a whole new product mix and HSA's and new options in my opinion.

MR. LERNER: We have got some time at

the end of the day for questions. My hope is the speakers will stick around for us at the end. Thank you very much.

I want to be respectful of our speakers who are teed up, and the next is Ms. Eileen Ellis, who is the former director of Medicaid from the State of Michigan. Eileen is with the Health Management Associates. We were going to have our colleague Steve Cure here. Steve is -- I think I am in violation of HIPAA by saying this. He is having some orthopedic surgery elective done and he is still hospitalized.

Thank you very much, Eileen, for joining us, and we are very excited to hear about the preshared program.

MS. ELLIS: As was said, I'm here in Steve's place today, and I'm going to talk about something that's not on such a global scale but maybe on a much smaller scale, and we're going to look at things that can be done at a community level.

We at Health Management Associates have been involved in this kind of activity

since the early '90's. We are initially in Michigan, which is where our corporation started and now more recently in several other states.

You have heard all of this information already today, so I don't need to repeat the fact that there are 45 million people who are uninsured in this country, but one of the things that we have focused on is the fact that the low income uninsured was just mentioned. Our population may require some unique solutions and in particular -- when you look at the uninsured, you see that most of them are working or dependents of working people. 20 percent though of the working uninsured are in small businesses, and that is an area that we have targeted with what we call three share plan that I would like to talk about.

You may say that's only 20 percent of the working uninsured and the working uninsured are only two-thirds of the total uninsured, but you are still talking about 6,000,000 people out of the total 45,000,000. It's a meaningful number to think about doing something about, and it may be a population that

most needs some special solutions.

We got involved in looking at these issues because it became pretty obvious in the late '90's, even in the early '90's it probably wasn't going to be a national insurance in terms of insurance for all. Working with local communities we developed community consortium to look at the issue of what can we do locally to help people who don't have health care coverage, and I'm actually going to talk about two models. I am not only going to talk about our three share model that focuses on working people. I am going to talk about another model for low income people who are not on Medicaid but need some help with health care coverage.

So the three share model has to do with subsidizing premiums for the working uninsured, and currently we have six such plans in existence in the state of Michigan. There are three in the State of Illinois that are in the very early stages of their implementation, and we have some conversations underway in Ohio, Oklahoma, and also in Texas. Another of these plans have been in operation for several years.

So we have some track record and the ability to see how this works over time.

So the term three share, third share, nothing magic about it. It just means that there are three parties that are sharing in the cost of health care, the employer, the employee, and some sort of subsidy. I will talk more in a minute about where that subsidy might come from.

It's not necessarily equal shares. In some communities they have chosen to do it that way. In other places the subsidy may be greater than a third. It might be less than a third, but typically we try to design these so that it's affordable for the employers and the employees.

Usually these are small employers, and most of the programs are limited to something like under 50. Some communities have even limited it to businesses of fewer than 20. Generally there is a limit on the medium wage, and that's a key mathematical term. Median does not mean average. It means middle. So if you have 50 employees and you start at the bottom

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and go up and you get to employee 25, that's your median wage.

So if you have -- let's say you have a veterinarian clinic where the vet makes a significant amount of money but has some people who are helping with boarding dogs and the like who are relatively low wage workers. The average wage might be fairly high but the median wage might not be very high. So that's typically how we structure these to look at the median wage of a business.

It's wage based. It's not income based, radically different than what you heard about with Dirigo. Dirigo requires that you look at all the people in the family and how much they are making in order to determine whether the family qualifies for Dirigo. Here you can just look at the employees in the business and the employer doesn't have to get in any way involved in knowing personal things about the rest of the family.

Then this last point, I just called Steve and said what did you mean by public subsidy does not mean an increase in cost of

caring for indigents. This is a mix of his slides and mine, but basically when you think about publicly subsidized programs I think a lot of times we think that this means that there is going to be more indigent care in the hospitals or something like that. Here we are talking about using some public funds to subsidize a private sector approach, so it isn't truly an indigent care program.

This is very much a community driven model, and I will tell you that from county to county of the programs that exist in Michigan they are very different. A local board of a private nonprofit organization makes decisions for their community as to who is going to be eligible.

First of all, in terms of what businesses and the size of the firm, which I already mentioned. The earliest of these plans actually didn't have a limit and had businesses as large as 200 employees being covered by the third chair program. The wage level. Again, very community specific to meet the needs of a particular community.

History of insurance coverage, that's a key point, and you have heard discussion of this as a design feature already in terms of the fact that you don't want to be substituting a subsidized program for existing employer coverage.

In our state in Michigan, which is a state of just over 10,000,000 people, we have 700,000 people in families with incomes between 100 and 200 percent of poverty who have employer based insurance. Nobody should be trying to design something that discourages that or replaces that. So one of the design features in each community is that there has to be a length of time where the employer has not offered coverage, usually a year. In some communities it's two years so that you don't have an employer saying that this is a better deal than what I've already got and I've got to drop coverage in order to move into it with a three share model. So that's a key design in the feature.

Also, community specific. Do you require that these are full-time employees or do

you want to cover some of the part-time employees, do you want to make this only available after people have worked for the employer or are expected to work for the employer for a particular length of time. You definitely don't want to do sole promises because you have a minimum number of employees of two or three. You don't want someone coming into the business who is your uncle who has got a catastrophic health issue just in order to get into the three share program. So the length of time becomes a design factor.

Then the local community also decides what's going to be covered and what the copays and deductibles are going to be. In our Michigan models we actually don't have deductibles, so this is the antithesis of what we were just talking about with high deductibles and health savings accounts. This is first start coverage, and then it has a lot of caps on the high end. So the idea is if you have got a person for whom is paying $50 a month is a real burden, you don't want to say you're going to pay $50 a month to get some coverage and, oh, by

the way, you have to also come up with $500 out of pocket before you start seeing any of that coverage.

So the copays tend to be nominal. The deductibles are either zero or very small, and I will talk a little bit more about benefits, but generally it's primary preventive care highly emphasized and then maybe it only covers 20 days of inpatient or has an annual cap on the benefits. Again, the community decides who the providers are going to be and who the insurers are going to be. So the financial responsibility, as I already said, gives each party a vested interest because it is split among the three parties, the employer, the employee, and the community program.

This idea -- to me there are two things that make this attractive for these employees. One is the subsidy. The other is that it's a bear bone program. We make these programs as inexpensive as possible, and then we subsidize them, and hopefully the marketplace for workers isn't what it was when we first started doing this in the late 1990's. We were

really selling this to businesses in 1999 and 2000 as a worker retention strategy and attracting worker strategy at the time when the job market was very competitive to get workers. I will say that experience right now in a couple of communities in Michigan is the argument that right now today's economy isn't as significant because there is a surplus of available workers in general, but in the right time you can argue that this helped stabilize your work force and is a future for worker retention and attraction.

So how do we get funds to subsidize this program? In most states there is already local subsidy of some kind of imaging care. That really varies from state to state, but there is something going on in almost every county that I have worked with where counties are spending something on services for low income people, and using a couple of different models if we can get cooperation from eight state's Medicaid agency we can take that local money and through the magic of Medicaid match draw down some federal funds.

Now, I know any of you who track Medicaid and what's going on know that there is a trend over time, very strong towards shutting down schemes, all the money laundering, dishwashing, whatever of Medicaid funds; but we are talking about legitimate techniques that have been in existence for many years and that still are valid, and I will talk about one in a minute; but if you can get these additional federal dollars, then they are the funds that are used to provide the subsidy.

You will see the premium numbers I am talking about here. The plan costs are radically different than other programs that you have heard about in the last couple of presentations. We are talking about something at a 150 to $250 month range in terms of the total cost. You know from that that we're not covering catastrophic conditions. Hopefully there are other vehicles through Medicaid through other opportunities to cover those costs or those are costs that would have been indigent care anyway.

The focus is on keeping people

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healthy, getting them preventive care, and meeting basic acute care needs. So the subsidy ends up being usually between 50 and $80 per member per month.

In Illinois the particular model that is being used or being talked about here is your local health departments get less than cost when they deliver care to Medicaid beneficiaries. In my state in Michigan what is being talked about here was already happening, that cost that they incur -- say they deliver a service that cost them $80 to deliver. Maybe it's a health department who has a primary care clinic or maybe it's something having to do with immunizations or a dental clinic or whatever the local health department is doing. If their cost of the service is $80 and the payment for Medicaid is only 50, they have incurred a $30 loss.

Legitimately, and this will always be true, states can bring that $30 incurred cost to the federal government and get the federal share of that, which in your state it's only 50 percent, but that's still $15 of new federal

money coming to that health department, which in my state the health department keeps because they have been doing that all along; but the arrangement that Steve is working in some communities here working with the health department is maybe some shared saving or maybe all of this new money will be made available to fund the subsidy for a three share program in that community. That's the vehicle for the funding.

In Michigan we weren't using all of our hospital Medicaid dish capacity, disproportionate care hospital payments, so we have been able to take money that counties were spending on non-Medicaid people and anything they were spending on low income health care and have the counties make an intergovernmental transfer to the state. It comes back with federal match to a hospital as additional payment. Right now in Michigan we are leveraging about 50 million dollars in additional federal funds through that vehicle.

Steve mentions a couple of other possibilities that again are other kinds of

local money that could be used as seed money to draw down federal funds. Also, the possibility of using waivers under the Medicaid program to cover some people who wouldn't normally be covered by Medicaid for limited benefit programs, and we can talk more about those at another time.

I want to show you a couple of the models that are in place and talk about some of the history. First of all, you may hear people talk about, especially the second one on this slide, the Muskegon program, the Access Health program. I want you to know that there is a very arcane provision of Michigan law that allows county government to set up an entity that arranges for health services without it having to be licensed as insurance. You probably don't have that kind of vehicle, but our first two three share programs were created under that vehicle.

So the Wayne County program, which is the oldest, and the Muskegon program, which is the most touted because they have got some people who go around the country talking about

their program, probably can't be done in other states. They are not insurance. In Wayne County they use unlicensed subsidiaries of licensed HMO's to be at risk and to manage the care, and they have about 4,000 members currently. At one time they actually had 22,000 people enrolled, but some changes in their available local funding caused them to have to downsize. Actually, I think they are close to 5,000 when I checked yesterday.

Muskegon County, which is in Muskegon, Michigan, which is a county of about 140,000 people has about a thousand members. To give you an idea of scale, there are almost 300 businesses involved in their program. So there are a lot of dry cleaners, day care centers, a lot of small businesses. They actually retain the risk and have a third party administrate or that manages the claims for them.

More recently we have been doing insured models in Michigan. Three counties -- four counties have programs like this. So you use the license insured as the underwriter. We have gotten -- we don't have as many -- we have

a lot of mandated benefits for our HMO's in Michigan, but not many for insurers. I think that's true here too. So it's first dollar coverage, nominal copayments, and as I mentioned annual and lifetime limits on benefits. So 100,000 annual cap, 200,000 lifetime cap on the value of benefits, 20 day stay inpatient. Those might be examples of some of the limits.

These have begun fairly recently, and what we're finding with these and with the prior programs is that in today's market with small businesses that are kind of on the edge in terms of their finances it takes a lot of hand holding, a lot of marketing, a lot of time to help them think through this decision and make a lot of contacts to get a very small number of people enrolled. It really is a lot of work but a value.

So Winebago County began their plan in July of 2003. Steve knows the details of this one. I don't. Once they got the funding secured, which has to do with working out the slide I talked to you about earlier with the Department of Health being able to leverage

funds through the Medicaid program, they will be able to cover $3,000 people, but right now they only have 50 members with some very limited funding available to them.

Steve asked me also to tell you about something that's much easier to implement and a very different model, and I have just two slides on what Steve decided I should call a one share program. This is just subsidized health care for low income people, and we have been implementing this as fast as money was available through the state of Michigan to leverage federal. It's primary preventive care. The idea is to give as many people as possible a thin layer of primary preventive care, very basic coverage. The formula is almost generic only. It doesn't cover any of the new or high cost drugs.

In the 70 counties that have programs, the income limit ranges from 150 percent of poverty to 250 percent of poverty, depending on how much money the county has. You have heard these numbers earlier today. 150 percent of poverty is 30,000 for a family of

four. Right now we have nearly 60,000 enrollees. We have funding that goes to 65,000 once all the current plans are at capacity. This enrolls very quickly. A county in Bell Creek, Michigan opened their plan for enrollment two months ago. They had 600 slots. I think there are 3,000 people who would qualify. They are full. They have had to close enrollment.

There is no premium. You sign up. You get the card, and you get this limited benefit of physician services, pharmacy, lab and radiology, no payment for hospital, including no outpatient hospital benefit.

We actually have two different models. In a few of our counties they are using volunteer programs, the upper peninsula of Michigan where physicians just aren't interested in participating in anything that has anything close to Medicaid rates, which these programs pay just a little bit better than the Medicaid. So the physicians are willing to volunteer to see a few people in a clinic. Then the plan pays for administrative costs to the clinic, pharmacy, and ancillary services.

The more predominant model is what we call our plan B programs. 52 counties have this. There are about 57,000 enrollees. We have enrolled providers. So the cost per member per month varies from $30 to 70, mostly based on scale. In Lansing, Michigan we have nearly 15,000 people that cost approximately $30 because we have a nice mix in terms of average health status and $70 in some of the smaller counties that don't have as much money, and they are getting more adverse selection. Again, the vehicle for the subsidy is the same as for the three share plan.

MR. LERNER: Thank you, Ms. Ellis.

How about time for some questions.

MS. JOHNSON: Thank you for your presentation. A question about the Wayne County program. I know it just started last fall, but do you have any idea of the number of enrollees at this time?

MS. ELLIS: Well, there are two programs in Wayne County. There is the health choice program, which has about 400 or 500. The four star, about 500 as well. They just changed how

they are going to allow marketing now.

MS. JOHNSON: How many enrollees --

MS. ELLIS: They could enroll -- in four star they could enroll 4000 people.

MS. JOHNSON: And in the other plan?

MS. ELLIS: Health choice in Wayne County is funded for 5,000.

MS. JOHNSON: How many are there eligible for each plan?

MS. ELLIS: Good question. Probably in Wayne County probably -- well, businesses have to qualify. Probably 50 to 100,000 people.

MS. JOHNSON: Okay. Thank you.

UNIDENTIFIED PERSON: In the limited medical plans you described what happens in the case of a catastrophic illness? Do you have any data on the experience of other people that might go on to require that and not have coverage?

MS. ELLIS: We are actually just starting to research that in Flint, Michigan that has 18,000 people in their program. We are going to be getting data from hospitals. We don't have that data right now. Generally what

happens is they were uninsured before. They are still uninsured. This is not insurance. It's coverage, and a couple of the larger plans do occasionally -- like right now a plan has a million dollars, not a lot of money, that they are going to give to their two hospitals based on the proportion of the members of the plan that they saw in the last two years as a token. Actually, the interesting question that we are also researching is whether these plans uncover illnesses that -- conditions that would have otherwise gone undetected and perhaps increase cost.

MR. LERNER: Is it true with the three share and the one share program that once assumed is the community benefit programs that providers are already providing hospitals and doctors? In other words, they are not jerking away from their responsibilities. That has to be an adjunct that we are presenting here.

MS. ELLIS: That's correct. Especially -- in fact, with the one shared program the argument is that we are keeping people out of the emergency department because

they are getting their primary care from a physician that they are enrolled with. With three share they are actually coming in as a person with payment for at least the first 20 days of their admission or routine inpatient if inpatient is routine.

MR. KOEHLER: Are these areas that have FQHC's or it's pretty much to the level of care?

MS. ELLIS: Good question. It really varies, but the FQHC's in some areas are a significant part of the delivery system for this plan. Other areas -- so we are in 70 of 83 counties of our state. It varies in terms of whether they have FQHC's there and also whether they are participating in these programs or not, these one shared programs.

MR. LERNER: Thank you very much, Ms. Ellis, for your great presentation.

Moving along, we have JP Wieske, Director of State Affairs for the Council for Affordable Health Insurance. He will be talking about initiatives that other states have undertaken to expand health care access in insurance markets similar to Illinois, and he

will even more so discuss successful approaches increasing the access and affordability of health insurance, which means that when he is done we are done. So I am really looking forward to this.

MR. WIESKE: Thank you. I wanted to kind of go over -- some of this is going to be repeating what some of the other speakers have done, so I will go over those slides quickly.

As we know, we are looking at some serious health insurance issues broadly, rising costs. We see it mitigated a little bit this last year. The increases are down to 9.2 percent. We are seeing a few businesses broadly offering coverage. The actual number of the uninsured are rising. There was 45.8 million in uninsured in 2004 nationally. It's up from 45. You can see that there is some trends up and down related to the insured numbers, and Illinois, as you can see, as well there has a slightly lower percentage of the uninsured rate than what was seen nationally. I think it's important to note when we look at these that the majority of these uninsured do work for small

firms, and those are primarily where the issues lie.

What is also interesting is who are the uninsured. The point here I think when you take a look at this is there is a general assumption that this is a modest group. It's clearly not. There are a whole variety of people who are uninsured for a variety of reasons. I think the broader point here is that, you know, it's very difficult to target these solutions when you don't understand it.

I guess the broader question here as well is can we give more? Can we provide access to low cost health insurance, especially those with low income? Can we decrease the uninsured rates? Can we assure that health insurance remains affordable?

As I said before, it's a diverse population. There is no one solution. This is a daunting task. It's hard for us to get our heads around it. It's hard to understand how there is one solution to everybody's problem when you look at one-sixth of the people who can clearly probably afford health insurance. You

know, the same solution that works for them probably doesn't work for the low income insurers.

I think it's important as well in the whole context of this discussion to take a look at how states regulate insurance. The large group market is largely untouched by state reflection. They voice state mandates. They are not required to -- they don't necessarily have limits on what they charge for their rates and there is a lot more flexibility in plan design and in the rating. In the small group market they are state regulated. In the individual market they are state regulated products. They do face a variety of costs that are out of their control, including health insurance mandates broadly across the states. We see this exacerbated in especially what we call the micro groups that are extremely small.

As we look at what states have done to the market place, you know, there is a wide variation when you take a look at ehealthinsurance.com and you see what the cost

is on a state to state basis. There is a big difference between one state, let's say what New York charges and Illinois charges for health insurance, despite the fact that the cost drivers may be relatively the same.

Mandated benefits, the availability of different claim designs have an impact. Community rating and rating windows, as was mentioned before, Illinois has a relatively wide window for rating the NEICC model.

The rate form regulation. There has been a number of questions on this, and I think the answers were correct. There is very little evidence that rate form regulation has a significant impact on the overall cost of health insurance. However, what does tend to happen with rate form regulation is that it tends to get politicized. We see incidents in a number of states, Florida probably being one of the best examples. When Florida has an election for insurance commissioner, every election year you can see the rates were officially held down. Following the election year the cycle continues and the rate increases are actually higher than

they were before because it's no longer an election date. So the politization of that process is problematic.

The other problem that you run into in rate form regulation is the fact that it just simply takes time. As you delay that process, it becomes more and more expensive for insurers, and they start billing those costs into the rates. So as a result, rate form regulation may in some cases end up leading to increased rates and also leads insurers to avoid that marketplace when the time takes too long. Also, there are differences in demographics and health care costs.

We have seen some efforts on the federal side. Take a look at some of this stuff. The Engi bill has been mentioned. I think it has been mentioned before. It includes small business health plans, also known as associate health plans are similar. The difference in Engi is it is a fully insured product unlike DHP's, which is a self-funded product. It eliminates some of the state mandates and ready rules. Choice Act deals with

the interstate sales of individual insurance, and Smart Act, which is a federal charter.

I think the point here is we need to be careful with what states do because the insureds, and especially in some other market places, are going to the federal government saying we cannot live under these rules that some of these states have imposed. These mandates are too expensive. These ratings rules are untenable. The rate form review takes too long. We need federal help. This is not happening in a vacuum. This is an important thing for you to take a look at is how this is going to broadly impact your marketplace.

We have seen a lot of state activity. Mandate life insurance plans have been passed in a number of states to help with affordability. High risk pools is an extremely important thing, and we are going to talk about all of these a little bit more, rate reform, pooling arrangements, and then some of these public and private partnerships that we talked about with Massachusetts, Healthy New York, and Tarren certainly highlighted Dirigo very well.

Private market site. We see some health savings accounts like low cost mandate preplans that have been designed specifically for the people who have affordability problems, limited benefit policies, and they are looking for plan design flexibility as well.

Pooling arrangements are an interesting thing, and we have talked about this in a number of states. Essentially what pooling arrangements try to do is they try to create a new group and an effort to mimic what an insurance company does, and what we found is that it has very little -- has led to very little cross decreases. However, I think the argument by a number of small employers is appropriate, which it is that it increases choice in certain marketplaces.

One of the specific ways that we look at this is state employee plans, and there have been a number of proposals over the years in a number of states to allow individuals, especially farmers, to join the state employee program. Now, this principal has had very little effect on health insurers. However, this

has had a significant impact on the cost of providing insurance to the state. I think Kentucky is a great example here with people and their experience, and the cost of the state employee plan became practically unaffordable.

MEWAS, this is something nationally that we have looked at over time. If you look at it again related to HP's, again this is still a funded plan related to -- that includes limited state regulatory authority, and again an issue here brought to me is that if the solvency standards are not appropriate, that it could lead to insolvency issues.

Co-op plans. Again, this is kind of similar and more broadly based. In more of the traditional kind of approach that we have seen with these pooling arrangements a cooperative or in some cases an association of business will offer this. Again, some of the concerns broadly is they have looked at community rating inside these plans which can lead to what's called the death spiral. Additionally, as they sign up individuals, the rate becomes extremely attractive to those who are healthy. People who

are healthy see the rates increase and as a result they leave, and the only people left in the pool are the unhealthy, which leads the rates to skyrocket, which means that the plan can end up being insolvent.

State run pools. We haven't seen any of these work in any of the states. I can't site any of them that has actually worked. This is where the state steps in as an insurer similar to the Dirigo plan, I suppose. Still the problems they run into is finding an administrator. We have experience with this in the early '90's, and most insurers understand it was a disaster then and it will be a disaster now. So they are not interested in running these pools. There are all kinds of social issues that tend to be involved that drive up the cost and make it untenable.

I want to take a quick -- I'm not going to go over Dirigo again. I think Tarren covered that in detail.

I think what's important when we look at these public-private partnerships, as they have been called, is the important thing is

to sit back and look at these marketplaces. These marketplaces are in disaster. They are community rated. They are guarantee issue. Health insurance has become absolutely unaffordable in those systems. Politicians in those systems do not want to make changes to those so-called reforms that have made the insurance unaffordable. So their solution is to prop up this failed system.

In the case of Dirigo, we have gone over that in detail. Massachusetts, again, we are looking at a market that has guaranteed issue and community rating. Rates there are broadly unaffordable. The plan includes employer mandate.

What hasn't been talked about much is the fact that employers who are not participating in the health plan are responsible for employee dependent claims and aggregate for 10 to 100 percent of those costs. It's very important from a privacy standpoint to note that not only are these employees being tracked as to whether or not they have health insurance, they have to sign a piece of paper under oath, as do

the employer, indicating that they have in fact health insurance. Their private medical information is going to be tracked by the state and charged back to the individual employer in these cases. I don't know about anybody else, but that's a chilling thought from a privacy standpoint. Individual mandates as well here -- they have decided that this is a priority regardless of affordability. It is based on a tax -- you lose your tax deduction if you do not have health insurance.

Also something that hasn't been talked about much is the combined individual and small group market. For those of you who have brought insurance in the individual or small group market or both know that those markets function very differently. You know the plans that individual buys are very different from the plans that the small employers buy. Combining these markets create a whole host of issues that I am not sure that they have thought about.

Lastly, we have talked a little bit about pool before. This also goes down to the insurer level and the employer level beyond just

the health insurance. You have the ability to gather any employee data to make sure there are no discrimination issues. You have the ability to gather any information of insurers to make sure that the plan is -- that the plans are following their requirements.

The connector also is an interesting piece. They haven't defined what affordable health insurance is, and what's interesting is what we have seen in a number of cases, including up in Wisconsin with Commissioner Gomez, is affordable health insurance doesn't mean that they have premiums that you can afford. They have plan designed this as well. There are deductible limits and those sort of things. It's extremely likely that what would be affordable in Massachusetts would be considered unaffordable every place else.

Healthy New York. Healthy New York actually again, as we talked about -- the largest problem with New York is the fact that they haven't reformed the rest of the marketplace. Healthy New York is not necessarily an atrocious bad plan by any means.

They do need to get rid of the guaranteed issue. They do need to get a high risk pool to cover the uninsured individuals and to eliminate guaranteed issues.

The plan essentially is the subsidized plan for those who are uninsured and who have limited incomes. It's allowed in both the small employer market and the individual market. We just published a paper on this, which is available on our web site if you're interested in it that covers the plan in more detail.

What is interesting in New York is we ran rates for health insurance comparing it to this Healthy New York plan. We ran rates for Eau Claire, Wisconsin, which the GAL has decided is the costliest health care rate in the country. So what we found in fact was for $168, I believe is the figure in Eau Claire, Wisconsin, you can get a plan that is more comprehensive than the $185 you would have to spend in New York, including the subsidy. So $185 is what you would have to pay plus a subsidy. For the same price you could move to

Eau Claire, Wisconsin and get a much more comprehensive and more affordable plan.

We have seen a number of states that have looked specifically here at premium subsidy plans, and these are just new. There isn't really a heck of a lot of data. They haven't put a lot of money in these plans. So it's something to watch.

Montana just billed out all of the money for this plan, and the commissioner had some wide discretion on what he was going to do on the part of very, very small employers. This is a very important thing to understand because this is where the affordability is probably at its peak for small employees. These 2 to 5, 2 to 10 lite groups are the primary life groups that you're seeing are uninsured.

Mandated lite insurance plans. We have seen a number of state pass these. Unfortunately, the uptake on these plans have not been all that high. We believe there may be a lot of reasons associated with that. Mandate lite plans essentially say, okay, we are going to offer a health insurance plan that limits

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kinds of benefits -- state mandated benefits in order to decrease the cost. I think personally that there has been some upscaling related to that. It's certainly appropriate, and I think as well that it has been effective in getting people to look at the marketplace. The key issue there is to get some of these people who have affordability issues to look at a plan and then they buy up from there.

Health savings accounts. What's interesting about health savings account -- I don't think they are necessarily the penny saver for everything either, but we have seen some broad success in the uninsured rate. We have seen 30 percent of purchasers nationally or uninsured. Some of the data that has come out from some other people have been higher than that. They are a pretty safe, conservative number. You're also looking at the small business market. 50 percent were previously uninsured that are a couple of numbers from our groups.

High risk pools. Illinois has them, and I urge you to maintain the high risk pool.

It's an extremely important piece of this puzzle and has helped affordability broadly. High risk pools insure that people who have health conditions are able to get insurance. I think what it also does is it prevents insurers from competing not to obtain those people. They share those risks equally, and in a number of states the insurer is actually going to pay full rate for the high risk pool.

Voluntary reinsurance pools. This has been talked about in a number of states as one of the solutions. What you find is health insurers don't feel comfortable sharing their risk with other health insurers. They are concerned that other health insurers are going to have poor business practices and they are going to have to pay as a result.

List billing. This is something that you may not have talked about. I believe it's allowed in Illinois. It's something that helps a lot of the uninsured. It should be promoted. Essentially what it allows an employer to do is it allows an employer to payroll deduct an employee's premium who

purchases an individual policy. The way it usually works is an agent comes in. He may or may not be able to sale the small employer on health insurance. The small employer may not be able to afford it or may have a large number of uninsured part-time workers. The workers agree to pick a plan. The plan -- the application is submitted to the employer -- excuse me -- to the insurer. The insurer accepts them. Then the employer payroll deducts the premium. It provides cost savings and it makes -- it eases the purchase of insurance. There is a huge hassle factor broadly in purchasing insurance for uninsured people. It makes it a lot easier.

Tax credits and tax deductibility. I think the key point here is to take a look at these two studies and see that there has been some broad success both on the left and on the right in looking at these issues, and I believe that tax cuts and tax credits can certainly help the uninsured to better afford insurance. I think it's also an important point to understand that the individual health insurance still remains naturally not tax deductible, which is

clearly a barrier to health insurance.

Underwriting, we talked about this briefly before. This is the ability of health insurers to determine the rates on individuals or on small groups related to health conditions, which I think broadly not understood is that the majority of individuals who purchase health insurance are healthy, and by increasing the rates on those individuals they leave the marketplace and it leaves the higher cost for those who are unhealthy. What you need is a broadly subsidized marketplace that ensures that the unhealthy, as well as the healthy can afford insurance. This is an extremely important piece of the plus or minus 25 percent that is currently in Illinois law.

Association insurance. This is just to let you know that there is another way that individuals are purchasing health insurance, broadly including in Illinois a number of associations located in Illinois who in fact sell health insurance to the members through the association. It's done on a national basis, and it's part of the variety of the uninsured and

makes insurance in a number of states, especially highly regulated states like Florida, much more affordable.

This is a private plan which you may be aware of Tonik and Sound offered through a couple of companies. This has been targeted at the young, and it has been extremely successful in California and Colorado in entrapping these individuals. I suggest you take a look at the Sound web site, as well as the Tonik web site and take a look at the design of the web site. You can actually sign up for the health insurance plan on the web site. The plans have a variety of fun games associated with them. They have bright flashey colors, and it's targeted at the young and it's extremely attractive. It's been extremely attractive and successful. You can see the premium rates have been very low.

The Right Start Plan. This is another private market solution done by insurance. It includes substantial premium savings by targeting, you know, unique plan designs, specific plan designs that help to cut

cost, limiting some of the top end expenses.

Limited benefit plans. This is something that's out there in the marketplace. I know there is some controversy associated with this. There are all kinds of different carriers on the marketplace who do a variety of things. It's important to be aware that this is out there as an alternative.

Depending on the plan it may have limits on the total amount of reimbursements. In other words, it may only cover $20,000, $50,000, along those lines or alternatively they may limit the availability of certain doctor and hospital expenses. They may cover a thousand dollars a day, $2,000 a day. It's usually done outright.

The criticism traditionally has been that it is inadequate to cover the health expenses of the individuals. I think that the companies -- the important thing here is that they are in fact informing consumers about what they are offering. As long as the consumers are aware and understand the limits, they don't tend to have as many problems.

Finally, one of the last few pieces that is important to understand I think is when you are looking at some of these things it's important to ensure that the regulatory market is done appropriately. A lot of these efforts on the national basis is targeted at the specific rules and make it hard for health insurance companies to offer these plans, to offer new plans, and to increase the rates if it's necessary or keep their rates stable.

It's important to make sure that the process that companies go through is both appropriate and speedy and that they are able to have the predictability that they understand when they are following rates and forms that they understand what the requirements specifically are. While Illinois does a pretty good job of this, there are states that have gone the other direction.

In closing we have got a variety of publications. I think you have got a copy of the State legislatures guide in front of you. There is a glossary in back. If you have got any questions, certainly feel free to E-mail me.

We also have a number of broader publications on Dirigo. Dirigo is coauthored with Tarren, a member of our staff. So thank you.

MR. LERNER: Thank you very much. It was very informative, very informative.

We actually are a little ahead of the game here, so we have some time for some questions. Let me start out with one real quick. This is probably the third or fourth time we have heard it today.

Is there not an example of a plan or cannot there be an example of a plan that covers the uninsured and the underinsured which also includes community rating and guaranteed issue?

MR. WIESKE: No.

MR. LERNER: Why?

MR. WIESKE: The reason is, first of all, those populations broadly are healthy and so community rating actually goes the opposite direction. It increases the cost. What it also does unfortunately -- what community rating also does is it forces the healthy out of the market. It increases the costs on those individuals who need health insurance the least. Those

individuals who need health insurance the least always wind up subsidizing those who need it the most.

What you see happening is there is this kind of push that as they start leaving the market the rates for the unhealthy starts rising. It rises well beyond -- if you take a look at the community rates in states, you can see that the rates actually rise far beyond what would have been a middle rate or high end rate for states where there is the rating flexibility.

MR. LERNER: But speaking a little Mary Poppyish and remembering my history of the American health care system, the people couldn't opt in and opt out. The ones who need it the least will eventually need it the most and eventually things will even themselves out.

MR. WIESKE: The problem is that you know, first off, obviously there is choice there. The other problem is when you're looking at individual carriers you're looking at a situation where they typically don't have a risk for more than a couple of years. The other

issue is, you know, when you're looking at individual mandate, I am not sure how you design that, especially if we are in a community rated area where it becomes unaffordable, and you always have the issue of the large employers who opt out of this market entirely. So you don't have those people subsidized.

MR. LERNER: David.

MR. CARVAHLO: I too wanted to ask a question about community rating. I thought the way -- the goal of community rating was so that you don't have the situation where people who are sicker and in more need of care face prohibited rates. If you move away from community rating, are you just trading off instead of the uninsured being the healthy and young, the uninsured are the older and sicker?

MR. WIESKE: There are two pieces to this. The first is when we are looking at the market as they stand now when we look at the individual marketplace, we are looking at the high risk pools and high risk pools -- in the individual marketplace you're allowed to actually decline this. Typically insurers cover

roughly a 0 to 50 percent increase in premiums depending on the carrier in the individual marketplace. Those who exceed that -- somebody who has, let's say for the sake of argument, an ongoing heart condition, those individuals can go to a high risk pool. The advantage of a high risk pool is that those risks are shared equally among all the carriers or in the case of some states the taxpayers or some other subsidization.

So you don't have carriers competing not to get those risks. You don't have carriers -- you have carriers broadly sharing those risks with the general public or in some cases paying for those risks amongst the carriers, you know, in its entirety, and it allows them to keep the rates for those who are healthy lower within their block because they know that they are not going to get the substandard risks because they know that their risk is equal. So you find with high risk pools that the overall -- the effect on the overall rates for the individual market are low despite the fact that you are able to cover individuals

who have serious health conditions.

In a small group market there is guaranteed issues. So there is guaranteed coverage, but there are rate limits as far as where the group goes. So you do have a plus or minus from what's considered the dip point. What you actually find is majority of individuals -- it's not a bell curve. Most people are not in this middle section. Most people are over here, and so in healthy sections even if they have got minor health issues what happens is when you push this side down, some of these people come out and the overall rates end up going up and you have fewer and fewer insured people. It's called the death spiral. It happens every single time.

MR. LERNER: Ken. I am sorry. Niva.

MS. JOHNSON: Thanks for the presentation and good information. You know, you mentioned that two-thirds of the uninsured are the employed, but on the other hand you make it seem like because they are employed -- I thought I just heard you say that they are the healthier. I guess I would have some concern

with that because okay -- I'm glad you're clearing that up because I take care of a middle class community, but they are persons of color who have a higher disease burden and are newer to the health -- some are newer to health insurance system, and I guess I had a problem with what I was hearing because of that.

Now, Illinois is not a community voting state?

MR. WIESKE: No, it's not.

MS. JOHNSON: What we have seen happen in Illinois is that a lot is done based on zip codes. There have been stories in the news about insurers where someone moves across the street, changes zip codes, and their insurance plan rate goes up because of where they live, and their insurance is being based on that community. I am also seeing that I as a physician I'm getting paid based on the zip code because of the community that I serve and because of the disease burden also.

MR. WIESKE: For example, I believe when I processed claims years and years ago you will find that every single anesthesiologist in Green

Bay, Wisconsin would actually technically practice out of Milwaukee because the rates were higher. They had actual technical offices down there. In fact, it is based to a degree on zip code, including the RDRS system with Medicare is based on where it's located. Hopefully it's suppose to be designed in such a way that it is neutral as far as the community itself, but it's suppose to indicate what the costs of the community are. You know, it's not suppose to include any type of demographic factors in the community. It's not suppose to include anything other than what the charges in that community are related to the rest of the area. So Chicago should be more expensive than say some areas in rural Illinois who have lower costs, you know, for a variety of reasons.

MR. LERNER: Ken Robbins.

MR. ROBBINS: For the sake of discussion, would you react to what I am about to say? In light of the complexities of underwriting, guaranteeing issue, community rating and the need to find ways to plug those holes such as high risk pools, why wouldn't it

simply be more effective and efficient to have either a single payer or Medicare for all types of proposals on the table for discussion?

MR. WIESKE: You know, I think if we take a look -- maybe this is my opinion, but if we take a look at the experience and the single payer systems, what's interesting is, you know, you have some dissatisfaction of the current system, but it's dissatisfaction in part from people who have to pay the rates who are not necessarily accessing the system as much and who are insured.

If you take a look at England and if you take a look at Canada and you look at the experience in Germany and other states, the people who are broadly dissatisfied with the system are those who have to access it the most. So when you're looking at the people accessing the system the most as being the most dissatisfied, then when you're looking at it in fact in Canada, the traditional disparities in care still exist despite the fact that everything is suppose to be planned. You know, that creates a whole another set of ethical

problems in my mind.

MR. LERNER: Any other questions? Sir.

UNIDENTIFIED PERSON: I have a question. Just for the sake of clarity, I want to make sure that my understanding is correct on this point. In this state and maybe in most states there is such a thing as guaranteed issue of community rating, and it's associated with group plans. My understanding is that a group that has ten or more employees really is a guaranteed issue plan and has a community rate. Is that not the case?

MR. WIESKE: Now, in fact, it is guaranteed issue under HIPAA. It's effective across the country. You're required to guarantee to any plan that the employer wishes to purchase. It's available through a small group market to any employer who want to purchase it. However, the rates inside of the group are going to be relatively equal, but demographically a group that's exactly the same in exactly the same region right next to each other have different health status right next door are going to have different -- may have

different rates.

UNIDENTIFIED PERSON: I understand that. So my question is I'm not sure I understand why this can't be. If I can have a smaller universe that is community rated, why can't I have -- and it works. Obviously there are insurers that offer plans that are community based within the context of employer group, not other employer groups. If that can work for them in the context of one employer group, why can't that work for them in the context of a whole state?

MR. WIESKE: Well, there is a variety of reasons. First, when you're looking at the group, the employer is primarily paying majority of the bill. So there is no participation issues with the employer. In those cases the average employer I think across the country -- I think the data I saw is between 75 and 80 percent of the cost is covered by the employer. So the amount that the individual person pays for themselves is very little. Typically there is some requirements inside of the employer to take the coverage. If you don't take the coverage, you don't get everything. It's not

really exactly the same as looking at the community at large, and you don't have the problem in the employer's side of the healthy individual deciding that it's much more affordable to go into the individual market or go uninsured because the employer is subsidizing those costs.

In the case of the broader marketplace at large, the individual has that choice, and the individual will end up going uninsured because as you drive up those rates -- you know, as you drive them up, it becomes unaffordable to them and of the people -- if you want an uninsured problem, take a look at New York. Take a look at New Jersey where the cost of an individual health insurance plan in the state of New Jersey I think it's a $1,500 deductible plan. It's going to cost you $264,000 a year for one insurer.

So we've had discussions with some of the people in New Jersey, and their advice on the individual market is to call your brother-in-law and get on his payroll because you can't find coverage in the individual market

in New Jersey that's affordable.

MR. LERNER: David Carvalho.

MR. CARVALHO: Earlier Tarren mentioned either one of the design clauses or unintended consequences in the Dirigo plan was by making a plan available to all. Instead of simply enticing folks who were uninsured, you also wound up with a lot of people who had a different insurance product that was more costly and now they found the subsidized product more affordable. I am wondering about some of the suggestions regarding mandate lite and association plan, how they address that similar concern on the flip side, which is say I work for company XYZ and the 75 other employees and I all currently receive health benefits that has the mandates and has the benefits and when an association plan becomes available or mandate lite plan my employer, who is currently offering this other policy, now chooses to offer the mandate lite policy and now all 75 of us wind up with a plan with fewer benefits and fewer mandates so that the business down the street that doesn't have a plan may elect mandate lite.

In other words, you know, you entice some folks who are employers who are not offering a plan with mandate lite or association plan, but you run the risk that other employers who currently offer the full benefit plan also choose it. In an end result a whole bunch of people get less while few people who were getting it get more.

MR. WIESKE: What's interesting about the experience that -- I worked for a carrier that had a self-funded plan that went all the way down. It was an experimental plan in the state of Maryland. It went all the way down to two lines. It was self-funded.

What's interesting about the experience of that was that you found -- and they offered three options. Option one was essentially no mandates. Option two was kind of a middle road. Option three was all the state mandates, if I remember correctly. What you found is literally nobody, none of the employers took the no mandate option. All of them either took option two or split out equally between options two and option three. That was an

experience.

I think the point here is that -- I think as well when you present employees with some of these options and they sit down, there is a moral obligation on the part -- a feeling on the part -- they are offering insurance in some cases despite the fact that their employees don't want it. I know my father ran a small business in Arizona and his employees asked him not to cover insurance and just give them money. He told them it's his obligation to cover insurance. It's an obligation there. When they sit down with a benefit professional, they are going to look at those pieces. I think typically they are going to try to find what they think best fits their employees.

I think in the same way we should offer the option for individuals to say, look, what works best for you, do these mandate lite plans work for you. I think the experience in the mandate lite shows us when they sit down -- when an agent sits down and describe these plans with employees, with individuals, they start off there and maybe they end up someplace else.

Maybe that's why the uptake on those plans haven't been that high, but it gets some people that can't afford the marketplace. As they can move up, I think they move -- they tend to move up into different plans away from the mandate lite.

MR. LERNER: One last question. David Carvalho.

MR. CARVALHO: For the state coverage mandates for Massachusetts being the most recent where they required, you know, all individuals, what do you think is the proper role for government to play in this whole issue? Because more and more we see that there is going to be public pressure because of dissatisfaction or whatever that may be to do something more. So what is the most significant structure or proper role for the government? Is it in the mandate area? Is it -- just comment on that.

MR. WIESKE: You know, I'm hopeful that when we look at the Democratic governor of Tennessee who is coming up with a replacement to the disaster skin care experiment that he has talked about setting the market and allowing --

creating a plan where individuals can afford to purchase that; and if individuals can't afford to purchase it, they are going to provide a state subsidy for those individuals. They are going to allow the market to design the plan that they can afford to offer under the idea that it's going to cost a maximum of $150 and if the state would subsidize per that premium.

I think when we look at the data that we have been talking about, the Brooking and the Irving Institute Study, as well as typically a left center group and a right center group of the American Enterprise Institute Data, I think there is some interesting ideas there related to tax cuts and tax credits indicating that if you provide a 50 percent subsidy for the health insurance that you substantially reduce the uninsured rates based on tax credit. That's some pretty compelling data.

Even if you lower it further and you can't afford to do that, there is still some compelling drops in the number of insured. That's an interesting -- these are not broadly targeted tax credits. These are tax credits

that are targeted at the poor and only the poor period. So we are not talking about subsidizing those who make 75,000 who are uninsured and that type of thing.

I think part of the point here is you need to understand that this marketplace is very diverse. There is a lot of different needs and that coming up with a one size fits all solution may not be the best way to attack this. Maybe the best way to attack this is to come up with a series of approaches that could target on a population by population basis those people who are uninsured.

MR. LERNER: That will bring a great conclusion to it because of the time I want to start to get into special population and those are the kind of disease problems of people with disabilities, etc, and then we can talk about different types of risk pools. Thank you very much. Great job.

While you take a stretch break at your places, because I don't want to lose your momentum, we are now shifting over to a presentation by Mr. Brad Buxton from the Blue

Cross Blue Shield Association -- Blue Cross Blue Shield of Illinois, who by the way has been the wonderful host for us today.

(Whereupon, a recess was taken.)

MR. LERNER: Our next speaker is Mr. Brad Buxton from Blue Cross Blue Shield.

MR. BUXTON: What I would like to do today is -- maybe it's a little different than the past presentations -- to go through just a little bit on what Blue Cross and Blue Shield has done some research on the uninsured, talk about some of the things that we are doing today that we think are having some impact, and then give you a recommendation on an outline of a plan that we think the state could take under consideration to move forward to at least help on the working uninsured. Again, this is something that's Blue Cross Blue Shield alone. This is something we are presenting. We have not collaborated with anybody else on it at this point in time. So this is a Blue Cross and Blue Shield presentation. This is not a health insurance industry presentation.

Anyway, one of the things we want to start with is this issue is really multifaceted. We are really going to focus on the working uninsured. We are not going to try to solve the government program per se. We are going to see what we can do in the private sector. So what we are looking at here is a private sector approach, and we do agree that the government needs to properly fund its programs. We understand the issues with government funding of programs, but quite frankly uncompensated care for the most part is caused by government underfunding. We would like to take a look at that, but today we are going to focus on the uninsured.

Anything that really promotes uncompensated care or not putting more money into the system is just going to exacerbate the problem. We feel very strongly about that. I think we have heard from some of the other speakers today from Dirigo and the last speaker that when you don't put the money into the system or you allow people who are buying full coverage to get into subsidized coverage, you

actually ruin or hurt the plan that you're trying to do rather than make any forward progress.

We think that in this we have to get private market innovation and have affordable and specialized products. We don't think the same products we make out to the public population today are going to work, but we think things such as that will work. We do believe that the government safety net has to continue to be there. It has to be funded, and whether that will be something on the Medicaid side and Medicare expansion programs or the high risk pool, we think are very important and need to continue to be funded.

Now, the uninsured population in Illinois is not really a homogenous group. I think you have heard this again through some others, but we have about 16 percent of the folks in Illinois are uninsured. 36 percent again have what we feel are -- at least for the research that we did could afford it but choose not to purchase health insurance. 30 percent are really uninsured and eligible for programs

but are not accessing them. 34 percent we feel will have difficulty purchasing coverage that is affordable for them.

We did do a research where we did actually focus groups of uninsured. We sat them down. We asked them what kind of coverage would they expect, how much could they afford, and quite frankly we found some very interesting things, and number one was that people did want to buy health insurance. They felt it was important, but they felt other things were more important. Whether that be food that they needed to buy, whether that be entertainment, whether that be a new car, those things were more necessary to them than health insurance, but they felt that if health insurance were in the $100 range per month that they had had some preventive and comprehensive coverage that they would try to afford it.

Now, 100 was an average range. There was some below obviously and some above, but based on that they then also looked at the working uninsured and found that 80 percent of the working uninsured in Illinois were from

working families and 58 percent are employed by small firms less than 100. So, again, we want to focus on the uninsured because we figure that is the largest block where we can get the biggest bang to try and create something better than what we have today.

What are we doing today that we think has had some impact? And quite frankly we have gone out in our individual products. Even though we medically underwrite those, we have been able to at less than $100 a month, and this would be for a single male who doesn't smoke, get down to 60 affordable product line, $70 temporary insurance, which we now offer for in between jobs, and $60 a month which has preventive and comprehensive care, and children's policies we can deliver at $58 a month.

Again, that is medically uninsured products, and there is a large range. You can even get on our website, Blue Cross Blue Shield of Illinois, bcbsil.com, and actually put your zip code and put in your age, nonsmoking, with maternity, without maternity and find out that

we have put out some very affordable health policies with good coverage.

One of the things about that we found when we asked people when they signed up for our insurance have you been insured before, 30,000 people within the last year that we wrote individual policies for said they were not insured before. They said they were not insured. I can't guarantee you they weren't, but they didn't think they were. So that is something that we feel being able to get those affordable policies out there has helped.

Again, in a small group we have put out some new products. We call them Blue advantage products. They are our Blue health savings accounts. Again, we haven't been able to drive the prices down below our larger network and higher benefits, but these are still good preventive benefits and good comprehensive benefits. We have been able to afford small groups who didn't offer insurance before.

Insurance, we sell them through our brokers, and there are a number of brokers here today, and I think they would tell you that

these are really well priced programs and have afforded people more coverage.

We think we offer some expertise. We have been doing this for some time. We have been -- we have been administering Blue Chip. We do administer Medicare Part D. We do understand how to work with government. We do understand community outreach. We donate millions of dollars a year to community outreach programs. We have our own caravan which we donate immunization. Those are only some things. While we are not here to brag about those things, those are things that we hope and would think that more people not only in the health community but in the business community would look at doing things such as this because these are worthy causes, and we think they are important to continue today and tomorrow.

The new legislation. And why we say new legislation is these are ideas about what might be in legislation because we think actually some legislation will help to get affordable policies out to small groups and those who are working and are uninsured. And why? I think I have

already said why. 80 percent come from working families. 58 percent are in firms less than 100 employees, which many do not choose to offer health insurance; and, no, this is not the Massachusetts plan, not. That cost a billion and a half dollars. I don't think we have that.

The guiding principals are very frankly is we need to bring new money into the system. If we put a plan out there that taxes somebody is already paying for care and don't bring new money into the system to cover care, we are just exacerbating the problems we already have. So one of the rules we look at is how can we bring new money into the system, how can we get someone to pay for a policy and make that policy affordable so that we are actually bringing money into the system rather than just taking money from there and putting it over there and doing a hidden tax. We don't agree with that.

We need to make it simple. We need to minimize administrative costs for both employers, providers, and carriers, and we want

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to allow the free market to work here. We want to allow some equilibrium, and we don't want to regulate. This is not a regulation of saying providers have to pay less, suppliers have to pay a tax, we do premium taxes or we do rate review on premiums. This is not that type of plan because again once you create that type of tax, that tax has to be passed somewhere. If you cut that tax off from being passed, then people go away. Kentucky so many years ago was a great example of that where basically almost every insurer was driven out of the state. Blue Cross, we did hang around. I was there at the time. It was not a fun time.

We do believe number one -- and I will go through these -- that we would like to be an employer mandate for all the employers who meet elgibility, which I will get into a second, would have to offer health insurance but not necessarily contribute to it. They must sponsor or offer. They do not have to contribute. That's number one.

Number two is eligibility. We would propose putting this under a new level of let's

say Sahara for the 2 to 50 employees and say those would be eligible, those who were not offered in the past year or medical insurance in the last year. The reason is -- one of the reasons for this and one of the reasons for the requirement is you don't want people who can afford private health insurance today to move into this pool because then you just create another problem with money flowing into the system.

We want there to be means testing. Today there is no ability to do means testing. Again, this is on a small group. What we are saying is that we would look at the employer's average wage can't exceed 75 percent of the state's average annual wage. Now, again we could play with this number, but that is what we came up with to this point.

Obviously these things are negotiable, but the point is you want to get a small group today who cannot afford it or its employees cannot afford health insurance. Those are the people you want to get in, people who are not putting money into the system today.

That $100 a month is going towards something else other than health insurance. They have to buy car insurance. If they have a home, they have to buy home insurance. If they have a life, they don't have to buy health insurance. This is a way we hope to get in front of them through a small group sponsoring it to at least get them an affordable rate so hopefully they will sign up. That's the means testing.

We also think that all health insurance carriers in the state should participate in this. It is important that we again -- so we are all able to afford to spread the risk that we would have that everybody would have to play.

The next thing is employer groups would be -- there would be guaranteed issue for employer groups who are eligible and that we want to make sure that 75 percent of the people that were in the group tried to sign up, and we have industry standards participation requirements which we would have to work on.

Program funding. Employers and employees would fund. Employers must offer, as

I said, but not be required to contribute, and we think that the state should offer tax incentives for small groups, and these eligible groups would offer state tax incentives if they offered in contributing to these plans. We will talk about how to fund that later, but we think such things such as sin taxes may be a good thing to do, but again we would leave that open to debate and again not to tax somebody that is already paying for health insurance to do this.

Standard benefits would be determined by the legislature in consultation with carriers and the Department of Insurance. Again, if this were a level of supplier it would be governed by the Department of Insurance so that we would ensure that everybody would be playing by the rules. We think that the benefits should include the first dollar in preventive coverage. We think that we should go from low options to more comprehensive options and the state should review the impact of mandates.

We don't believe that all mandates

are bad. There are some mandates out there that are expensive, and there are some mandates out there and preventive care that are not that expensive and are very smart to have in place. So while we think that mandate lite is not a bad idea, it's certainly not a good idea to get rid of all preventive benefits because that is something that this population needs. Again, there may be some other things -- I don't want to mention this, but there may be other things that are very expensive that not everybody has to have for a healthy life that we would talk about not having in there.

So the potential impact as we have looked at it -- and, again, I'm sure there could be differences on this, but right now on that small group 2 to 50, we think there are about 500,000 people who could be impacted. We realize and are not silly enough to say that, oh, if we did this every one of them would be insured. We realize there could be other things that get put in place, but quite frankly if people are offered affordable health insurance through their employers so we can put that in

our small group pools, we think that we can have an affordable program and have the opportunity to get 500,000 more people in this state insured.

Given that would happen, we feel very -- we feel confident that that would be a good first step. So in conclusion there is 16 percent of the people in Illinois that we have got to figure out how to get coverage for. 84 percent are insured. That's a good thing, but we know they are insured. They have some coverage. We have got to work with the private sector. There will have to be some legislature for this small group idea to work. We want to work with the state to reduce the uninsured. We don't need to overhaul the entire system at this point in time. You know, there is no silver bullet. I think we all know that and if we tried to do a silver bullet, I think it's been proven in other states that you get unintended consequences. Here we can limit the consequences. We kind of know what they are. We can work together. We can head this population. We think that this proposal is a

big step in that direction. While we realize that we did not dot every I and cross every T, we think this would be a good direction for the legislature to discuss moving forward on.

I can't answer every question that you have today, but I will do my best.

MR. LERNER: Thank you very much. Great presentation.

MR. KOEHLER: I'm intrigued by your proposal. Tell me a little bit more about why employers shouldn't be required? Is this politically pragmatic.

MR. BUXTON: I was in a meeting the other day with a small employer, a small employer who would like to offer health insurance coverage but wants the decision to be theirs and say I may be in a situation this year where I can't. I may be in a situation next year where I can. I want to hold that decision. I want my employees to have access to health coverage. I may be in a small business time in my development but I can't quite offer it yet. I don't want to be forced to, or if I am further along in my development and I have the revenues

I would like to be able to. So that's the idea of putting the tax incentive in.

UNIDENTIFIED PERSON: So it can be an incentive or disincentive?

MR. BUXTON: That is the idea. We wanted to use the carrot.

MR. LERNER: Ken.

MR. SMITHMIER: I have a couple of questions. Would this be portable?

MR. BUXTON: Yes, we think it would have to be portable.

UNIDENTIFIED PERSON: Would it have a major medical component to it?

MR. BUXTON: We have gone through some ideas. If you look at our individual products, those would be some of the ideas that we would put forward, which do have some major medical. The fact to the matter is there would be a lot more managed care looking programs and preventive benefits and comprehensive. To get to the price points there may have to be some annual maxes. We realize they can't be low. They have to be very -- I don't know the exact number, but a lot higher than some of the things

that we have been seeing in the 5 digit. They would have to go up to the 6th digit.

We did not want to be presumptuous to say this is the benefit design that does it. We think this needs to be done in collaboration with providers with this state with other carriers. So I can't tell you that we had the exact benefit design, but if you will look at our individual and small group you will have an idea where we are headed.

MR. LERNER: Craig.

MR. BACES: This is sort of along the lines going with the previous speakers. The support for a limited benefit plan that doesn't include major medical I guess could be yes if there is evidence that people end up moving eventually into plans that cover major medical issues. Is there any evidence that people -- individual employers, employees start out at a more limited benefit, more affordable plan and that they ultimately drift to something more -- something that actually solves the problem?

MR. BUXTON: I would love to tell you. I have the answer to that. I would tell you

that we do see people that come to us and say if we had an opportunity to have, you know, that temporary coverage where we are going job to job where we couldn't afford the individual long term, we are just trying to get a job, we do know that those people want to get insurance and they need temporary coverage. I don't have that. That would be some good research. We would probably be happy to look at research like that with others. I don't have that answer. I would tend to think that from the focus groups we did people want health insurance.

MR. LERNER: Dr. Jones.

MR. JONES: Why should the state subsidize a small employer who chooses not to provide health insurance but is very profitable and has 25 employees and now all of a sudden the state will subsidize them? At the same time you can go across the street to an employer who has 75 people who is not very cooperative, who can't afford to provide health insurance, and they won't be eligible for this. Does that seem a little unfair to you?

MR. BUXTON: I think the point of where

we started is we have to start somewhere. We don't feel that employers who can afford private health insurance should be eligible for this program.

Now, we started on the 2 to 50 on the Sahara because we thought it was a good starting point. Quite frankly if the legislature came back and said, gee, whiz we really need to look up to 100, we are not going to say no. The fact to the matter is -- I think in the Dirigo presentation today one of the problems that they found was that state sponsored plans, subsidized plans, people who could afford it got into them, and that created problems. We want to stay away from that problem. We want people who really need this coverage to be the ones that are in that coverage. We wouldn't -- let's just say Blue Cross. We probably have some folks that are working at $15 an hour. Should we be able to go in and say, hey, we want to put these in people who work for $15? No, we shouldn't. We need some type of means testing. Is this the perfect -- no, we could work on a few things.

This was a pretty good start. What you say we agree with. Do the details need to be worked out a little bit? Sure.

MR. JONES: You would do some means testing for the employer as well?

MR. BUXTON: Yes.

MR. JONES: I didn't say that --

MR. BUXTON: Means testing for the employer is key here. If I didn't explain that well enough, I apologize. This is means testing for the employer, not the employee. This is not an individual program. We are leaving the individual program alone. We think it's working well. We think it is signing up people. We don't want to destroy those pools. We don't want to have happen what happened in New York and New Jersey. My own niece could't get a health care policy. A very healthy 23 year old couldn't get a health care policy for less than $500 a month.

MR. JONES: I think you're misunderstanding. You are saying means testing as far as what their average salaries are. I am saying as far as the responsibility --

MR. BUXTON: We are more than happy to look at how we do the means testing. Today means testing is not allowed.

MR. LERNER: Let me see if I can clarify. The most important thing I got from that one was just the experience from other plans. You don't want to hop down and they have to stay in, but you want the people who can get in to get in, and there are some details we have to work out. Is that what I heard?

MR. BUXTON: Right. We gave you an idea on means testing. We obviously could work through.

MR. LERNER: Dr. Johnson.

MS. JOHNSON: When did you plan on introducing this legislation and about how much would the premiums be?

MR. BUXTON: Given we didn't be presumptuous enough to design the plans ourself, I don't have a cost of that. We would like them to be the 100, $150 range let's say for an individual. I can't give you that price yet until we do the work.

When would we put this in the

legislation? Obviously in the next legislative session. If someone wanted to go sooner, we would be happy to talk about it.

MS. JOHNSON: Veto or next spring?

MR. BUXTON: Next spring is when we would be talking about.

MR. LERNER: You know what, today he didn't generate any conversation. Are you going to stick around for a few minutes?

MR. BUXTON: I am more than happy to stick around.

MR. LERNER: Thank you very much.

We are going to have one more presentation, and then we have time to open for more questions. Thanks, Brad, you did a good job.

Our next speaker from the formal presentation of the day is Mr. Martin Mitchell from American Health Insurance Plans, and he will talk to us about administrative costs in the private insurance industry, and then we will have time for a few remaining questions for the speakers who are still here.

MR. MITCHELL: Good afternoon. My name

is Marty Mitchell. I am with the America Health Insurance Plan, which is an organization based in Washington representing over 1,300 health insurance companies. We represent a whole host of insurance companies in Blue Cross Blue Shield organizations, commercial insurance organizations, or managed care companies; and on this day I am pleased to be able to talk to you about the administrative costs late in the day.

According to the national spending estimates by the Center for Medicare Services -- Medicare, Medicaid Services, the chart is up on the wall that shows over the past 20 years or so administrative costs for commercial insurance organizations, not organizations that are handling Medicare and Medicaid, that have remained hovering around the 12 percent figure.

Unfortunately, if you go to the CMS data, they can't tell you much more than that, but fortunately here in the last few months we have published this pamphlet, which I think most of the Task Force members have. It's the factors fueling rising health care costs from

2004 to 2005. It was a report that was commissioned and it was performed by Price Waterhouse Coopers. They were an organization who did the report -- similar report for us back in the year 2002, and we had them update it. I do have some extra copies for members of the public who might want to have a copy. Just see me after the presentation.

What we did was to ask them to not only look at the issues that have fueled health care costs, but also to pay particular attention to administrative costs, and they were able to do that. So what they ended up doing was to break out what we call the health care dollar. You will see on the right hand side of the dollar where it's basically green there is 86 cents. Those are the payments that are made by the health insurance companies out of the premium dollar that are paid to us by employers and individuals that are in turn paid over to providers of care.

The 14 cents of the dollar on the left hand edge of the dollar are the dollars that are spent by the insurance companies. I

will call them insurance companies organizations which have traditionally been called administrative expenses. In the old days in the '40's and the '50's it paid for precomputers. It paid for a lot of labor for people to pay claims. It paid for the billings and sales and management of the organization, but there has been a lot of change within the last 15, 20 years in health care. We have been talking today about many of the changes in terms of the policy of health care, but there has been a lot of changes in the administration. So what we have done is try to break that out into its component parts.

The first part on the very left hand edge is 5 cents, and it's labor consumer services providing support in marketing. Unfortunately or fortunately I am not responsible for the heading, and in fact I tried to see if we could get the headings of these to be a lit bit more declarative, but you have no idea what has gone into the effort of labeling this health care dollar, and I am not allowed to change it at all.

Let me tell you a little bit about what's in that 5 cents. It's things today like disease management. It's things like health care coordination, health promotion programs, wellness programs. It also does include traditional administrative expenses, such as claims payment. It does have the computer in there for the claims payment systems, but you will see where in the old days it was purely billing and it may be a little bit of telephone customer service and payment of plans, it is now much more focused on providing services directly to consumers, to the policyholders of the insurance companies. That's why I wanted to stress the fact that issues like wellness is in that 5 cents.

The next bracket over is government payment, compliance, and in this area we have traditional fees such as premium taxes, not a big issue in this state, but nationally it's a much larger issue. Compliance is becoming a larger and larger issue for insurance companies, also for doctors offices as we have -- HIPAA has come in, federal laws have come in on privacy.

A whole host of activities have been created in the last four or five years that have to be paid for, and that's coming out of that 5 percent -- I'm sorry that 6 cents that's labeled government payments.

The next one is one that I'm sure you have had some discussion about. That's the so-called insurance company profit. In their review Price Waterhouse was able to carve up that administrative expense and found that there was 3 cents of the dollar that's being retained by insurance companies for so-called profits. In my estimation it was a large amount. For a Blue Cross company if we could have had 3 percent every year, we probably would have been quite happy.

The fact remains that the administrative portion for profit is three cents, and it's that next item across. As you go beyond that, you are now entering into part of the dollar that's paid out by insurance companies to the medical various providers. The first piece is other providers. They would be things like home health care, nursing homes.

The next piece over is drugs. Obviously in the last five or six years it's becoming an increasingly important issue in terms of health care spending. It's one that over the last couple of years has slowly come under some control as programs like three tier programs have been put into place by insurance companies, and that price pressure has been reduced somewhat.

The next bracket over is payments to physicians. We all probably know what that's about, and also the next one over is 35 cents to hospitals.

We have on the very right hand edge this last bracket, which is medical liability and defensive medicine. We wanted to pay particular attention to that issue. I know when the director was here a few minutes ago a little bit before lunch he mentioned the fact that my CEO had talked about member malpractice being a major issue. I think what she was talking about was this defensive medicine issue. Medical malpractice within that defensive medicine is only about 2 percent of the 10 percent. It's

the line share, but it's all the other aspects that go around the issue of liability, not in terms of necessarily the payment of the policies, but just the impact that has unfortunately on the medical profession as they are trying to live within that world and find that they have to do things that they probably don't necessarily want to do, and we have to pay for it. So that's why that piece is at the end and it's shown in red.

One thing I would like you to do in the document which goes into discussions about what's the drivers behind the physician increases, half of it -- half of it is inflationary increases, general inflation, but there are additional pressures, more inflation on physician services and hospital services. That's pretty much detailed in that booklet, and I will recommend it to you for your attention.

There are also a couple of other things in there that you may want to take a look. At the very end of the booklet it talks a little bit about good quality and poor quality medicine issues that are now becoming real

issues of the forefront in terms of the practice of that medicine. There are issues that AHIP is particularly interested in, and we have our own programs. We are trying to bring aerospace medicine to the forefront as we go forward in the 21st century. There is a little bit of information in there on that. I will also draw your attention to that one.

At this point that's the five second version of where the administrative dollars are spent.

MR. LERNER: Questions?

UNIDENTIFIED SPEAKER: I have one, and this may not be something that you can answer. We often hear that under Medicare the cost of administration is three or four percent or some such number.

MR. MITCHELL: Right.

UNIDENTIFIED PERSON: Are those assertions accurate if you're doing an apples to apples comparison?

MR. MITCHELL: It's honestly very difficult to say because even if you go back to the Medicare dollars that CMS -- the CMS data

that Medicare puts out there is no good tie back to all of that information. I can tell you a couple of things about those CMS numbers of three or four percent.

One is the cost of capital, which is clearly in the three percent -- the numbers I'm showing you for the insurance industry. The cost of capital for the federal system is not included in it, and if we just look at the cost of benefits that are being paid out that have not been funded because of the Medicare trust fund, if we take a look at those dollars, that's probably 6 or 7, maybe 10 percent in terms of our numbers. So 3 would probably go at least to 10, and all of a sudden we're 10 to 14. We are starting to talk apples to apples.

There are other mechanical issues, such as membership. Many of the membership -- much of the membership effort comes out of Social Security. That's not something that's charged back through. I'm not sure that many of the salaried positions within CMS that is actually supporting Medicaid and Medicare are being wrapped into the Medicaid, Medicare

numbers. It is a very difficult analysis to do. I think we are nowhere near matching fruit to fruit. I know that's somewhat of a bias position.

MR. LERNER: From Task Force any other questions?

Sir, did you have a question?

MR. FRAZIER: Yes. I am concerned --

MR. LERNER: Will you identify yourself?

MR. FRAZIER: I am Frank Frazier. I am co-chair with Unity Temple Social Mission on covering the uninsured. I have some questions about the internalization of costs. Let me give you a little story, and then there is a question associated with it.

My understanding is that many of the costs in the public domain associated with delivering medical services or the funding for medical services actually isn't really represented in most budgets because many of the organizations that are delivering this are not-for-profits charity organizations and those costs are not included in the cost associated with the program.

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In the similar way I'm concerned as to whether costs associated with the similar service in the public markets are being expressed here, namely the conditions that agents are providing. Agents not only sale products, but they are also providing a great deal of value service to the consumers and their policyholders in mediating their claims or whatever it may be. So are those dollars being expressed here?

MR. MITCHELL: Yes, they are. They are in the first portion of the first five sentences under marketing for this analysis that includes marketing and sales. Sales would be direct and also commissions. So those numbers are included in here.

MR. LERNER: Thank you, Mr. Mitchell. Thank you very much.

We have a few minutes left, and as I see it Mr. Buxton is here. Mr. Bachman is here. Ms. Ellis is here. Mr. Bragdon is here, and Mr. Mitchell is here. I think that I have got everybody. If there are any questions these people -- if there is any question now, let's

fire them up.

Dr. Johnson, who are you directing to?

MS. JOHNSON: One is directed to Mr. Bachman, and the second one is directed to both Mr. Bachman and Mr. Mitchell.

To Mr. Bachman concerning pay for performance, one, I like what you said for pay for compliance. I am totally against to a large degree pay for performance because what I have seen is providers are going to get paid based on how patients behave, and I could do everything I can, but I can't walk somebody through the door to get a diabetic eye exam, but I am going to get paid based on their behavior. So I really like the idea of pay for compliance much better, and I hope you will continue to promulgate that and less for pay for performance.

And then the second question for both of you all --

MR. LERNER: What was the question?

MS. JOHNSON: What do you think about that as a comment and --

MR. MITCHELL: If you believe that

health care consumers -- is going to be successful I'm just trying to read -- I'm not selling any particular concept, but I see it moving in a very direct line towards that model I was describing. I don't think you can get there unless you do have the pay for compliance aspect built into the products.

I will give you a good example of the pay for compliance that should be out there, and it's going to take a little understanding by the vendors, by the employers, and by individuals to carry that whole concept out. As an example let's take an insurance policy with somebody who is insured. If they are a diabetic and they are taking care of themselves, who will benefit by them taking care of themselves? They have an individual policy. It's fully insured, so the insurance carrier will benefit. They will have greater profits if that diabetic is taking care of themselves. It's not the employer who is going to benefit. We are talking about the insurance carriers benefiting if an individual is compliant with good evidence based care. So you have got a good relationship

between the patient and the doctor, which is the whole idea of the health care consumers, and you bring that relationship back into line where it should be giving.

I contend that a good product design would be to reward that individual so basically the insurance will be giving him a dividend, if you will, of a shared savings model reward back into their account balance for helping the insurance company make more money. So you don't wind up with the insurance company making profits off of the changed behaviors and the more appropriate behaviors that are out there. The only way to ensure that those savings don't get into the pocket of somebody else is to have a competitive market place so that if an insurance carrier is offering that kind of a product in competing with lower prices by sharing those savings. It's absolutely critical.

MR. LERNER: Dr. Johnson, do you have a second question?

MS. JOHNSON: Yes. Mr. Bachman and Mr. Mitchell, what do you think of the HEMA's

deal with health insurance modernization because it looks like it cuts out a lot of preventative services, and that's a concern?

MR. BACHMAN: I think it's -- I think it is absolutely amazing that a Republican governor talking about personal responsibility and sort of coming at it from that political perspective works with the Democratic legislature. I think the Senate is 85 percent Democrat and they get a unanimous vote on it.

I think from the standpoint of figuring out how you get a collaborative approach around an international health care issue doesn't get an ideological divide and prevent any kind of advancement is a major step forward with what's happening in Massachusetts. They have got people together from both sides of the political aisle to work on a --

MS. JOHNSON: This is the Engi bill --

MR. BACHMAN: I'm sorry, an Engi bill. I'm very much against the Engi bill. The reason I'm mainly against the Engi bill is it made a substantial change at the last minute when it changed from saying okay what is the definition

of a health care policy. They started off with a definition that could have some variation when they said a health care policy is defined as those things that are unique that have been passed in 45 of the 50 states. It's consistently passed in 45 states, and that ought to be part of a basic health insurance program.

Engi at the last minute removed that and said instead what we will do is provide an option. If your health insurance carrier offers one benefit design that's offered to state employees in the five most popular states, which Illinois is one, then you can offer anything else you want. So it's a big loop hole. If I offer this plan, it's offered in one of five states to some segment of the state employees. They don't have one plan. They have got dozens of plans. New York state has 40 different plans. You can offer any plan you want and you do not have to meet any kind of standards for benefits, coverage, or categories of rent, which means every state mandate out there can be avoided, and I think what we have lacking there is a basic definition of what health care means,

and so technically and theoretically you can eliminate diabetes, cancer, mental health issues.

I told you earlier that one of my passions is serving the uninsured and mental health issues. I think all those things, mental health parities and mental health benefits, would be avoided if we wind up with selected uninsured. You may have a piece of paper that says you're uninsured, but in fact the reality is you're going to become uninsured for major conditions.

In fact, I think I will go a step further real quick. One of the major policy designs behind all of this movement I am talking about is the health savings account. There is no real definition of what insurance is under the health savings account. They have to have a maximum out of pocket, and they rely on the state approval process to say this is a legitimate health insurance process.

Under Engi I believe that could be changed without any state definitions of benefits, coverage, or categories of providers,

and you can wind up with a very limited policy that's designed only for the tax advantages for the health savings account and not the insurance protection that really should be there. So I am very concerned about Engi.

MR. LERNER: Thank you.

Do you have a question?

UNIDENTIFIED PERSON: I have a question. I was just curious about the diabetic example. Let's say that the person has diabetes because of obesity and so they are being rewarded to take care of the diabetes. That's good, but what about the employer next to them that stayed healthy and didn't become obese? Would they be rewarded also?

MR. BACHMAN: Yes. You have to have a balance there. What you can do with the approach that I have described is for those people who are healthy you can also give them rewards and incentives. You can do -- for example, you can take a high deductible plan -- and I mentioned earlier that there are four conditions real easy to identify that can create enormous savings for the state, body mass index,

blood pressure, nicotine use, and cholesterol level, four very easily recognized.

Any medical director can give you what the national standards of accepted levels of all those conditions are. If you were to get a population within the recommended guidelines for those four, I contend you can save a whole lot of money. What you can do with healthy employees is you can say, okay, your deductible is a certain level. If your numbers are in the acceptable category, we will actually lower your deductible to a lower level because you're healthy. If you're not healthy, we have a health insurance program that can get you the medications and help that you need to get those numbers down to the right area where you can get a better benefit. You can adjust the deductible or you can say I will give you so much money in your account as long as those numbers are in line.

Again, it's the pay for compliance. It's the recognizing the healthy lites. You have got to remember the healthy lites begin with if you're going to set up an initial

account balance especially. They are more likely to have excess dollars at the beginning of the year they can carry over. Right away the traditional sort of initial deposit of these accounts benefit the healthy, but the rewards and incentives that can accumulate in those accounts, I think, also have to have a balance of both healthy and the real big dollars, the 20 percent of the claim. That's where you really want to focus the intention on the behavioral change. The others is kind of a reward.

MR. LERNER: Let's gets back to the conversation that we had a minute or two ago about the cultural or ethical differences between the populations, how norms may be different, et cetera.

UNIDENTIFIED PERSON: My question is for anyone. When you're getting at this personal responsibility I understand that -- maybe it's more of a frustration, but I understand that the wellness section of the Massachusetts bill is something that the governor vetoed; is that correct?

MR. BRAGDON: I don't know. I know he

was going to veto the employer tax portion of it.

UNIDENTIFIED SPEAKER: The wellness portion too that provided for a possible decrease in premiums if you took care of yourself basically. I guess my question is has anyone ever done this successfully to get at that shift in the health care consumer to start taking more responsibility?

MR. LERNER: So the more responsibility you take for your behavior, the more you're rewarded?

MR. BRAGDON: It's working in the employer marketplace. We have seen an emphasis, I, believe in the last few years. Because for many years in my consulting world job the reality was most employers didn't give a lot of attention to wellness because of the employee turnover rate. If I do something now, someone else is going to benefit from it. In the last five years it's really a change in attitude about that, especially in larger employers to get involved and provide health clubs and health benefits and health risk appraisals and

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nonsmoking programs.

It's really been a major shift over the last five years, and the health savings account and the health reimbursement arrangements, they almost all have the wellness portion that says we are going to pay for mammograms, you know, PSA tests, and normal wellness activities, which curiously enough actually changes the environment because it use to be you only got reimbursement if there was a sickness or diagnosis. So when you take your child in for a wellness check, you always have a diagnosis to put whether they are sick or not. Now that would cost you money out of your account, but if you tell the truth and say it's really a wellness check, it comes out of the wellness account, which is part of your insurance. So we start getting back to the truth. We don't play as many games. There is more going on in that area.

MR. LERNER: Any other speakers want to add to that? No.

MR. BRAGDON: In Massachusetts previously a small employer would not get a

discount for having a wellness program. I don't believe that vision was vetoed by the governor. In the rate regulation in Massachusetts you can get a discount if you're a small employer and you provide a wellness benefit where before they couldn't be considered.

MS. ELLIS: I would like to reinforce what Ron said about the large employers where GM has them for life. Really in terms of disease management even a decade ago it was the very large employers who were leading that movement. They were the ones that had the incentive to keep people well and were also doing the wellness programs, but if you can do the transformation where it isn't the employer but it's the individual that has the incentive to stay well, then that can transfer beyond employers.

MR. BRAGDON: That's really the issue that I heard with a number of the solutions I heard. That's good. In a lot of the programs does the employee really have a choice? Somebody else is setting the guidelines of what the benefits are, what the limits are. The

employee doesn't have a choice. Maybe the employer is going to choose something. What health consumers is about is giving the employee that power of choice to have the coverage, not just the employer.

MR. LERNER: Any other questions or comments, statements? Do you want to make a statement, sir?

UNIDENTIFIED PERSON: I have a poem I would like to read. I am serious. It would take two minutes, and it would be very relevant to the issue.

MR. LERNER: Go ahead, two minutes.

UNIDENTIFIED PERSON: This was a poem that was published in 1936 in a book that, as I recall it, was titled The Best Love Poems of the American People, and it starts like this. This is by Joseph Malines.

Towards a dangerous cliff as they freely confessed, though to walk near its crest was so pleasant but over its terrible edge there had slipped a duke and many a peasant; so the people said something would have to be done, but their projects did not at all tally. Some said

put a fence around the edge of the cliff, some in an ambulance down in the valley. But the cry for the ambulance carried the day for it spread to the neighboring city. A fence may be useful or not, it is true, but each heart became brimful of pity for those who had slipped o'er that dangerous cliff and the dwellers in highway and alley gave pounds or gave pence not to put up a fence but an ambulance down in the valley.

For the cliff is all right if your careful, they said, and if folks even slip or are dropping, it isn't the slipping that hurts them so much as the shock down below when they're stopping. So day after day when these mishaps occurred, quick forth would the rescuers sally to pick up the victims who fell off the cliff with their ambulance down in the valley.

Then an old man remarked it's a marvel to me that people give far more attention to repairing results than to stopping the cause when they'd much better aim at prevention. Let us stop at its source all this mischief, cried he. Come neighbors and friends, let us rally. If the cliff we will fence, we might also

dispense with the ambulance down in the valley.

Oh, he's a fanatic. The others rejoined dispense with the ambulance never! He'd dispense with all charities, too, if he could. No, no! We'll support them forever. Aren't we picking up folks just as fast as they fall? And shall this man dictate to us? Shall he? Why would people of sense stop to put up a fence while the ambulance works in the valley?

But a sensible few who are practicable too will not bear with such nonsense much longer. They believe that prevention is better than cure and their party will soon be the stronger. Encourage them then with your purse, voice, and pen and while other philanthropists dally. They will scorn all pretense and put up a stout fence on the cliff that hangs over the valley.

UNIDENTIFIED SPEAKER: Can I mention one thing we didn't get to talk about with any of the speakers here? I think as we talked about competition, one of the things that has been missing a little bit is the competition to improve quality among the providers, and that's

the transparency of information. I would suggest that one of the things that you might consider if you aren't already is total and complete disclosure of the provider mortality rates, risk adjustment mortality rates, and complication rates among every provider in this state.

UNIDENTIFIED SPEAKER: We actually have a Hospital Report Card Act that is in the process of having rules and regulation.

UNIDENTIFIED SPEAKER: Will it be generally available to the public?

UNIDENTIFIED SPEAKER: It would be generally available to the public.

MR. LERNER: On that note I would like to ask for an ominous round of applause for our speakers, for Joe Roberts, who was gone both times. Tell him we appreciate him, for Mike Murphy, and for our now associate Sarah for putting together just a wonderful day and a special thanks one more time to Blue Cross for being such a wonderful host. Yes, a round of applause.

I would like to remind all -- I

would like to thank all the members of the Task Force, especially the ones who stayed all the way to the end. We have our next Task Force meeting on Wednesday of this week. In spite of all the suggestions for improvement, go back to the charge for the Task Force. You realize how daunting our task really is, and you realize also why there is no single approach that's going to succeed, but there are a lot of great ideas that have been brought forward. Have a great weekend.

(AND FURTHER DEPONENT SAITH NOT.)

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I, SHERRY L. JONES, a Certified Shorthand Reporter for the State of Illinois, do hereby certify that the foregoing was reported by stenographic and mechanical means, which matter was held on the date, and at the time and place set out on the title page hereof and that the foregoing constitutes a true and accurate transcript of same.

I further certify that I am not related to any of the parties, nor am I an employee of or related to any of the attorneys representing the parties, and I have no financial interest in the outcome of this matter.

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