ILLINOIS DEPARTMENT OF PUBLIC HEALTH

MEETING OF THE ADEQUATE HEALTH CARE TASK FORCE

TAKEN MARCH 29, 2006

AT 10:30 A.M.

Michael A. Bilandic Building, Room N502,
160 North LaSalle Street, Chicago, Illinois

APPEARANCES:

Mr. Arthur Jones
Mr. Randy Hall
Mr. Jim Moore
Dr. Niva Lubin-Johnson
Ms. Iris Martinez
Mr. Jerry Hitpas
Ms. Pamela Mitroff
Mr. Joseph Orthoefer
Mr. Kenneth Robbins
Mr. Craig Backs
Mr. Kenneth Boyd
Ms. Catherine Bresler
Mr. Timothy Carrigan
Ms. Elizabeth Coulson
Mr. Jim Duffett
Mr. Terry Dooling
Ms. Jan Daker
Ms. Margaret Davis
Mr. Joe Roberts
Mr. David Carvalho
Mr. Wayne Lerner
Ms. Collen Kannaday
Mr. David Koehler
Dr. Quentin Young
Ms. Ruth Rothstein
Ms. Gwyn Davidson
Mr. Greg Smith
Mr. Ken Smithmier
Mr. Ralph Schubert
Mr. Mike Jones
Ms. Ashley Walter
Ms. Elena Butkus
Ms. Teresa Hursey
Mr. Bob Hamilton
Mr. Patrick Gallagher

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MR. LERNER: Some review of the public hearings that have taken place. Here it is. I don't think we reported on the Springfield hearing. We did report on the campaign hearing as I recall. Springfield hearing. Anybody from the Task Force attend that meeting? Margaret.

MS. DAVIS: Springfield I just thought it was heart-filled testimony. The people really had significant, what we thought was uninsured problems for impoverished people. We learned that uninsured status affect all levels of society, dentists, principals, all had stories to tell.

One of the things that the people told me when we were exiting, they weren't sure if we -- if we heard them. Some of us don't give any feedback, facially or hand clap or anything. So the audience doesn't know if we actually are hearing them. And they have a great need to know that even though we don't predict the outcome of this Task Force, that at least we hear them.

MR. LERNER: Thank you. Terry.

MR. DOOLING: I agree with the comments. We were good presenters. I think there were

three things primarily that I came away from meeting with, is we had testimony from a safety net provider in rural county that expressed the problems that they have dealing with uninsured men or insured people. And maintain the funds to carry on as a safety net provider in those areas.

We also heard from the people who were unable to afford insurance because of under employment or unemployment. But little more surprisingly people who you would ordinarily think could afford insurance. People -- the teachers retirement system who all of a sudden have insurance premiums with $21,000 or $22,000 a year. And then those people -- yet a number of people there who had chronic health problems that were just not coverable.

MR. LERNER: Jim, did you have something to add?

MR. DUFFETT: No.

MR. LERNER: Okay. On the Cardan Bill, Congression District 12. What I'd really like to key on is if there is anything new or a spin that we haven't heard from before because now we're up to like a lot of these we be heard. And I'm

really interested if there is something different in the hearing.

MS. DAKER: We used to have 40 doctors in the area now they're down to 20. Some of the reimbursements are the same since 1993 that they get back and they did a lot on mental health and universal care.

MR. LERNER: Jim.

MR. DUFFETT: I think there was one individual who was not Medicare eligible because he didn't pay into Social Security and with teachers insurance and had lost their job and had a problem in keeping there. So I don't know what percentage of people or how many people that does affect.

A lot of discussion around EMS services and it's primarily a volunteer base, an issue of more training, coordinating services, equipment. And then there was another issue that I know I talked a little bit with Ken about it. And so I may be wrong -- I may be wrong here in explaining it but some of the individuals who went to an emergency room were kind of stabilized and needed to be traveled to another hospital.

And before that can happen, they needed to get the verification of a doctor who has services within that -- within another hospital. And what they were saying, they were having a very difficult time in being able to find doctors who would say yes you can bring that patient to my hospital or to the hospital that I have practicing services at.

And so they were taking about numerous times that the ambulance would have to drive by several different downstate hospitals and take the patients to either St. Louis or to Kentucky or Indiana. I may be wrong on that assessment but that's -- I thought that was --

MR. LERNER: That was the same story that you were hearing as we were dealing with the malpractice crisis and the lack of supplies sought by aides and specialty mechanism of other issues. Anything else on the Cardan Bill?

MS. DAVIS: One of the cases that we went to observe on the EMS system was going to contact Ashley to get an ordinance with the big group because they've done some extensive studies about the long wait times for the EMS services in

that -- those rules for committee.

MR. LERNER: I just read that report. We sent it out in rural Illinois --

MR. CARVALHO: Two different things. The World Health Association did a study on EMS situation in Southern Illinois, we distributed that. The organization that Margaret refers to separate organization fee -- if I could take this opportunity if not to sound like a scold but please don't promise people that they'll get access to our meetings we are very tight scheduling this.

MS. DAVIS: We didn't promise --

MR. CARVALHO: I think that they were promised. So we're going to accommodate them and we're going to have to present but we really will not be able to allow every organization that wants to present to your large meeting there is not enough time.

MR. LERNER: Thank you. I guess what I would recommend is that people should submit written plans or testimony, get it around to everybody. We're already running into scheduling problems and we've been trying to -- Steering

Committee trying to manage that. In fact, we're supposed to be doing work the same time we're getting educated. And there is a lot of stories out there so we need to pay attention to that that turn people off. Anything else on Cardan Bill. Rock Island Congressional District 17? I said Rock Island.

MS. ROTHSTEIN: You mean, Rockford?

MR. MOORE: I was in Rock Island. Rock Island was not a large -- it was actually 17 individuals who testified and I would remark -- I don't think there was anything spartanly new, feel free traditional free market people in the traditional simple payer people and then always has a handful of compelling individuals stories of lack of insurance and lack of access and care along those lines.

MS. DAVIS: In Rock Island what is unique is that this town is emerging with the greater level of poverty. It has 78 different ethic groups that are coming into this port city. They have had an international relief effort organization in that area which has been not funded.

So there is not only a problem with health but a problem of food distribution. They have great advocacy going on. And what they are contemplating doing is to have hand prints, 1,300 hand prints of the number of people who have died as a result of lack of insurance in Illinois. And they are going to present that to their congressional people as well as their state legislators. So this is an area, Jim, that I think would be right to deal with the advocacy about this adoption of a piece of legislation in the future.

MR. LERNER: Okay. Thank you. Rockford?

MS. ROTHSTEIN: I was in Rockford with Rosie and then Preston was there --

MR. MOORE: I was there.

MS. ROTHSTEIN: And I'm trying to think. And, yes, you were there as well and Ken Robbins. Ken Robins chaired the session. I would say about 23 or 24 people testified. I don't know how many left their testimony with us but 24 approximately testified.

And it was generally very much of the same. It was a lot of emphasis on access to

care. The mental health issues that were met and had not been much addressed. There was one person who testified for minority health advisory group. And her testimony was very interesting and that she felt that we felt that the clients were not generally -- patients were not generally treated with dignity. That there was a problem with the language and language barrier.

And there was also quite an acute problem with transportation generally from institutional place to place and agency to agency. And there were a couple of doctors who testified. Some -- one testifying not enough -- not enough payment for care. The others testifying that he was paid -- a single pay system. And so generally that was the sense of the meeting and the testimony. And one physician testifying on behalf of children.

MR. LERNER: Thank you. Anything else? I need to remind everybody to speak loud and clear. Good comments. I want to thank everybody for not only attending the hearing but for reporting back on them. That will be very important summary information for us to factor in as we start to

deal with the specific models.

With your permission, I'm going to change the agenda a little bit in order to accommodate schedules, so this is the way we're going to play it. The Illinois Hospital Association presentation by Elena and Teresa will go first as a result of some scheduling issues that they've got.

If Brent Adams and his colleague are ready to go after that, we will proceed with the Citizen Action presentation. If they are not ready to go, then I'm going to ask the Illinois State Medical Society who want to package their presentation, right, going go together.

So we're still going to have a break after that but it may be delayed a few minutes as a result of the presentation, is that okay? Elena you're up.

MS. BUTKUS: This is the most humbling experience to talk about hospitals in front of a bunch of people who were my mentors and who have been in this field for a long time. So feel free to jump in you've been in this field a lot longer than we have. Teresa and I are both in the

Finance Department. We have totally somewhat different vents on what we do.

I concentrate on insurance in the private payer market and workers' comp and issues like that. And she's -- definitely her expertise is in public programs, so we're going to duo this presentation up. In general we want to talk about hospitals and Health Care. Health Care in terms of trends, more than anything else because hospitals are really a central piece to the infrastructure of a committee Health Care.

We will go through issues that this particular Task Force will be dealing with, such as Medicare, Medicaid, third party payers, patient and community needs. While there are many many other issues that we could talk about for hours that would include quality, payer performance, we're trying to only touch -- because we have a half hour, on the issues that may ultimately affect the health benefits plan that you will put forward.

When we make our concluding remarks, we would just like to add that the IJ Board has prepared and approved a health benefits

plan for this particular Task Force consideration. We hope that you will permit us to present this particular plan in one of the next meetings to come.

In general, the way hospitals look in this particular state, is that the number of hospitals is shrinking 22 less over the last five or ten years. The number of staff beds is relatively stable, albeit in the past year, we have seen a slight uptake in the number of beds that are being approved.

The number of admissions is -- was absolutely -- has gone up in the last three years or so, as has the number of days. The average length of stay -- this includes long-term care beds. But in general, it is 5.3 days if you -- if you remove the number of long-term care beds in hospitals, it's about four and a half days.

And just so you get an idea, the number of long-term care beds is about 10,000 of those 34,000 beds. The number of outpatient visits absolutely continues to increase since the early '80s. ER visits, most of them are -- 50 percent of our hospitals are at capacity or

over capacity in terms of the number of ER visits. And that's where you see a lot of changes in construction going on and the number of births has generally remained stable albeit we are absolutely expecting increases there.

With respect to how we fair with respect to the economic climate or how we input into the economy in our communities, the number of hospital employees is about 230,000. Annual salaries and benefits paid in Illinois alone, $11.5 billion.

That means of every dollar, 64 cents of the dollar goes to wages in our institutions. The number -- we are one of the top three employers and about 50 percent of our counties and you can see here where we are, one of those top three employers.

We think it's important to talk about hospital profitability or negative margins in terms of, that you get an idea of what we need with respect to building up our infrastructures and where we are generally. What this slide in general says is that 60 percent of our hospitals lose money when they provide patient care.

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Percent of Illinois hospitals with negative patient margins. Albeit one third, 33.3 lose money overall.

I think what's important on the take away of this slide, is that while these are averages, every community, every hospital is very, very different and this is an aggregate number. And in terms of the aggregate number, it's not the rosiest of pictures.

And I think what's also important is with respects to capital spending. We've got a humongous population coming. The baby boomers are just coming in for care. There is a work force demand growth rate. And in general, there is going to be a huge -- a larger cap continuing between those hospitals who have money and those hospitals which do not have money. Overall, however, hospitals need to build up there infrastructure because over the past 40 years in 2002, they hit an all time low of spending and putting money into their facilities.

So since 2002, all kinds of needs have arisen both in terms of demographics and epidemiological changes. But also in terms of

the need for IT. The need for emergency room capacity. The need for operating room capacity. And so in general over the next five years because the average age of plant has decreased so much, you are going to see hospitals trying to put more and more money into developing those facilities.

And that's what takes us in general to the number of downgrades versus upgrades with respect to depth ratings. I think what the important issue to take away with this slide, is that there is still more bound downgrades than there are upgrades, albeit it is somewhat leveling out. But it's going to be very, very important as hospitals try to take care of the communities and the patients they serve.

In addition to that, you should know just in general and again we're finance people so that's why we're concentrating on some of this, that the debt is piling on. And the raising bad debt includes -- reasons for it include the rising number of uninsured which you're trying to address, the uninsured. And

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while, yes, we believe everybody should have an HSA, I think maybe the hospital community might have a little bit of different feelings than some of the other rest of the group with respects to very high out of pocket co-pays and deductibles.

So what we want to go through for a little bit is in general where the revenue sources come from for hospitals. And these are the issues that you're considering have not included issues like capital and other philanthropy, other sources that are included in in our revenue dreams.

But in general an average hospital and this is very average and it will go very different for example, for a disproportionate share hospital for critical access hospital or even for a Downstate hospital. But in general 40 percent of the money comes from Medicare. 13 percent of the money comes from Medicaid. 40 percent from commercial third-party payers, and four percent from self-pay and three percent from other which includes charity care and other things in the bucket.

What's important here that as a

percent of cost, Medicare pays about 93 cents on the dollar of the cost of the care. Medicaid even less, 78 percent on the dollar.

MS. HURSEY: I'll just take a few minutes to talk about the public funding side of things where hospitals are concerned at what they're looking at in the future. I think it is important to note that the Federal Government has come out with the projections of their Medicare spending all the way to 2011.

And as you can see, it's increasing at a decreasing rate. Where as we all know that not only are the eligible increasing because of the age of the population, but we also know that Medicare is taking on new programs for the cost such as Medicare part D, the drugs. So it is a little concerning they have gone -- as you can see here what they've started to do is talk about how we're going to make those reductions and how they're going to have that at increasing rate.

And part of that is that hospitals have to think about is right now they can claim the co-pays and deductibles that they can't

collect from the elderly, as Medicare beneficiaries as bad debt and they get part of that back through Medicare.

The proposal in the presence budget is to take that option out. To no longer allow that debt to be part of the Medicare cost report. And that will affect the hospitals and their financial way. And in fact it will affect the enrollees. I always put this slide in because I think we all feel this way about Medicaid sometimes and it's just impossible sometimes to explain how Medicaid works.

The next slide just kind of tells you how Medicaid plays a really significant roll in the national Health Care system. It pays for if you look at nursing home care -- 46 percent of all nursing home care in the nation. Pays for 17 percent of all hospital care in the nation. It's a very significant role for all providers.

I would like to always point out that the biggest numbers of enrollees in Medicare Medicaid, are not the ones that cost Medicaid the biggest dollars. The largest number enrollees are your children, pregnant women and parents

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probability amount to 30 percent of the cost.

The blind, disabled and the elderly amount to your biggest amount in cost. In fact, in Illinois, almost eight percent of all nursing home care is paid for by the Medicaid program. Hospitals about 18 percent of all Medicaid. All care is paid for by Medicaid.

As you can see from the Department's projections, enrollees are growing, you know, adding programs. And when I look at this, what I want to point out is that this is just Medicaid. This is all medical enrollment the Health Care family services oversees, which includes their senior care program and their All Kids program.

And the reason that I bring this out is that those enrollees are also reimbursed to the hospital at the Medicare rate. And that's significant because as you noticed earlier, the Medicare rate for hospitals on the average is around 70 percent of their cost. And that's something the hospitals have to deal with on a daily basis.

Hospitals are reimbursed for

various methods for Medicaid, one being diagnosis related groups DRG as most people -- see it? Those rates were established in 1992, have not been increased since then to hospitals. There are outlier payments. Those outlier payments include the safety net adjustment payments that started in 2002, some hospitals get disproportionate share. There is the assessment that's out there that hasn't been approved yet and the hospitals are reimbursed on a fee for service basis through outpatient for Medicare.

MR. LERNER: You want questions now or you wanted to finish the presentation?

MS. HURSEY: Whatever's best for the committee.

MR. BACKS: I just need clarification of the term cost. Sometimes versus confusion between the term charges and cost. And I think it might be helpful for all of us since we're all on the page and what we're already to talk about it.

MS. HURSEY: When I'm talking about cost I'm not talking about charges that you bill someone. I'm talking about what it costs to

provide a service. Does that clarify for you?

MR. BACKS: Yes, I understand that way.

MR. MOORE: Cost is defined by the Medicare cost report or Medicaid cost report and the economic cost even there is different issue.

MS. HURSEY: Right. This is defined by Medicare cost principles.

MR. BACKS: Which is lower than economic cost most of the time --

MS. HURSEY: That's correct.

MR. LERNER: Say that again, Craig.

MR. BACKS: Medicaids cost is lower than economic cost. Because they have certain exclusion --

MS. HURSEY: Correct. Base on Medicare cost principle.

MR. LERNER: Just so everybody is clear it's not charged.

MR. KOEHLER: Is it what's reimbursed?

MR. BACKS: No, they don't --

MR. MOORE: Well, reimbursement is different. They reimburse below that number. That's the 79 percent number of Medicaid cost.

MR. LERNER: It's slightly more like 78

percent of the cost.

MS. HURSEY: On the average.

MR. LERNER: On the average.

MS. HURSEY: And I think this slide shows you by county on the average what those hospitals are reimbursed (inaudible).

MS. ROTHSTEIN: I think it would be helpful because most people don't quite grasp the cost of charges, what gets paid under Medicare & Medicaid. I think it would be really helpful if you had something that would be on that and that you could add to your document as a handout.

MS. HURSEY: Sure.

MR. LERNER: That's a great good suggestion. If IJ could produce that, get it to Ashley we'd get it out to everybody. I think that's a great glossary terms. Good call. David.

MR. CARVALHO: There is significant differences between Medicaid payment and present of cost. I have see a chart in the past that lays out the highest reimbursed hospital as high as 140 percent of the cost as low as 60 percent. Can you provide that information as well?

MS. HURSEY: The range.

MR. LERNER: Well, something that shows how you go from lowest to the highest from here to where. That would require some explanation also why someone getting 170 percent cost. Why don't we leave it to IJ to produce something for us.

MR. BACKS: You took the words right out of my mouth again. Because I think Dave's question is good but I don't think you should let it sit without the explanation. And the reason why there are some hospitals in the State, let's say you get 150 percent of the cost for Medicaid is because their patient population is almost exclusively Medicaid and indigent. And so Medicaid becomes the body that they (inaudible) it to and the statement and federal government write that up.

In a hospital like mine where our Medicaid percentage is about seven or eight and our Medicare percent is about five 44, I to a degree we can take the cost that Medicare and Medicaid do not pay and I pass it own to private insurers. But the hospital that only serves the

indigent, doesn't have any private insurers that pass it on to. And most although not all of those hospitals are right here in the City of Chicago.

MR. LERNER: Let me make a suggestion. This will get evolve into or devolve into a very interesting discussion. Let me suggest the following. Since this is one those issues that can become heated but also needs to be understood. Why don't we get the information out from IJ. And if the Task Force would like to take a half hour and really delve into this so it's clear, I think it's a very important thing.

First of all, if we're to understand how hospitals are trying to deal with these types of issues. But secondly, we don't have a direct charge to fix the Medicaid program. We need to understand how the Medicaid program affects the work that we're doing. And so I think it's important to lay this out. Why don't we take one step at a time.

MS. HURSEY: Let me go ahead and point out on this earlier slide. What I was talking about here is those hospitals that have high

utilization and Medicaid and charity care -- not charity, uncompensated care, engenic care, those are the ones that get out those outlier payments and a disproportionate share payments. And that's why there's different mechanisms and that's why some of those do have a higher percentage.

MR. LERNER: And to the extent that you have access to or had access to health physician payment is affected by Medicaid payment, that would be great as well. I'll just give you one throw away. Our doctors at the RIBb Institute gets 39 cents on the dollar for every Medicaid patient that they see. It's not a way to make a living. So there is a lot of issues that are bound up in this one. Go ahead, Ms. Hursey.

MS. HURSEY: With respect to cost shift that was mentioned earlier, in general, the uninsured is about 14 percent of the market. Medicare and Medicaid provide about 46 percent of the market. And the rest of it where the revenue comes from for hospital is that 58.8 or 59 percent of the market is generally people insured either under group or individual policies for the

most part group insurance policies and those payment rates are above cost.

When a hospital takes a look at their contracts or figures out or -- I'm sorry. Or looks at how it will sustain revenue and sustain growth, it takes a look at the number and types of insurers that operate in a specific area. And there are certain insurers that can demand much larger discounts than others.

In addition, they take a look at the market itself contracted versus noncontracted rates. They take a look at which insurance companies might be risk bearing versus those who may not. Their project mix of services, HMO, PPO, point of service all require different types of executions. They take a look whether those companies serve the state or interstate or really full regional areas, and what that means when a teamster drives into Illinois and needs services in an Illinois hospitals, for example.

And so the provider contracts very attitude, the benefit designs require very much, varied implementation. For example, with the new products coming forward hospitals really are now

getting on the ball with respect to pricing transparency, quality issues and report cards, et cetera.

I think the last core tile of what we wanted to talk about with respect to the structure of a hospital, and we talked about Medicare and Medicaid third party payers, is that really hospitals put in a lot to patient and community needs. For the most part hospitals were established as ohm houses for the poor. And what they deal with is that they are a part of a community and they have to be profitable to the extend that they have to be open 24 seven and serve the community and the population at hand.

And so the most important thing is that they service the community how it needs to be serviced and, that includes the provision of uncompensated care which includes charity care to the tune of $1.2 billion and that's a number from 2002, we don't have a more updated number.

In addition to that, as of last year, we have begun reporting community benefits to the Attorney General's office. And that includes all the services that hospitals provide

that are not profitable but are very important to a community. It may be that they are trauma units or other types of services in order to service the population 24 seven.

Your slide and your handout is -- there is a word that's wrong but it is correct on this particular slide. In the midst of maintaining that type of mission to the community, we wanted to explain to you in general why costs are escalating in the hospital sector.

Many times when we do these presentations this type of question pops up. But in general, spending has to do with utilization and price. And as you saw, the number of admissions are increasing and that average length of stay has generally remained stable. That means that utilization is increasing overall and so is the price. And people ask us many times why the price is increasing and we want to in general outline to you why. First of all there's a labor shortage of hospital workers in many different realms from nursing to physicians and it runs the spectrum in a different depended kind of area where your hospital is in.

There is raising costs due to project and technology and the types of services that patient demands, inflation and lately professional liability coverage, the cost of professional liability coverage have not gone down and we don't expect them to do so until the Supreme Court has made a final decision.

In addition there is rising demand to certain services. As we talked about the population is growing and aging, there is constraint capacity in certain types of services that hospitals provide. And there is absolutely an increase in the intensity of care of the services we provide.

We're seeing more people that are older with chronic and multiple conditions and Mr. Lerner's hospital or Dr. Lerner's hospital specifically takes care of a lot of those types of patients. In addition, there is regulatory burden on hospitals. Hospital readiness that public health can probably talk a little bit about, quality and IT requirements. And it's so easy to scheme over this but just the quality requirements with respect to the national

requirements, those are a huge portions of what hospitals are focusing on today.

In addition, this is decreased access to capital. Because as we talked about, facilities are aging and there is still more bound downgrades and than upgrades. There's payment short falls that Teresa talked about from Medicare and Medicaid. There is even payment short falls with respect to some of the larger payers in this particular market depending on what area your hospital is in.

And there is the growing number of uninsured that we try and take care of. As you know, anybody who comes through a hospital's ER we take care of them. And so there is a direct correlation between the number of uninsured to the amount of uncompensated care that hospitals provide. And so this moves you in the end to the fundamental imperative.

You got limited resources, unlimited expectations and the bottom line is that this Task Force is looking at how to insure the $1.8 million uninsured. There is no law in the U.S. that says that you have to provide

insurance. If you're lucky enough to be part of that 58 percent of the market that's insured, what's important to remember is that 50 percent of that 58 percent is fully insured meaning it false under all regulations of the state. The other 50 percent is self-insured and does not fall under the regulation or the mandates of this state but that of the Federal Government.

So whatever this particular Task Force does, it may or may not affect 50 percent of the market. And if you don't -- if you're not lucky enough to be part of that 58 percent, you rely on the safety net which is the hospitals, the public health clients free care clinics. And so in Illinois you can see that there has been slightly a downturn in the number of uninsured mostly because of the number of eligibles for Public Aid going up. And what the IJ board adopted were three general principles upon which we based our plan and wrote a benefit plan that we hope to present to you.

But our main principles are universal and continuous access. And not to destroy the system that we got at hand with

58 percent being insured mostly through the employer market, but to work off of that system. In addition to that, maximizing federal funding for state programs. And that those state programs are adequately funded and paid in a timely fashion.

Lastly, a very important principle for a downstate hospital is access to care for everyone in every community without extensive travel of likely not more than 30 percent. And so what we will bring to you and this is just a snippet, is one plan that focuses really on addressing the major barrier in the uninsured, getting coverage and that is the cost. It's a population base plan. It's a high bread, it addresses different portions of the uninsured market because we don't believe that there is one single solution to -- how to insure $ 1.8 million. And again as I said, it built off the existing private and public sector insurance program with that, I thank you very much.

MR. LERNER: We got a few minutes could somebody grab the lights for me. We got a few minutes for some questions, David.

MR. KOEHLER: How much threat to hospitals is it that we have groups that set up their own surgery centers and really compete and take what I would consider the cream off the top because they're mostly dealing with the insured individuals and they compete for that small portion of folks that actually have the bills paid, how much of a threat is that?

MR. MOORE: Well, it's a problem I think for a couple reasons. It's a threaten -- basically an underlining safety net hospital infrastructure because you're right. They did tend to stream off the top and not necessarily take -- or even the Medicaid enrollees that's why more importantly especially hospitals currently being examined particularly focusing on those two especially because procedural basis is where the money. It's not in treating medical patient or the mental health patient doing a procedure and that's why it's there.

So to me it is a real threat to the underlining if you will stability to what the safety net in communities and that's the hospital and yards. They don't have emergency room in

these facility where you still have that cost structure but your incremental gains being creamed off into the issue.

Part of this to be fair a little bit balance is that I understand to a degree why a physician wants to do it because they're under the same pressure that hospitals are about under payment for Medicare and Medicaid and pressure from Medicare replace revenue that they may be losing somewhere else.

I understand why they -- some physicians choose to do it others don't. When you get into some of that solution, you have to come up with something that packages across the board so you don't get into this ying and yang about me versus they type of issue, you have a continuum of care, one system of care not this peaceful system.

MR. KOEHLER: As a follow-up -- comment on that. It seems to me what I would like to know at point along the way from an economics point of view is what the system is. Is this a free market, you know, capital system or is it a social system. Because it seems like we got two

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different kinds of players that are playing on different rules.

Just as Jim has said. The hospitals have some mandates of care that create, you know, a social system there. And yet, a lot of the other players are playing on a purely market basis and it seems like that's not aiding the consumer or the health care industry very well so --

MR. LERNER: Well, we can pick up on that when we do the -- I would suggest to you the answer to your question is yes. They're all living under both -- meaning hospitals, are living under both the social system and competitive system and different levels of competition. But this desires some depth, take the time to do that. It's time to do that break, there may be time for two maybe other questions.

MR. YOUNG: I'm interested in differential charges that patients or the insurers get. In passing or losing, keep discounts and so on. Could you talk about that a little bit.

MS. BUTKUS: In general in and possibly there has been a lot of change in movement with

respect to this area as you know. But in general the larger insurer that can deliver volume to our particular hospital or that are very intrenched in certain areas, they command much larger discounts than an insurer who may deliver ten or 20 patients to a hospital a year.

And hospitals for the most part in many instances may have to contract with those insurers in order to sustain the community and the patient base that they serve. With respect to charges in uncompensated care, a hospital has one charge master. We don't and cannot change our prices based on the particular patient walking through the door.

So when a patient comes in through the door, our charge master prices are stated on the bill. And then in return with some of the insurance companies, we have negotiated discounts and those discounts go to those people. We have now in a much more transparent form, also developed guidelines that every hospital in the state has complied with for the last three years with respect to charity care. And who is able to get care for free and total at what percentage of

poverty and then sliding scale of discounts in between a second level of the poverty level. So if you're at 100 percent or below our hospitals, you're entitled in general to do Precare in between a hundred and 200 it's up to the hospital's policy.

In addition to that based on a bill we negotiated in general very recently, we will be adding a third layer with respect to giving uninsured and even insured patients who can't afford it what is called a reasonable payment policy that the hospital will work out with you. Is that answer your --

MR. YOUNG: Yes, thank you.

MR. LERNER: I only want to take a couple more.

MR. BOYD: Is there any effort on the way to kind of rebase this pricing system that we're on the Medicare program in the first place. City hospital is realizing 25 percent of their standard charge and that's very confusing to everyone that picks up a newspaper or sees the price.

MR. MOORE: The answer is no. Because the

existing system really doesn't limit itself to rebase anything. I took the comprehensive restructuring of the system for reasonableness to come in to pay. It's just too many conflicting regulations out there that limit what you can and cannot do in my opinion.

MR. LERNER: Right. In short all of us around the hospital that do multiple system books and arrangement, none of them make any sense. So if you want to wave the magic wand and change the whole system, I think we can. All right.

DR. LUBIN-JOHNSON: My question is concerning what you stated in terms of the proposal for the president's budget in Medicare. Would those changes go through and what spend in terms of the hospital's ability to be able to write off the bad debt for Medicare patients as bad debt. Is this about to go back to the Attorney General and then rework the debt from these Medicare patients as to what hospitals will be allowed to, you know, put as charity there.

MS. HURSEY: I think exactly if those proposal -- president go through --

MR. LERNER: You need to talk up.

MS. HURSEY: I'm sorry. If those proposals do go through the president's budget, that it definitely will be and I think that's part of the reason, not the whole reason, little part of the reason why hospital 5,000 is put on hold so we can look at all of the factors before that is -- that hospital is reintroduced.

DR. LUBIN-JOHNSON: House in Illinois or the --

MS. HURSEY: Here in Illinois itself.

DR. LUBIN-JOHNSON: And what is that?

MS. HURSEY: It's house bill 5,000 it's the attorney general's bill on charity care.

DR. LUBIN-JOHNSON: Okay.

MR. LERNER: Last question, Craig.

MR. BACKS: No.

MR. LERNER: I want to thank you for making the presentation as we suspected most of these presentation lead us to other presentations. Before I go to the next one I think we've got a quorum now. Let's assume we have a quorum. I like an economist, let's assume away all the problems. I would like to entertain a motion for approval of the minutes of January

25th and February 22nd.

MS. ROTHSTEIN: Second motion.

MR. LERNER: Second. Any additions or corrections? All in favor please say aye.

MS. ROTHSTEIN: Aye.

MR. YOUNG: Aye.

MR. KOEHLER: Aye.

MR. LERNER: Oppose nay. Thank you very much. We're going to continue on with our agenda and now go to the two presentations from representatives from ISMS Mr. Gallagher and Dr. Hamilton. We're going to tee them up with the same presentation mode. And when we're done with these presentations, we'll take a break and then we'll come back and we will do healthy Illinois. Mr. Gallagher.

MR. GALLAGHER: I have a handout actually that wasn't in the package.

MR. LERNER: Thank you very much. You can stand down at the end.

MR. GALLAGHER: It's a pleasure to be here this morning. My name is Patrick Gallagher, I'm the director for Health Policy Research and Advocacy for the Illinois State Medical Society.

And this morning what I'm going to do is briefly go through some of the factors that are affecting physicians, as well as highlight some of the society's policies that relate to health system reformed. And then we'll conclude our presentation with Dr. Hamilton's presentation really going into detail on one of those policies as it relate to health savings accounts.

ISMS has looked at health system reform for a number of years as established number of the policies and goals. And you see here some of the goals that the society has. And really they want to expand health insurance for all citizens, allow individuals to have control over there insurers. Also as part of their policies, society is opposed to government mandated single payer programs and also for those without insurance. Society has encouraged its members to participate with communities in developing community based approaches providing care to those without insurance.

And as you see the next slide. If you look at the uninsured today. The loss of employer based coverage is the leading cost

without gross without insurance. And that is due to multiple factors, loss of job or in between jobs or perhaps the rates have increased so they can no longer afford it. Or that the employer is no longer affording the insurance.

But it's clear that Medicaid cannot take up all of these folks that have lost insurance, that they cannot completely offset those that have lost their insurance. One of the things I think it would be important to look at if you develop your work with the contractor is to look at who are the uninsured in Illinois. And look at the different categories of individuals about whether it be based on income or employment status or age. Because had he developed policies to address these groups, may be important to see what categories of the uninsured are currently in the state.

And also I noticed it has been discussed at prior meetings but also, there may be a role for the development of some sort of clearing house function. I know that the underwriters that present I think plans immediately had a program to identify the

different programs that are available for those without insurance. And combining that with perhaps public programs that are available so that people can easily identify what programs and what options they have.

So if you look at who are the uninsured. In general it's young adults, those who are employed in small firms and those that are low-wage earners. If you look at those without health insurance in terms of age. It's very interesting that it is mostly the younger individuals. And you see here that one large group, the 18, 24 age range that's 30 percent of those without insurance. And that made -- these are things to consider as you develop proposals to look at different categories of the uninsured.

These data are based on census bureau data and I know there is some controversy in terms of this data may overstated the number of uninsured but it gives an indication in terms of percentages. If you look at in terms of income, here you have almost 25 percent of the uninsured are with household income of under $25,000.

Now, for those without insurance, the physicians play a very important role in the safety net. And the AMA looked at the provision of charity care over a number of years. And in 1999 published a study looking at provision of charity care. But they concluded almost two-thirds of physicians were provided charity care in 1999.

If you looked at this further this averaged about 8.8 hours a week for a position of charity care. One of the things that they found is that physicians that owned their own practice or physicians from smaller practices, are a little more likely to provide charity care than the physicians that may be employed or a much larger group practices.

Again, they concluded though that overall commitment to charity care is strong from the physicians. In 2005 they had another survey completely different methodology and they quantified uncompensated care with is charity care as well as bad debt and they quantified that as physicians providing about $2,000 uncompensated care every week.

Now, just -- I think it was about two weeks ago, there was published a new study looking at the physician provision charity care from the Senate group studying health system change. They had more sobering numbers but there was some consistencies with the earlier AMA data. And they fund that the percentage of physicians providing charity care declined. From 76 percent around 1996, '97 to currently about 68 percent.

And they identified some similarities with the AMA data, again, the smaller practices for the solo practice physicians were more likely they provide a higher level of charity care. Although they have found that the percentage of physicians providing charity care declined during this time, the physicians naturally increase numbers of physicians nationally the number of physicians providing charity care, remained relatively stable.

What was interesting here though is their conclusion was that there were pressures that physicians are facing that may affect their ability to provide charity care. And this has

very important implications for the future which I will touch on. And it's not just the private payers that are -- that physicians are facing financial constraints from but also from the public payers Medicaid as well as Medicare.

And these are really structural changes in the marketplace, including looking at the structural changes physicians may be moving from smaller practices to much larger practices. I think the most important point here is to point out the cost pressures that physicians are facing.

And I want to go through some of those issues in more detail. I'm looking at public payments and comparing those with inflation and how Medicaid and Medicare payments have not even come close with keeping up inflation increases. If you look at from 1993, the Medicaid payment increases here in Illinois have averaged probably less significantly less than one percent a year here in Illinois.

Whereas physician practice cost during that same time period has increased 47 percent, that's the cost to run a physician

practice. Medicare payments have only increased as of 23 percent. And it's important to remember the national numbers as they vary on specialities, depending on the speciality they may have seen increases larger than 23 percent. But if you look at Medicaid compared to Medicare rates, it's very interesting. If you look at Illinois rates they're about 63 percent of Medicare rates, the next lowest pay.

If you look at an example recently, we just increased I think 12 preventive services, the state was required to do this in a settlement of a lawsuit, and on average these payments were doubled. But even after doubling these payments, they were only still 88 percent of Medicare payment rates, they're still very low.

There is also Medicaid program today that are issues of timeliness. Physicians are not getting paid for very long lengths of time. And these are implications in terms of physicians willing to participate in these public programs. So overall the cost of increase but the payments haven't kept up with these

increases. And if look at some of the programs that are being proposed, obviously you have the All Kids program which has many admirable qualities in terms of enforcing the need for primary care in the medical home. Some physicians are concern in terms of the funding needed to really provide incentives for physicians and increasing number of physicians to participate in these programs.

This gives a little bit more detail. If you look at specific procedures in terms of Medicaid payment rates compared to Medicare rates. As I mentioned on average, the percentage is 63 percent but it varies considerably amongst some of these procedures and -- as you can see in this chart.

Now, in addition to the Medicaid payments, you also have Medicare payments. Which the future doesn't look very good with Medicare either. The Medicare is predicted now for next year nothing changes, physicians will be faced with almost a five percent cut, overall cut in Medicare payment rates. This is on top of a freeze that was imposed this year.

Over the next nine years the total cuts to physicians will be a 34 percent, while at the same time, the government predicting the practice cost increases of 22 percent. And clearly such a system isn't sustainable. You also have the added pleasure of the private payers who many physician contracts from tied to a percentage of medicare. Because Medicare payment rates increase, private payments will also decrease.

Also if you look -- I'll go to the next slide. This talks about how physicians might respond to the future cuts and really it has an impact, not only on their ability to purchase technology but also their willingness to accept new Medicare patients. This slide shows that for 2006 if you look at the Medicare payments down there on the right the zero percent on the physician, the only providers and others that participate in the system will propose increases, so it is a unique situation for physicians.

While everyone as you heard earlier potentially are losing money by treating

certain patients. Physicians are the bottom in terms of any cost regarding payment increases. As I mentioned earlier in terms of single payer programs as you discussed those options, it is the policy of the society that they are posed to those. So as you consider these options, just look at them in terms of the affect it would have rationing Health Care emerging technology and some of these other issues.

I want to conclude by going through some of the ISMS principles for health system reform. And these two points, again, are saying Billy we really need to build it on the strikes in the current system not replace it on the new system. Again, the society is in favor of guaranteeing Health Care access to all citizens. But also there may be a need to increase the level of cost sharing as it relates to income as well.

We talked about briefly about the need for adequately financing the health care system. And this gets at the payment rates that we discussed earlier in terms of the Medicare and Medicaid payments. And whatever system is

developed, it needs to be adequately financed so that providers have an incentive to treat those patients.

Talk about here about principle professional liability reform and how that would affect and reduce the need to dispenses medicine to the possible health care system. And also the need for patients to be more cost conscious in terms of the provision of care. And to encourage personal responsibility for their lifestyle choices.

The society is -- recognizes for those who can afford to pay, they should be involved in there -- they should have some -- assuming of personal financial responsibility. And also patients should be educated in responsibility for maintaining their wellness. Really this gets at improving the physician and the patient's relationship. Because we want the patients to be active participates in the medical process. Where as other plans may look at ways of reducing care or rationing the care. Really what the principle of society are getting at is how do we encourage patients to discuss the

various options with physicians. Make them more aware of the cost involved in the provision of care and you'll see that in Dr. Hamilton's presentation, one the policies of the society is to promote and publicize the health savings account.

And one of the premises of the health savings account is to make patients more aware of the cost of the Health Care, be activity participates in the medical decision making. And you see as the last slide sums up, it really gets at people being aware of the cost of care and making decisions based on the cost of that care or at least being aware of that care.

MR. LERNER: Thank you. You want to take some questions first or do you want to go on with Dr. Hamilton's presentation?

DR. GALLAGHER: Whatever your preference.

MR. LERNER: Why don't we take a few minutes for questions. Let me start out with one just for clarification.

MR. GALLAGHER: Sure.

MR. LERNER: On the pressure and physician slide it didn't make a lot of logic to me. It

said movement toward larger pressure arrangement may affect charity care, that's not logical to me. I'm just curious what the derivation of that was.

MR. GALLAGHER: Yes, what the study has shown with both physicians in smaller solo practices and less bureaucracy in terms of the decision making process including the right charity, whereas they found in larger groups, there was more of a bureaucracy and less latitude in terms of the provision of charity care. It's not a huge difference in terms of percentage and I don't have them with me but that's one of the trends that both of the studies found.

MR. LERNER: Okay. Thank you. Dr. Johnson.

DR. LUBIN-JOHNSON: Thank you. An example would be of what he is saying let's say Advocate Health Center is here in the Chicago area or in California college. You know, large stagnant amount of HMO. I'm sure they're very little leeway in terms of charity care and entities like that.

My question was related to our

comments, what you talked about in terms of Medicaid versus the Medicare rates. And in light of the study that you mentioned for any physician who cares for and in my case I'm an intern of seniors, anyone that cares for adults accepts patients with Medicaid and Medicare, you're automatically doing charity care. Because since the Medicaid rate is less than the Medicare rate, if a patient comes with both theoretically their second insurer the Medicaid should cover the deductible or co-pays for the Medicare.

But since what we get paid for Medicare is higher than what the state would paid for Medicaid. We don't get that hundred dollar deductible, that 20 percent co-pay. So in effect you're practicing charity care right off the bat.

And yet another point is you touched on but the differences in terms of how much pediatricians you know our paid for Medicaid versus internist, those who take care of adults in any form or fashion. Because unfortunately it's gotten to the point where -- and you almost think there is an attempt to pit us against each other. But pedestrians can afford to take care

of Medicaid patients.

And actually it's got to the point where they are actually are able to take care of Medicaid patients outside of HMOs better than in an HMO setting. And so it's become more advantage -- advantageous for their patients to come out of HMO even before the state eliminated most of the plans.

MR. GALLAGHER: Just to add on that you're right. That starting this year, I didn't read the actual payment rate for the preventative medicine is the provision of care in Medicaid for children doubled for providing the same service to adults.

MR. LERNER: Mr. Jones.

MR. JONES: If you look up a continuum of income across the state, where to you think the physicians stand in the state?

MR. GALLAGHER: In terms of --

MR. LERNER: Any question?

MR. JONES: Across the State of Illinois, where do you think they stand like eight percent, nine percent.

MR. GALLAGHER: I have no idea.

MR. LERNER: Dr. Jones, could you repeat the question for me?

DR. JONES: Yes, the point is because if you look at income for physicians across the state, I suspect they are well above 95 percent of -- everybody across the state. So when you start to look at disclosure, you can't afford to take care of uninsured kids going to All Kids programs. I think that doesn't speak for very many physicians and you wonder why the physicians go into practice. And I think what a society we're looking at as a profession. What is it that? It's a big sacrifice now to take care of some kids that get public aid rates. I'm not willing to take Public Aid rates I'm willing to take all kids. If you look at their income compared to the rest of society. And actually if you look across the world you know physicians don't have this position of income compared to the rest of society. Many other industrialized countries.

MR. GALLAGHER: I think I would look at it a different way that there is a very high percent that are providing charity care. And I think as

you develop any system you want to continue that ability of physicians to provide charity care because they are a critical portion of the safety net.

DR. JONES: I have to question your statistics. If you look at it 8.8 hours of charity care. Now, unless they are going to say every time I take care of a Medicare patient that's a charity care, is that how they define it?

MR. GALLAGHER: No, they defined it as those cases where you don't expect any payment, it's not uncomplicated.

DR. JONES: Let's think about this. Nine hours a week that's what 20 percent of your time. That's higher than the percentage of my insured even in this country, in this state. It seems impossible for me to say that the average physician is spending 28 hours in charity care. I don't believe that. Think about it. It's not that many uninsured people. So I think those numbers are inflated and I think we as a profession have to step back and sort of say are we going into medicine to protect our income or

are we going in as a society. I think that physicians are more than welcome compensated when you look at how we compare to the rest of our people that are in our society.

MR. LERNER: Thanks. Jim.

MR. MOORE: If I'm correct in one of your slides on -- I think was on recommendations there you talked about expanding Medicare, calling it a different program but in instance working in a means testing so you can expand coverage or means testing income other than that --

MR. GALLAGHER: Yes, there isn't a concrete proposal there in terms of specific system but that was one of the concepts in terms of society and policy in terms of graft inducing more reason testing for the program.

DR. JONES: I guess.

MR. LERNER: Are there any other clarifying questions, David. Totally clarifying -- two of the slides talked about one of limited goals being -- enable also like citizens who had health insurance. I just want to make sure we're drawing a distinction between citizens and residence.

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MR. GALLAGER: I would have to go back and look at how it was worded. I believe it was citizens.

DR. JONES: Just so we're clear, are you opposed to programs for residents that are not citizens.

MR. GALLAGHER: I don't think society has a specific policy --

MR. CARVALHO: The second clarification for me. The third goal was dismiss was approved to compulsory Government mandate and health insurance plans was --

MR. GALLAGHER: Right. As it was discussed in society that a single pair was obviously the most frequently used example. It's not that specific in terms of any Government mandated program.

MR. LERNER: Okay.

DR. YOUNG: I'm going to ask along the same line. The older people remember how vigorously and almost incisively the national local AMA resisted Medicare in 65. But the question I'm asking is does that imply that you continue to impose Medicare.

MR. GALLAGHER: I don't I think we'll find any policy that went back that far.

MR. LERNER: We better make sure we get the transcript right on this one.

DR. LUBIN-JOHNSON: Let me for clarification. Thank you, Dr. Young. Good point. And the reason why I think he brought that point up is Medicare was created back 50 years ago, 40 years ago. AMA opposed it National Medical Association endorsed it. So I think that's the point he's getting to.

MR. LERNER: Jim.

MR. DUFFETT: On your goal slide you talk about the medical society continuing to support health savings accounts and much and the trust. I'm not sure if you touched on what the reform and antitrust trust.

MR. GALLAGHER: No, I didn't. And in terms of priorities it was the -- more so in terms of professional liability reforms and the HSA. These are all ways of reforming the market very strict antitrust law but I didn't even propose to get into that with this group because that's kind of beyond the scope of this

particular group.

MR. LERNER: Craig.

MR. BACKS: As part of the organization that the practice represents, I feel the need to just weigh in. The questions that have come up, I had some answers that oppose Medicare. I think the terminology that's used is a result of a committee trying to say single pay and usually that would be pretty much more complicated then this needs to be.

The reality I think is that many of the concerns that were expressed about when it would happen in a government financed single payer program for any individuals or a large group of individuals, has largely prove to be the case and that would be their ever increasing demand to entitlements expected in the program with ever decreasing pressure, ever decreasing funding due to pressure from the public to want -- not want to pay for it.

And I think what many of the statistics point out is the concern about those pressures creating access problems for patients. Some of the comments about payments to physicians

and physician income and status. They also come out with significantly higher college and postgraduate training debt and serve a very useful and important role as society and certain -- tie those two issues together, it's probably somewhat not relative. I think that the real issue is what is happening to access to health care in those states that failed to deal with cost issues and where physician are not -- by covering at least their cost care and what you're going to see is that the patient will get hurt not the physicians. The physicians land on their feet or they move. And it's an access issue that is the primary focus that we're hopefully on target.

MS. DAVIS: I would like to just drive the point. As you're traveling along this state, I used to think that the urban areas of Chicago had the worst health of anyplace in the State of Illinois but I'm seeing severe pockets where people don't have doctors. They don't have child psychologist, psychiatry. They don't have dentist.

One of the things that, you know,

it was a glib joke. This guy was the student of Dr. Young but he said in Danville, how do you know that you got a dental problem you look out in the waiting room and there is six clients waiting for a hip replacement and you got one set of dentures, you know.

So this area that you're talking about with the doctors is severe, and I don't think that we should be waiting to reenact this issue of health insurance to address this issue that is critical in many of these communities.

MR. LERNER: Some of us would suggest that there is a similarity between the underserved in urban neighborhoods and the underserved in the rural community and that some of the suspended problems are the same. Now, one of the charges for the Task Force is to look at some of those aspects. I also want to remind -- I want to thank everybody for the great discussion that's going on. But I want to remind everybody that especially as we get down to the ends of our activities, the opportunity for heated discussion may come about. And that certainly for the sake so far I would like to continue it.

While people may have individual opinions which we should be doing now is clarifying the issue and not debating the issue. And we've been doing that so far and I want to thank everybody for that and continue that in the future. Are there any other questions for Mr. Gallagher. Can we move to Dr. Hamilton's presentation? Let's do that. Dr. Hamilton, you're up.

DR. HAMILTON: If you don't mind, I'm used to standing up when I talk. I feel a little better about it. So if it's okay with you, I'll be more comfortable doing it this way. Also if you -- as you mentioned if you have any questions as to clarification or what I'm saying, fine, I will be happy to entertain those as we go along. Otherwise if there is discussion sorts of things or debate, I would rather wait until the end.

I've given this talk a number of times through the years. I've been interested in what used to be medical savings accounts since the early '90s. And I'm blocking somebody off. How is this? So we copyrighted this talk in 2004 but the numbers I'm giving you for the most part

are updated to 2006. And I've entitled it Health Care Reforms Best Kept Secret because it's been very frustrating for me and other proponents of what are now generally considered consumer driven health care. To see health savings accounts relegated to the very bottom of every list of things we might do to improve the health care snap we would have ruined in this country, and now it's starting to move up. So I'm probably going to have to change the title of this talk but I'm not going to do it yet.

The general topic that I'll be talking about is consumer driven health care. There are three major types, Health savings accounts, HSH, flexible spending accounts, FSAs, the use it or lose it type thing you heard about and health arrangements -- reimbursement arrangements.

The health savings accounts grew out of the old medical savings account and I'll talk more about that later. Mainly, I will be talking about health savings account but I will mention more about FSAs and HRAs later. If you understand this slide you get the basic concept

of what HSAs are all about.

An HSA plan has -- first of all, has to have a qualified high deductible insurance policy but is used to pay for large bills. Now, in addition to that, there is a tax free account, a personal health savings account HSA which is used for covering the small bills. Where does this money come from, do we take it out of the kids shoes, groceries, salary. The money is available because catatropic insurance cost considerably less than low deductible or first dollar cover.

And this money is then available tax free for contribution -- for contribution to a health savings account. We've heard a lot about the problems with government programs. But one of the major problems in the country in the whole health care service, health care system is that we've all been using someone else's money to pay the bills.

And as human beings, physicians, hospital people, patients, whomever, if somebody else is paying the bill you don't worry as much about the cost. And so cost that factor has

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really become a problem in the disproportionate rise of health care cost. A lot of the cost is due to technology. A lot of the rising cost is good because it's the things that keep us alive. But of this sort of things that's resulting from people not caring what something costs, that can be dealt with. And it can be dealt with in a way that is not off steer. You do it by high deductible insurance, take the difference and make it available to put into a health savings account. Next.

Now, HSAs and catastrophic insurance. See HSA was a special purpose financial account much like an individual retirement account. The HSA is used in conjunction with catastrophic -- with a catastrophic felt insurance policy. I'm going to emphasize that several times. You cannot have an HSA without an accompanying qualified high deductible insurance policy. Next.

Now, these policies can very considerably in the deductible and co-payment structures, the benefits that are covered, the approved and contracts bids PPO provider list.

We're hoping eventually to do away with the PPO association because it interferes with some of the economic efficiencies of a true SHA plan.

But right now, most of the plans are backed by some sort of a PPO and I think in some ways that's necessary at this time. Maximum allowable fee schedules but we're hoping that eventually be more like a traditional indemnity insurance in terms of relationship to that insurance company. Next.

SHAs are authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2004. Some people say 2003, Congress passed it in 2003, the President signed it in'04. These are available to all taxpaying citizens under age 65. So Medicare patients -- I can't have one. People who are on Medicaid can't have one unless they're a taxpaying citizen.

If you're a dependent, you can't have one but you can have one -- you can be -- participate in one whoever you're dependent upon has. So it's all taxpaying citizen under age 65, we would like to see that expand. Contributions and withdrawals from medical expenses are tax

exempt. In other words, the money going in is pretax. If you need to go in for a chest X-ray or an EKG or whatever, doctor's visit, preventive medicine care, that's all pretax money that comes out of there. Next.

Nonmedical withdrawals are taxed an assessed at ten percent penalty, kind of like an IRA. Except IRA penalties are 15 percent. Contributions to HSAs are made by the employer, the employee or both. This is very important. The old MSA was either the employer or the employee. This to me leaves room for negotiation. And for those of you who represent labor organizations, this is an important feature because these things are coming. They're coming down the pipe and you going to need to deal with them. And one of the things you're going to have to look at is the employer -- is the question whether or not the employer is going to be willing to pay their fair share of a contribution to these HSAs, some of them wanted to dump the whole thing on the employee and that's not right.

They save -- they save the money from the insurance policy but don't contribute to

the HSA, that's not right. Unused funds in an HSA account being tax free compound interest. So this is what I call, you know, the hat trick. It's the triple crown. You got tax free money going in, tax free money going out, tax free annual compounded interest building up in that account if it is not spent. And here is the place where it puts a constriction, a restriction, however you want to term it.

On the patient spending money unwisely and therefore affects the hospitals and it affects the doctors. To make sure that the money being spent is spent wisely and not frivolous. I don't know how many times I've had patients as they're walking out the door, Doc, order anything you want I've met my deductible. It's all covered.

And once again HSAs must be combined with a qualified high deductible insurance policy. Next. Now, some details about the law and about the policies that back them up, the high deductible policies. Minimum deductible. $1050 for an individual, $2100 for a family. Maximum amount of pocket expense $5250

for individuals $10,500 for families. Maximum annual HSA contribution is the lesser of the deductible and $2700 for individuals and $5450 for families. So if a person has a $4,000 deductible for policy, he can't put $4,000 in the HSA. He can only put in $2700 in any given year. Next.

MR. LERNER: So should that slide read or with lesser the deductible or $2700.

DR. HAMILTON: You're probably right, yes. You're probably right that's -- probably be better. We probably ought to change it.

MR. LERNER: Thank you.

DR. HAMILTON: Because that's what it means. Yes, it probably be better grammar. Here for those of you that like charts this is the same numbers in a chart. Can you put the chart back up, just give them another look. 1050, 2100, 5200 are out of pocket 5205, 10,500. Okay let's move on.

Contributions may be made monthly or any other increments that -- and the contributions to the HSA are used for deductibles co-payments, other medical expenses. But at the

present time, cannot be used to purchase the high deductible insurance. This is something that President Bush would like to change. I think it is very -- I think it would be a great change. Because for one thing it would -- you see tax law has made a very inequitable system, it caused a gross distortion in how we're paying for our health care issue -- health care.

Employers have been able to use pretax money for the whole thing all these years. To pay the same insurance policy, the employee would have to pay after tax money. And the object of this is to level the playing field between employers and employees, so they'd get the whole thing being pretaxed. And that's why the President wants do this. And it would certainly make the plans much more appealing, even more than they are today.

Catch up contributions for those over 55, I'm not going to get too much into that. Now, the next one fees and services are covered by -- covered by HSAs are defined by two entities. And the physician and the hospital and patient need to understand this. There are two

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groups saying what you can spend this HSA money for. The IRS has in publication 502, has some very liberal, very liberal listing of what you may spend money for legally.

The insurance company may not be that liberal. So, you know, the IRS is almost a no brainier. I mean, you can't pay for diapers and that kind of thing. You can't pay for dance lessons. But you can pay for so many things that aren't going to be covered by your insurance policy. The only thing is that doesn't mean the patient shouldn't spend money on those things if the kids need braces or whatever. It's just that it won't count towards the deductible. It's still -- you can still use legally the money pretaxed to pay for those things, glasses, all those kinds of things. Okay. Next.

Now, the money is handled by insurance companies, banks, credit unions or any other entity that meets IRS standards with IRA trustees or custodians. Banks are just starting to really get into this in a very significant way. I drove through my bank at home the other day and I was amazed. I went to get some money

through the ATM and the little advertisement up there said check out with us for your HSAs. And Millen Bank and many others are really getting into this.

The insurance companies are also starting to get into it. But on occasion I have heard that the price that the rate that they want to pay, the fee that they want to pay for managing those funds at least on occasion is unreasonable. I'm not saying the whole industry is doing it. At age 65 the HSA can be converted to an IRA. It can be used to buy long-term care insurance. Or used to pay Medicare part A and B deductibles and other medical costs. But just as in the pre-Medicare group, it cannot be used today to pay Medigap insurance, pay for what Medicare won't pay.

At death the HSA passes tax free to a spousal beneficiary. If there is none, it goes into the estate and is taxed just like the rest of the estate. At retirement -- now, these are 1969 figures when things cost a lot less, but the percentages stay roughly the same. At retirement 80 percent would still have over

50 percent of their contributions remaining in their HSA. A lot of people have said, well, these are for the healthy and wealthy. It really is not turning out to be that, and I'll show you later on. But for many people who are going to have relatively low incomes all their life, this may be one of the few ways they have saving any money, is judicious use of their Health Care expenditures.

Five percent would retain less then 20 percent of the contributions in the HSA. Next. Now, about these -- about this money saved. These are real relatively conservative estimates. Now, this is judging the 2000 a year -- dollar a year contribution at a five percent growth rate per year and with annual expenses of $500.

At 20 years it would be $52,000 in that account. With annual expense of $1,000 which is -- that's fairly significant. I mean, you know, you all know situations where it's going to cost you more than six -- $1,000 -- than $1,000 to get through the year because of your medical expenses. But you tend to forget about

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the years where you really didn't spend that much.

So at any rate at $1,000 a year expenditure over 20 years there would be 34,000 a year. Next. Now, with a $4,000 a year contribution the money starts to get much greater, $500 annual expenses, $121,000 for 21 years. You can start that out when you're 20 years old -- 30 years old say and continue on till you're 65 you'd have to earning $30,000 in there at $500 a year average expenditure. Next.

Now, for a family rate -- for a family of two just to go through how this works compared to a present system and these are figures from golden rule insurance company they're a couple years old. A $500 deductible policy costs $84.60 for a family of two. $2500 deductible policy cost $3900. This leaves $4500 savings.

This is available for tax free HSA contribution and can be saved for the future health care cost if you don't spend it in that year. Now, note that the maximum, you said earlier the lesser $2700, the maximum HSA

contribution in this case would be the $2500 per person deductible which is $5,000.

You have to watch those policies because sometimes it's a family deductible period and sometimes that number refers to a hidden deductible that you still can't go over the total amount of out of pocket. Next. Now, the advantages. Now, I structure this talk different depending upon the groups that I'm talking to.

And I'm not going to spend as much time on this, maybe I should, but I think patients or -- and physicians, are apt to be very interested, maybe more interested in this than some of the numbers. But I think they are vital importance to everybody. Preserve patient choices. I think we all know that top down mandated programs, HMOs, manage care, somebody running your life, diminishes the number of choices. Many times a patient can't pick their doctor. They have to change doctor. I've had -- I was a surgeon, I've had patients who had to change their physician two or three times because their company changed their HMO.

Preserve patient doctor

relationship. I think it's going to be -- not only preserving, it's going to enhance it. Because the patients aren't going to be able to make these decisions all by themselves. They're going to need to be able to sit down and discuss, what is the most rational thing to do. And I think this is where the physicians come in, this is what we do.

We are accused sometimes of not doing it, but the good ones do and I think by far the majority of physicians do this. You can always site the exception. Built in cost of effectiveness incentives. I think I said about all I need to about that and the savings that involved.

There is also savings involved for employers though because then their overall health bill goes down. Promote savings for employers and employees. Reduce Health Care costs. The jury is still out on whether or not applied over millions and millions of people whether or not the overall Health Care bill will be lessened. Theoretically it will be lessened significantly. But what really counts is the

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proof is in the pudding. I will cite that Milman and Robertson did a statistical study back in early '90s that showed that if you had 65 percent of the population covered with MSAs and made it mandatory for Medicaid but excluded Medicare. Okay. They showed that the overall savings would be over five year period, would be in the neighborhood of $288 billion $56 billion of which would be administered. This was done by Milian and Robertson, Malmilian USA by Mark Litzow.

DR. LUBIN-JOHNSON: I have a question.

DR. HAMILTON: Yes.

DR. LUBIN-JOHNSON: How is somebody who is on Medicaid able to have MSA --

DR. HAMILTON: Let me get to that later.

DR. LUBIN-JOHNSON -- with little or no income?

DR. HAMILTON: Let me get to that later. I know that's burning and it's burned a lot of people's minds and I do have some things to say about that. Next. Portability. 5.7 million people who do not have insurance at the present time are simply between jobs. The HSA account belongs to the individual. And can be taken from

one job to the next. During that unemployed period, they can use that money to pay for Cobra insurance or pay for by the qualified high deductible plan. Then when they get their next job, then they have to cut a deal with the new boss, but that money belongs to them period.

Promote preventive medicine. People that are in these program and early results would show, that people want to safe their money and they tend to get involved in wellness programs and things like that and want to stay healthy so they don't have to spend the money.

Reduce the number of uninsured. I mentioned the fact of covering people between jobs. There are also those -- a number of uninsured was mentioned earlier. But 14 million of those people are people that would qualify for present programs but just have them signed up.

15 million make more -- 15 million make more than $50,000 a year and a significant number more than $70,000 a year but present insurance policies available to them and they're often young they think I'm not going to spend the

money on them. I'm not going to get sick and most of the time they don't.

But many of the people who were signing up with these things were previously uninsured and we'll get into that. Buffer manage care and government abuses, I won't go into that as much now. Decrease administrative cost, we'll say more about that later. Cost Benefit Discussions. We're going to need to be able to sit down with people and discuss what is best for them.

I think personally there will be a growing industry of consultants who can help -- and whether or not they are already insurance people or hospital people whoever they are, there is going to be a knitch, a need for sitting down and going over with patients the cost of what things will be. And this is particularly true when you start to apply this maybe to some of the Medicaid groups and some of the high risk groups.

Sound preventative medicine program. Once again it's being shown in practice as well as in theory. That in order to save money and because they're thinking being what

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things cost, these programs promote preventative medicine. Plus the IRS has said that if the insurance company that backs up the HSA, if they want to write their policies so that preventive medicine procedures or certain preventive medicine procedures do not have to go through the HSA. In other words, they go directly to the insurance policy without having to meet the deductible that is legal.

So it's up to the insurance company to decide how far they want to go into that. Fee discussions would be very important. This Mr. Moore is it, mentioned something that has been very interesting to me and also Elena. One of the problems and I was -- really probably should talk about this later but I wanted to be sure I covered it.

Many of the problems that people predicted would be -- would exist with HSAs, they are not just for the healthy and wealthy. They do save money, at least on an individual basis. One of the problems we're having as this builds up from the grass roots, is that patients who have these plans need to know ahead of time what

things are going to cost.

So physicians are going to have to be able to tell their HSA patient my routine visit will cost this. If I have to do this, this is what it will cost. The hospital is going to have to be able to say if I have such and such a test and an outpatient, that's what it's going to cost. A patient is going to have to have access to that information. And part of the problem is that the -- and I'm finding this out from talking to local hospitals and administrators in the Auckland area where I live, that -- they really don't know. What they're calling cost is Medicare's cost. The true cost they don't know.

The hospital has to meet in order to survive. They have to have cost plus what it takes to cover other areas that aren't being covered like people showing up in the emergency room with no insurance that they have to see. And whatever they think is a necessary profit. But this -- when you ask them what the cost is, nobody seems to be able to tell. And this is a significant problem. It won't be so hard to discuss fee problems with physicians, all they

have to do is make the decision, yes, I'm going to do that. Hospitals have a significant technical problem I'm convinced but it shouldn't be insurmountable because mainly because of the history of the way prices have gotten to where they are now.

Okay. We have to accept the fact that there will be occasional poor decisions. Some people won't want to spend their money on things that are necessary. And some people will decline to spend the money because they don't want to spend the money and they should. I think the majority of the patients will do what is reason, do what makes sense.

Okay. Next. Simple payment -- practical aspects of HSAs. They have a very simple payment mechanism. You can either have a checkbook that deals with your HSA account, you go into the doctor's office, you receive the service, you write the check and that's it. Or even super you have a card, you swipe the card and the transfer of funds is done electronically.

Once again authorized expenditures are defined by the IRS and the patient's

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insurance policy. Physicians and this is something I tell more to the physicians group but I think some of the problems with hospital billing, physicians are going to have to take the patient advocacy position on occasion. And I think they will, they already do.

Patient retains receipts. This is important -- this all can sound very complicated, but when you stop and think what the patient has to do, they have to keep their checkbook, they have to understand that for the little scruff and totally repay deductible, they got a rider check or swipe the card.

But the other thing the patient has to do is they have to retain the receipts for two reasons. Either if -- so if they have an IRS audit they can prove that they spent the money legally. Or if they exceed the deductible they have to prove to the insurance company that those expenditures were for things that were allowed and covered by the insurance policy. Next. PPO plans may have maximum allowable fees. Let's see. This is more for physicians let's go on.

Okay. Now, I'm calling this HSA

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pilot project, that's the old MSA before they signed the Medication Modernization Act. There are about 100,000 of these sold, who bought it? 95 percent were over a 30 years old. A third were over 50. 70 percent were in households of two or more. 50 percent were families with children. Ten percent were in single parent households, over 40 percent were previously uninsured.

That number of roughly 40 percent is running true to form. Even today in the new policies. And it's coming from the fact that you got people who are between jobs and people who previously didn't field that they needed to buy insurance because they are making enough money but they didn't want to spend that much money.

And another group is small businesses who previously didn't offer insurance but now offering health insurance to their employees, is getting down into a realm of something that they can afford. 80 percent have money in the HSA at the end of the year.

Next. Now, a few words about flexible spending -- well, okay. I need to get

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into a little bit of MSAs Medicare savings account, Medicaid and how this applies to high risk procedures. Flexible spending accounts. This is the use it or lose it account. The problem with these is that there is no incentive for the patient to save. Next.

Health reimbursement arrangements. This is not the use it or losing it but the HARA funds rollover but the patient does not own it. And doesn't say with them between jobs and there is less incentive to compromise. Next. Let's keep going. Early CDAC experience this is what's going on now.

March 1, 2005 over 1 million enrollees. 37 percent had no prior insurance. 40 percent earned less than $50,000 a year. 50 percent were over age 40. 90 percent were over age 50. 73 percent are families with children. Chronic conditions, 20 percent or more -- 20 percent of the patients felt they were more compliant. Insurance premiums for HSA plans were down 15 percent. Premiums ranged from 100 to $46O per month. Next.

Patients were more involved in

their own care. Tax free HSA contributions and withdrawals and patient choices are very popular -- as I mentioned earlier one problem is that 70 percent of-- that patients are unable to many times find out ahead of times what things are going to cost. That's the single biggest cause for dissatisfaction or single biggest criticism in the plan.

Of those employers who had greater than 70 percent employer participation, they saved 13.4 percent in health care cost. Those with less five percent of participation, had a 9.9 percent increase. Now, at this time the estimate was that by 2008, there would be six million enrollees. These are the results from several studies, okay. Next.

This is what's going on now. According to information strategies, it was published just in March 2 of this year. They are already 6.5 million plans of both in HSA and HRA type combine with 6.9 billion. By 2010 they estimate there will be -- between the two types of programs there will be about 40 million plans. So these things are coming. There will be $133

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billion in the bank.

A thing that I have not had a chance to make a slide on, I don't know that I will, comes from IRS, it says that with HSAs alone as they stand together, by 2008 there will be 20 -- no. There will be 25 to 30,000 people covered by these things. And if they -- if the president is allowed to expand these the way he wants to, there will be more like 40 to 45 million people covered by 10,000 -- by 2010.

Now, I want to get into some suggestions. Maryland health insurance plan was put together -- this is for the high risk, put together by a fellow named Richard Popper. Now, the way they have set it up they have a qualified high deductible plan. They also have an HMO, $1,000 deductible PPO and a $2,000 deductible PPO. The deductibles are $2,000 -- $1200 for an individual $2400 for a family. Maximum out of pocket $2500 for an individual, $5,000 for a family. Co-payments of 20 percent in net worth, 40 percent out of net worth and the lifetime benefit of 2 million.

Next. Funding is 47 percent by

the member, 53 percent by state from assessments on payers based on hospital bills paid by the payer. The member funds the HSA of course it's pretaxed. The HSA contributions, medical withdrawals, and compounded annual rate of interest are all tax free. The unused funds roll over in years end.

We would like to see HSAs made available also to Medicare patients. There is an awful lot of expenditure on the out of pocket for Medicare patients as I have listed on the left. Now, this is based on 2000 -- on paper that was published in the year 2000. These numbers are significantly higher. At that time the average annual Medicare benefit was $4800. Now, it is $7,125 so these numbers are up. But it includes part B premium, Medigap on the left. We're talking about part B premiums 518, Medigap 1200 part D deductible, $100 part B deductible is now up to 914, something like that.

Well, at that time the potential out of pocket of 2582. Using those old numbers you could have gotten -- and this was actuarially determined. But you could have bought a 2 --

$3,000 deductible at $3,000 and left $1400 over for and HSA contribution leaving $1600 out of pocket.

Now, the number, the study, the paper that I got the 7125 annual benefit out of also suggest, but this is not actuarially determined. But even if you spent $5,000 for a $3,000 deductible -- in other words, government money going to buy that $3,000 policy for $5,000, that would still leave over $2,000 a year for contribution into an HSA. Next.

With Medicaid there is a lot of flaws. Perverse in -- funding stability. Uni-official utilization. Poor reimbursements, social cost, poor take up rates, crowd out. Florida and South Dakota are leading the way in offering innovative means of paying for Medicaid patients. And this -- the Florida plan goals are to restore integrity, beneficiary responsibility and get those patients as many as possible into the main stream of health care financing.

In other words, they -- the patient -- the patient buys insurance from state approved plans but there is still private

insurance. Using state funds, this covers comprehensive and catastrophic care. Vendors and providers then are competing for these patients. You have to qualify the providers, they have a grievance process and particularly important, they assess the program continuously and counsel the beneficiaries as to how to get them into the plan that best suits them.

This isn't that everybody is going to go into a plan like this, it's available, it's choice, it's an opportunity. Now, they set this up so that if the patient then is receiving this money and has money in this fund, that money can stay in that fund for as long as three years. And if they get a new job or if they get a job and suddenly would be no longer eligible for Medicaid, they can take that and use that funding to purchase insurance when they get out.

But counseling is very important. I mean I maintain that, yes, some Medicaid patients are not very bright, some of them are irresponsible, some of them are both but an awful lot of them are just poor. Now, seven percent of my practice, I don't know about ours but I know

about numbers. Seven percent of our practice was uncompensated, that was for indigent care. And I took care a lot of those people and I did so gladly, some other people didn't want to do it. And I didn't agree with that, it was wrong and we all ought to do our share. I think everybody should do their share.

But the money -- what I felt that I was seeing was a large number of people who just didn't have money. And who would be more than happy to try to manage something if they had anything to manage.

Next. It's even more encouraging for patients to try to get into this mainstream of health care. Now, Martin Feldstein you heard from Milton Freeman. Martin Feldstein, Wall Street Journal, the Hale Sadies Account that President Bush recently signed into law, may well be the most important piece of legislation of 2003.

These new tax and medical insurance rules have the potential to transform health care finances, bring the cost under control and making health care reflect what

patients and their doctors really want. It is remarkable that this legislation has received so little public attention.

Now, before -- now, that concludes my thought but I would like to say one thing addressing to your question. John Goodman who is at the center for policy analysis in Dallas has been one of the major proponents, and it came from him. That's the first place I saw. Okay. We're talking about people who pay taxes. And they're getting this terrific tax break. What about the people who don't pay taxes, that can't pay taxes because they don't make enough, and that really unfair.

Just as it is inequitable for the employer to get a tax break as employee not to get a tax break, so it's inequitable for those who pay taxes to get this great government benefit by the absence of tax when those who don't make enough to pay tax, don't get that.

And when you see things about tax credits, funding programs for innovative programs for Medicaid, that's what they're talking about. And I saw it first from a very conservative

gentleman who really has been one of the major proponents. So I think that's important to keep in mind. We, all of us, want to solve that problem. Okay.

MR. LERNER: Thank you, Dr. Hamilton. We'll take one or two questions and get on to a break, Margaret.

MS. DAVIS: One of the things that we're seeing as we go around this state is the -- your issue of mainstream, that is very important as we roll out a product. Because the people feel that to have a card tied to Public Aid has no utility. No one will accept it and when they get into the doctor, they will be treated as a second class citizen, you know. So those two observations run clearly from the people. So that notion of mainstreaming is going to be very important.

DR. HAMILTON: Well, you know that's the hope. None of this, you know, has to be played out. That this is a grassroots effort and as, you know, the predicted shortfalls of the program aren't happening. It's not just for the healthy and wealthy. What's the biggest problem right now? Price transparency. What's it going to

cost me? How can I choose this hospital against this hospital against this hospital if I don't know what either one charges. And then there is problems, the hospitals have their difficulty in trying to determine what that number ought to be. But we'll work these things out on the -- from the bottom up but it's going to take some patience.

MR. LERNER: Ken.

MR. SMITHMIER: Dr. Hamilton, on of the big issues that people faced is the difficulty or inability to get insurance for the preexisting condition. How do HSAs address that?

DR. HAMILTON: Well, I'm sorry I was running short of time because -- can I show that next slide or third or whatever fourth to last. And I think -- I don't know what the scope of this committee is. But -- no, no, keep going back, back. Your going the wrong way. Next. Next. Next. Yes. This University -- go back another one.

This Maryland -- this is the Maryland high risk health insurance plan. And I think -- I don't know if there is anybody else in

the country that is doing this. But the idea is that the government, the state government pays 47 percent I believe it is of the premium. The premiums range from what I've read from about 125 percent to 175 percent per individual depending on what the problems -- what the medical problems are, okay.

So for many people that is just too much money.

DR. LUBIN-JOHNSON: 125 percent of what?

DR. HAMILTON: Of the average health insurance premium. And those are pretty darn high. We're trying to lower those too.

MR. LERNER: So what happens with people --

DR. HAMILTON: Well, then 53 percent are paid for. Next slide forward. The funding is 40 -- I'm sorry, 47 percent by the member and 53 percent by the state which is paid for by assessments on payers. This gets by the IRISSA laws. Because as we're doing it in Illinois about half the people are exempt because their state law, state governments can't -- can't monkey around with IRISSA plans, in other words

government sponsor. And so we make -- but they can do this. This is legal. They get 53 percent of the state assessments. The money for that comes from the payers and is based on hospital bills paid by that payer during a given year.

And of course it's all passed down to the hospital and to the patient. But that's how they get their money. And that's one of the problems that I read about the high risk program in Illinois is that it's under funded. You got these two level systems, what section seven and section 15 and only, you know, some of these people, some of these insurance plans -- some of these hospital expenditures are not being reimbursed, can't be reimbursed.

MR. LERNER: Is this a tax on insurance companies?

DR. HAMILTON: Well, that's how they get around the IRISSA law. But, of course, they're going to pass that down, sure. It's a tax -- it's a way of defusing it to the whole public which is what we need to do for these people.

MR. LERNER: Last question, Dr. Johnson.

DR. HAMILTON: Can I just say one more

things because obviously it didn't get across. The member then funds the HSA pretax. And everything in the plan, the money that bills up or money they spend is tax free. Now, a lot of us think that the high risk people going to spend that deductible every year. But a lot of them don't, they just can't get insurance because they carry this diagnosis.

MR. LERNER: Let me ask a very specific question.

DR. HAMILTON: Sure.

MR. LERNER: Does that mean that anybody with any preexisting condition can get into the Maryland program?

DR. HAMILTON: Anybody with any preexisting condition.

MR. LERNER: That's the issue though. I don't want to argue about where the money is coming from or who's getting assessed or any of that stuff. You have a preexisting condition, you qualify under the program and you get this kind of help?

DR. HAMILTON: When you say anybody then I start thinking 100 percent. I don't know

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whether -- it's all risk adjusted. So my assumption is, yes. But I did not ask Mr. Popper specifically that question, but I think we can find that out.

MR. LERNER: Yes, the issue for us is that we're dealing with the uninsured and the under insured.

DR. HAMILTON: Yes.

MR. LERNER: Many of them with preexisting conditions and they preclude them from going into insurance coverage. So if they haven't got the money to beginning with, rate adjustment doesn't make a whole lot of sense. The real question is how do they get access to this program --

DR. HAMILTON: Well, many of the people in the high risk programs have money, these are not the enemy.

MR. LERNER: But that's not the question.

DR. HAMILTON: They are indigent but they go through the Medicaid sort of things and that's risk adjusted in the Florida plan, that Governor Jeb Bush had set that up so that is risk adjusted. They money that they get to buy this plan, that the individual -- see, I'm the

patient.

MR. LERNER: Yes.

DR. HAMILTON: The amount of money that I give to the state, from the state to buy this insurance plan is risk adjusted. So if I had all kinds of problems, I'm going to get a lot more money than this lady who has very few medical problems.

MR. LERNER: So then the state is fronting that cost so it will obviate the issue of the preexisting --

DR. HAMILTON: For the poor people. For poorer people. But for the high risk people, many of whom, you know, I got personal friends who I play golf with and I can't keep up with that have -- that can't get insurance.

MR. LERNER: Last question.

DR. LUBIN-JOHNSON: Yes. First of all our charge is to create options to present to the legislature to cover uninsured in Illinois. Reality. Annual expenses of $1,000 a year. My practice is located in one of the most stable medium class communities in the country and they're African American so a high disease

burden. But, you know, a $1,000 a year is nothing in terms of what patients have to spend if they have high blood pressure, diabetes, high cholesterol.

So when you look at annual expenses of 1,000 and what they can save over X amount of time, you know, it doesn't relate to, you know, the middle class patients I take care of. The cost of insurance. My insurance is through my husband who is a retiree of a city agency. And for a hundred dollars deductible policy which by the way I tried to change the deductible so it got lower this year but there was a huge increase from, you know, the boys on Randolph is $500 a month now. And so if I go up to 250 it will drop to 350 a month so, you know, that is $6,000 a year. I just don't see -- especially what you said in terms of Maryland in giving 125, 175 percent of usual --

DR. HAMILTON: I think that's more --

DR. LUBIN-JOHNSON: The usual rate is sky high to begin with and I'm talking about this is group rate, you know, I'm paying more.

MR. LERNER: What's the question?

DR. LUBIN-JOHNSON: I guess how -- this doesn't seem -- it doesn't seem very realistic in terms what it means to the average middle class person. I'm not --

DR. HAMILTON: The average middle class person is going to fall within $1,000 but not everybody. Certainly it's hard -- going to be awfully hard to make any money out of being sick. I don't know anybody that can figure out how to do that. The question is should you be losing money if you're not sick and how do we take care of those that are.

MR. LERNER: I don't mean to cut you off --

DR. HAMILTON: Your questions are all -- it's a complicated anything. It's hard to get around and fairly simple for the patient, medically to have one of these things and be taken care of. But when you start addressing the whole thing and trying to get around the whole thing, I spent a lot of time doing that and let me you there are a lot of people around that know a lot more about it than I do.

MR. LERNER: Well, I want to thank

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Elena and Teresa from IHA, Mr. Gallagher and Dr. Hamilton from the ISMS Medical Society for very wonderful presentations. I would like to suggest we take a ten-minute break and we're going to come back to Citizens Illinois. Thank you very much.

(Whereupon, a short break was taken.)

MR. LERNER: Ladies and Gentleman I call the meeting back to order. We have Senator Halvorson on the phone. Is there anybody else with you?

SENATOR HALVORSON: Yes, I have Julie Faxton and Colleen.

MR. LERNER: Close enough. Thank you very much. What I would like now to do is turn this over to Brent Adams the policy director for Citizen Action who is going to make a presentation for us for Healthy Illinois.

MR. ADAMS: And I think Senator Halvorson is going to say a few brief words to open.

MR. LERNER: Oh, Senator, please do the floor is yours.

SENATOR HALVORSON: Well, thank you.

First of all, I want to say thank you for giving me the opportunity to present what we believe is the health care expansion plan. And I think my knowledge this may be actually the first time it's been presented. As you know, I'm the lead sponsor of the Healthy Illinois Act which is credit bill 2561. And now the Senate Healthy Human Services Committee for two years in a row.

So now we have the bill sitting on second reading. We've extended the deadline until January 9th of 2007. I'm sure a lot of you heard about the campaign. But basically the Health Illinois campaign was launched in early 2004 which was before the Health Care Justice Act passed the legislator.

Since that time, we've been talking with state holders, holding meetings trying to crack the plan that that's -- harmonizes with everybody's interest while at the same time I think we recognize that everybody is going to have to sacrifice something if we hope to solve the state's health care crisis.

We believe that our work that we've done has and will promote and strengthen

the work all of you've done on the Task Force. Certainly it's been brought more attention and enabled us to have a more informed discussion about the realistic yet effective approach to addressing what I consider and I think everyone in the room consider as probably the state health care crisis.

So if, you know, as we continue to advocate for Healthy Illinois so true of other state holders and we continue to push, oh, they call maybe a market driven approaches things like Health savings account, bare budget insurance plans, among other things. So I know there is a lot of expertise on the Task Force and we certainly welcome your input.

I know we've always said that we only have one bottom line and I think you heard this over and over again, and most of you don't probably believe to do nothing is not an option anymore. So I'll stay with you on the phone as long as you need me or if you have any questions but I do have to go to committee about 1:00 o'clock. So just thank you for your time I appreciate it.

MR. LERNER: Thank you. Senator. Brent you're going to take it now?

MR. ADAMS: Yes. Right now met with Matt McDermott who was the senior organizer with United Power to say a few brief words. They were very involved in the family care efforts and he's going it talk about how this relates to family care and how it's an extension thereof.

MR. LERNER: Before you get started fair warning, 1:15 presentations is over. Because I don't want to run into the same problem.

MR. ADAMS: I got to be gone by 1:15 so that's good for me.

MR. MCDERMOTT: Again, Matt McDermott I'm the senior organizer for United Power for action and justice. We're a broad base organization in Cook County made up of all kinds of congregations, churches, synagogue, mass, several local neighbor organizations and a good handful of the nonprofits federally qualified health centers, community health centers in the City of Chicago and the area.

Founded in 1997 as a coming together of people of many different faiths,

races, incomes, city and suburbs, to begin to form an organization to advocate for the issues of all of our members broadly defined. But as we begin that project and launch it -- founding convention of 10,000 people at the UIC Pavilion, health care almost immediately rose to the top of the list of concerns that United everyone across the region.

So we put to work trying to figure out pragmatic winnable but still significant efforts to deal with the problem of the uninsured which are members knew firsthand. If they didn't know it firsthand, they knew it intimately through friends, neighbors, fellow congregates and their congregation. One of our first victories was the creation of the Gillette Center which many of you now may know which does partner with the health care industry directly in metropolitan Chicago health care council. The advocate health system, a number of Blue Cross Blue Shield partners in the Gillette Center to engage and enroll an out reach to communities where people could take better advantage of programs that already exist.

I also produced the annual report on the uninsured as becoming a kind of a standard for the statistical look at what this problem is, but that we push forward to try to create the family care program. And we're successful in that getting toward the end of George Ryan's term his support and ultimately a federal waiver to expand Kid Care in Illinois to cover working poor parents who continue push to grow that program with Governor Blagojevich's administration and it now is at it's full capacity in terms of eligibility as of January 1, and offering insurance the estimates are about 400,000 people. That didn't just happen and though it's now very politically -- in the interest of the administration, it took a major grassroots push to make that happen.

We had 70,000 postcards signed, hundreds of people going to Springfield, mass rallies and assemblies and organizational events in the metra Chicago area over several years to get family care passed the first time. And we see Healthy Illinois amongst a few other ideas as logical next step. Family care takes now

eligibility up to $35 a year for a family of four.

Many workers obviously make more than that and are not eligibility. And many small businesses who employ them, can't afford the coverage or afford to offer their employees cover. And Healthy Illinois begins to address that next population, it's already a little bit too much beyond family care and a group of people who can't get insurance through their employer at all.

So I'm going to leave the details of that but as a representative of an organization that's pulling together grassroots people around these issues of the uninsured, we see Healthy Illinois as a logical next step, pragmatic next step to expanding coverage. And though it certainly short of universal coverage, it's a massive opportunity to step in the right direction, thank you.

MR. ADAMS: So now on to the substance of Healthy Illinois. Two of our basic founding principles, the second of these two Senator Halvorson just mentioned. Senator Halvorson, can

you hear me? Are you still there? So the second was to do nothing is not an option.

SENATOR HALVORSON: I can hear you.

MR. ADAMS: You can. Okay. The first is that the current system is simply not a system. It's not a systematic attempt to write health care to the population. And one thing we say that we know doesn't work, is what we're doing now. And this is certainly echoed by the testimony that's been presented at the public hearings.

These headlines, you don't necessarily have to depend on public hearings to know about the problems with the current system, endless weights for health care and rolling dice on insurance are the way many consumers would have to scope with the health insurance programs in the state today.

The basics of the program are first working in partnership with private insurers, use the purchasing power of a massive risk pool to establish a statewide health insurance plan. This idea in terms of public, private partnership is entirely consistent with

the ideas mentioned by the hospital association and the men's society in terms of building on the current program. And also one way to look at this as being analogous to the state employee health insurance program. In terms of establishing a plan that works with private insurance.

Secondly, implement reasonable measures to control cost. And three, initiate new strategies for quality improvement. Healthy Illinois working alongside existing State programs. Like Family Care, Kid Care and All Kids, would make quality affordable health care available to every man, woman and child in this state.

Healthy Illinois is an integrated approach that focuses simultaneously on increasing access, controlling, cost and improving quality. The concept being that to address one without addressing the other two, can create an adverse impact on those other two. For example, we know that just expanding access can cause cost to escalate and it won't be sustainable over the long term.

To just focus on cost can result in decrease quality. The program is completely voluntary. Individual and small business participation is voluntary and businesses can keep their current coverage if they choose. Access is the first of the three components. These are the eligibility groups. Individuals -- sorry. Small businesses including not for profits. Small municipalities and by small I mean two to 50 employees.

The self-employed individuals and in answer to a question raised earlier there would be no preexisting exclusion. Which for us means that the so-called uninsurable would finally have access to quality affordable health insurance. Speaking of affordable, small businesses would be charged only 50 percent of the premium. Discounts would then enabled individuals to join the healthy Illinois plan affording to their ability to pay.

This discount is above and beyond the 50 percent discount for the small business. The discounts run up to 300 percent of the federal copy level which means that a single

individual earning less than $27,930 and a family of four earning less than $56,500, would be eligible for discounts.

The coverage will be comprehensive and will include at a minimum, hospitalizations, mental health, prescription drugs and preventative care, including routine doctor's visits and disease screens would be covered at 100 percent. How much will it cost? I would like to note that these members are based on early actuarial analysis. Our actuary is Miliman so these numbers are not just made up.

They have, in fact, they are not -- I'm not prepared to handout the actuary's report necessarily but we are nearing a point where we might be able to do that. The revenue generated by the assessment which I will talk about later in terms of describing the assessment is about $400 million. And this is based on premiums collected about two years ago. There's a lot of time and agreement data is published, so that number is higher now certainly.

The individual employer discounts in year one, you're estimating would cost about

$192,000,000 and that's assuming an enrollment of $50,000 in year one. Which that amounts to a count per year about $33,840 we're estimating $100 million for administrative cost which I think is a very generous estimate for how much administration cost in the first year and which would leave reserve of $108 million.

An example, a single mother earning $32,000 a year which is 250 percent of the federal poverty level, her total premium would be about $400,000,000 -- strike that. You all might agree with actuarial number. It would be $400 per month for the employee only, for her only, this is not including her kid. And the reason for that is All Kids would be a much more economical option for her and reconstruction of the program that such that if you're eligible for All Kids, the kids join All Kids because it's more sufficient a way or less expensive burden to the state, to the revenue. The employer discount would be 50 percent of that. The discount would amount to $200 per month. The employer would pay 60 percent of that which is $200 which would be $400 per month.

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The employee discount would be 40 percent of the remainder which is $48 per month which would leave $72 per month that the employee would pay for comprehensive health insurance for herself. Cost is the second of the three components. The key cost containment measures are insurance rate review which would mirror the new medical malpractice law with respect to insurance rate review.

Insuring health care facilities, major expansions are consistent with state health goals, introducing the unpaid cost of care for the uninsured which the hospital association described very well, which would limit the degree to which such costs are passed on to consumers with health insurance.

And this number $1.8 billion is the updated number to the 1.2 that Elena mentioned in her program. And this is Families USA 2005 report on which this number is based. And finally public recording providers and insurance companies cost increases and profits. This is just a visual showing the added cost of care for the uninsured. About nine percent of

premiums are devoted to pay for uncompensated care.

Quality is the third of the three components. The quality improvement functions include promoting nationally established performance standards and best practices, not creating a new set of performance standards. The goal here to eliminate some of the regional, economic and racial disparities in the health care system.

And secondly, establishing incentives for consumers to adopted healthier lifestyles, including health clubs discounts, 100 percent coverage of preventative care which I mentioned earlier and smoking sensation programs. This program Healthy Illinois recognizes that consumers too play a role in health care cost. This is not seek to completely relieve consumers of the burden of thinking about their own health care.

And then finally the financing, financing is obviously and has been the lightening rod of this entire issue. I would like to recognize that financing is not necessary

one of our core principles. Our core principles is that it needs financing with a mechanism by which that financing is established is not a core principle as such. So we're open to ideas to bring ideas to the table about how to finance this program.

Right now the funding courses are three fold. Employer contributions, individual contributions and the Windfall profit assessment. The Windfall profit assessment is first as we've discussed, insurance companies pass on to consumers the unpaid cost of care for the uninsured. And this is that nine percent that I talked to you about earlier.

Under Healthy Illinois, the cost of uncompensated care will be reduced because more people will have health insurance. Insurance companies will continue to charge the inflated premium. And therefore, will experience an unexpected problem, a windfall. A portion but not all of the insurance company's windfall, will be used to help fund discounts for lower income people, and this assessment is known as the windfall profit assessment.

And the current level of the assessment as specified in the legislation is four percent of premiums collected which equates out to the $400 million estimated revenue generated that was sighted in the earlier slide. Next steps.

The meetings with the state holders are ongoing. SB 2561 as Senator Halvorson said is on second greeting in the Senate with the deadline having been extended to January 9th, 2007, and the last is my contact information. I have for two years now welcomed any group no matter how strong the opponent or what have you -- disinterested or small entity what have you, to contact me if you want to provide input or engage in a dialog about how we might better go about this program. That is the entirety of the substantive presentation so if there are questions, comments.

MR. LERNER: Can I ask somebody to turn on the lights for me. I want to thank you for a very kosher presentation. I just want to ask -- can I start out with one quick question. Your windfall profits assessment slide. If the

insurance companies continue to charge the inflated premium therefore have that unexpected problem that's getting taxed, isn't that essentially a hidden subsidy. Because the inflated premium is going to be passed on and retail rates to everybody else. So to everybody who's paying the premium will in fact be the ones that are paying the assessment?

MR. MCDERMOTT: The economic basis for that principle is that savings will not in fact be passed on through the system.

MR. LERNER: I understand that. But if they're inflated rate -- I mean, theoretically the other way to look at this is that you take the inflated rate down to a less than retail rate. Insurance companies that are able to charge a lower rate now have to worry about where that money is going to come from.

What you're doing is keeping the inflated rate high, you're taxing that difference between the inflated rate real cost but everybody is paying that inflated rate. Employers are paying it, individuals are paying it, other citizens are paying it. So in fact it's

everybody else who's paying their assessment, not just the insurance company.

MR. ADAMS: Okay. I know what you're saying, yes. There is a number of responses to say that. Number one, if the rate of inflation for an insurance premium in one year was four percent, many small businesses would go singing in the streets about celebrating because that's relative to the rate of increase on a yearly basis. That's really small as we've talked about double digit increases. Two, rate review.

The rate review provisions would create a vast degree more stability and inability in insurance rates that we have today. And three, small businesses who are people in a small group market, primarily those who are not self-insured are the entities to whom the assessment would apply.

If the small business finds that the assessment plus their premium increases is too expensive, they can join the Healthy Illinois plan which again provides the 50 percent subsidy which would vastly overwhelm the four percent increase that would be the result of the

assessment.

And that's in fact that incentive is not unintentional because there is strength in members which is part of the problem with the small group market day is that there is a divide and conquer. So encourage them to join in with the plan would health our ability to negotiate more favorable rates and so on.

MR. LERNER: I just want -- and I'll but I want to point out to the Task Force the complexities inherent with the financing uses that go on here. My guess is that the Chamber of Commerce especially ones that live with the small businesses is not going to be thrilled with this approach. David.

MR. KOEHLER: I had some other questions that came up with that. Let me ask -- my first question is how does this differ from the three shared plan?

MR. ADAMS: It differs -- it's more of a traditional insurance model this is in terms of public/private partnership. It has a dictated revenue source whereas the three share plan does not. And from what I understand in terms of the

implementation of three share plans on pilot project basis obtaining that third share mainly the government funding has been a significant problem.

So that among other things is one difference. It is -- it does recognize though that multiple parties ought to pay their share. And it's often times assumed that employers of individuals who pay their share and in this context we are saying that the insurance companies also should pay their share.

So it's three share in the sense that the third share is insurance company assessment. But it's different in terms that it creates its own independent self-funded insurance plan and now it's just state employees.

DR. ROBERTS: The question relates to effort selection. Currently in the group market there are no preexisting conditions and cannot be excluded because of anything. But on the individual market in planning on allowing everybody to get into a plan, it would seem to be that you're creating a high risk pool. As we've been told here at this Task Force, the current

Illinois state high risk pool is running out of $52 million deficit and funding at 143 percent of premium. So how can your figures regardless to look at make them work?

MR. ADAMS: The fact of the high risk pool that you described in terms of the rate, cost that's running versus premium selected is exactly why high risk pool standing alone are difficult to maintain. And why we ought to try to encourage the buy in of younger healthier people which is why we got a substantial discount. I tried other state holders say the discount is too substantial, such that you're going to get too many people buying it which is going to drive out some of the smaller insurance carriers. So there is a balance to be reached here.

But right now the reason for the major subsidy is try to encourage the younger healthier people to join in. But this program has been definitely crafted an eye towards addressing potential adverse selection problems.

SENATOR HALVORSON: You guys I don't mean to interrupt but I have to go to committee. I just want to thank you for your time day.

MS. DAVIS: Senator Halvorson.

SENATOR HALVORSON: Yes.

MS. DAVIS: Margaret Davis from Health Care Consortium.

SENATOR HALVORSON: Hi, how are you?

MS. DAVIS: Good. There is a careful question about quality in the slide. In the State of Illinois you're not going to get quality unless you deal with this provider shortage. And I wanted to ask you if you and Mary Flowers could have a subject matter hearing on the subject of provider distribution. There are some issues that could be corrected even before we get the legislation passed. Because to have a plan and have nobody to accept it because they're nonexistent, is not going to work as it relates to quality.

SENATOR HALVORSON: Oh, I'm absolutely open to any sort of meeting you think we should be having. I know we've held many meeting and -- for the different state holders. So just let Brent know or myself and we'll do whatever you think is important.

MS. DAVIS: Okay. Thank you.

MR. LERNER: Thank you, Senator. We really appreciate you taking the time.

SENATOR HALVORSON: And the only other thing I do want Brent to may be address real quick is the fact that I know I heard somebody previously say that the Illinois Chambers especially small business was not before this. I think that's quite the opposite. A lot of the smaller companies who cannot afford to give their employee insurance are in favor of this. So I know we need to make sure that people know that the Health Care crisis affects the employers also.

MR. LERNER: Senator, it's me, Wayne Lerner, who made the comment but really it's the issue of the ones who can't afford to pay it versus the ones who can afford to pay it. In a regular sense that really doesn't reside. I think that's part of the complexity of the financing that we would have to get at. And have to peel that onion back a little bit and obviously we don't have time to do that today.

SENATOR HALVORSON: True. But, you know, as long as people know it's a lot of the small

business owners that come to us with their real crisis at hand that they would love to be able to offer their employees insurance and they can't afford it. Please let me know where I need to be and when and I'm more than happy to do it.

MR. LERNER: Thank you very, much Senator, have a good committee meeting. Ken, you have question?

MR. SMITHMIER: Yes. In one of your early slides you had your three facets of your program, and one of those was reduced cost. Is your goal to reduce the cost to an individual getting insurance or reduced cost within the Health Care system as a whole. It's not clear in your statement.

MR. ADAMS: Both.

MR. SMITHMIER: Okay. Thank you.

MR. LERNER: Other questions?

MR. HITPAS: Back to the windfall part assessment. I want to make sure I understand your logic here under the first thing about the insurance premiums because for the most part insurance carriers don't pay for uncompensated carry, that would be done by whoever provides the

service, a doctor or a hospital, you know.

So therefore, you know, the insurance company is not the one actually getting the quote windfall. Obviously. The reason it affects insurance premiums is because we providers have to raise their overall rates to compensate for that. So it seems to me like there is a step missing in here somewhere that you're taxing the entity that's not getting the windfall.

MR. ADAMS: The reason -- the step is the one you just described; namely, that the uncompensated care burden is passed on to the insurance companies by the hospitals and then that burden is thereby passed on to the consumers. This information were based on this report entitled paying a premium, the added cost of care for the uninsured which is published by Families USA which I highly recommend as being very important reading. Which in this research to some extent the basis for our analysis with respect to the windfall profit assessment.

And I want to point out -- I'm sorry, Senator Halvorson asked me to address the

business angle of this in terms of support and opposition. Over 1,000 small businesses have endorsed a campaign. So the individual businesses themselves are much more receptive than the entities that represent them.

MR. LERNER: Well, and, you know, for instance is no proof of anything I always like to say that. I say that to myself. But my wife runs a small business, if she had the choice between getting a discount versus paying assessment to subsidize a program that theoretically can be subsidized by someone else in order for her to stay competitive in health care market, I don't think it would be really a tough call for her. This is a woman who's got a social conscious. So as we get into this issue, the economic equation, the algebra of how you make this work. It's going to require a lot about for our Task Force to really understand how we're going to make this thing work for everybody.

So, again, I think what we're trying to do here is clarify the issues, put them on the table but understand the complexity of the

issue in front of us.

MR. ADAMS: But the cost analysis slide so to speak would be the example. In that the employer would put that individuals employee, pay $120 a month period, and so that's the analysis. If the employer is paying less than that, I would like for them to come to me and tell me how. Like what their insurance plan is. Is it as comprehensive as that so it's a pretty straight forward economic analysis for them.

MR. LERNER: Other questions? Well, thank you very much we really appreciate that. It's obviously going to lay a lot of thought or for a lot of conversation. It's really what we're all about so thank you.

MR. ADAMS: You're welcome.

MR. LERNER: Let me move on to the rest of the agenda. Don't I have the Department of Public Health update and we've got a series of updates and some things to call your attention to. And I do want to spend some time going over the schedule, make sure everybody knows what's going to be keyed up because we're going into the final throes of our work.

MR. CARVALHO: Let me give you the most important updates. First off, we received for responses to the RFT for the research entity. A team of 3 of us within the department evaluated those responses according to the criteria laid out in the RFT. And the successful response was a team headed up by and Advocate consulting team with Mathematica. And I think Milman actually an actuary mentioned earlier this morning.

We have with us the project manager Gwyn Davidson, who was kind enough to come to the meeting today even though we haven't crossed all the Ts and dotted the Is on this. We did post the notice of selection a week ago Tuesday.

So we will be signing up the contract as soon as the state apparatus for doing that sort of thing runs forward, which actually may be in the next couple of days. So I want to thank Gwyn, give her an opportunity to say hello and introduce herself and correct anything I said in terms of who her team is.

MS. DAVIDSON: Well, we're very very excited about working on this project and what it

means for health care in Illinois. I just wanted to hand out and hopefully I have enough copies. I may not have enough copies back here. But I think a copy of an executive member -- a proposal we submitted. And that walked through -- that walked through the main steps that we anticipated taking in this project and also our skills and experience. And for those of you who may not be familiar with that we're a very large large consulting firm that does a large variety of financial analysis for different firms.

We have a very substantial health care practice that is both on the provider side and on the payer side. So we're very familiar with issues that providers are facing but also issue that payers are facing and that includes both insurance companies, state Medicaid, health care, payers as well as the federal government. So we're very excited about working on this type of project where you really need to look at all facets of health care policy.

We have also brought with us to the table Mathmetica to provide a lot of support in terms of looking at things that are received

with the employer sponsoring insurance. One of the members actually by Mathmetica, is a subcontractor, spoke to the Task Force back in December, so we're very excited about that.

We also have Rob Domler on our team from the Dunn of Indiana. He has been working with the State of Illinois for many years now. We have been working with them as well and he has a lot of experience with Illinois Medicaid specific cost as well as experience in the other states as well as health care coverage. So we're excited and we look forward to working with all of you.

MR. LERNER: Are you officed here in Chicago?

MS. DAVIDSON: We are actually. I just walk over one block.

MR. CARVALHO: In fact in between the time that they submitted their initial interest and the word was made they moved closer. Originally they were on the South Loop and now they are a block away, so that will make things convenient as well. But obviously they were selected for their qualifications not for the proximity. And

then on a less happy note. One of you saw the talent that Ashley Walter has brought to our team and hired her away so Ashley will be leaving us in about a week and a half. I want to thank Ashley tremendously. And a note, Margaret Davis probably won't let me get away without pointing out that we hired away one of her people recently too so I guess what goes around comes around.

But we wish Ashley the best. For all I know her employer may assign her to monitor our activities. I do not know. But Ashley has done an outstanding job for the Department and therefore for you in putting together much of what you have done in seeing over the last nine months. So I want to thank Ashley greatly for her services and wish her the best.

MR. LERNER: On behalf of the Task Force. I also want to express our thanks not only on behalf of the Task Force but also the Steering Committee. We will miss you and know this department will continue to support us in great ways but also a wonderful career. Can you tell us where you're going, is it secret?

MS. WALTER: Inaudible.

MR. LERNER: Well, good. We expect you to represent us well when you go over there.

MS. WALTER: I would like to thank each and every one of you too. You've all been a pleasure to work with and really great getting to know all of you and all the interest that you represent so.

MR. CARVALHO: The next item on the agenda actually is from Ashley.

MS. WALTER: I would just like to draw your attention to three handouts that I e-mailed out to all of you and that are also in your folders. Two of them pertain to the special meetings that will be on Friday April 21st at Blue Cross Blue Shield of Illinois and it's a private sector solution meeting.

There is a -- some finalized agenda and there is also a registration form here. So I just need you to complete this and either e-mail it back to me, you can do that electronically or fax it back to me by April 10th. And just please note, this is very similar to the meeting that we had in December. And so only Task Force members and those that represent

state agencies and that have been distributed indirectly can register for the meeting. It is open to the public so they can attend. This has to do more with security and other issues.

MR. LERNER: I strongly encourage members of the Task Force to try to attend this meeting, it's a very critical issue going to be discussed there.

MR. SMITH: Just a real quick question. For those of us that are down state, will we be able to stay all night. And night before?

MS. WALTER: Definitely. And I'll resend out the travel guide, that talks about what hotels in the city.

MR. LERNER: Or David's house. Whatever comes first.

MR. KOEHLER: I got burnt once so I always remind people if you're coming from down state and you would expect to go to St. Louis to supply here. That requires some preprocessing of out state rivals request. So if that's your method getting up here please work with our staff before you depart.

MR. LERNER: Ashley.

MS. WALTER: And the third document is just an updated presentation plan. And now while I'm looking at this again, I realize that I updated all the possible presenters but I did not update the time with the future meetings. So if you flip to the back side, the start time for all of those meetings should be 10:30 and the end time should be 4:30. Because the Steering Committee did agree to accommodate the request of the numbers that would like to take the train.

MR. LERNER: And I would just remind the Task Force members this is the critical period you know we haven't even hit the hard part yet. This is where we're going to be both learning and working with our consulting term of the department evaluating models hopefully between August and October.

MR. CARVALHO: One thing I would like to add too and I apologize I was not back in my seat the start of Brent's presentation. The first six or so meetings of the Task Force is geared towards broad general presentations on themes. We received requests right from the start from folks who had models. If they wanted to present

then we ask them to hold off until we had done some of our presentations. We're are now starting to interlace those. Brent happen to have been the first to request back in November I believe and so we held him off until today. We have others who have asked to present. To a certain extent it's going to be a combination of Steering Committee direction versus trying to generate a spread of visitation and hospitalization has approached us with requests to present the plan.

The Steering Committee meeting today is really going to be talking large about scheduling this and developing a plan for -- to bring to the Task Force on how to decide the six plans that they would like to research entity to evaluate. So today happened to be Citizen Action, Healthy Illinois, upcoming meetings would include -- I was somewhere in the middle of a sentence but I think it was going to conclude with in the future we'll have some additional presentation and we'll meet with your teams and that's why we see extended dates because obviously that's only so much people can express

in presentation.

MR. LERNER: I'm very concerned about that and I'll just tee it up right now. If you look at the second page that Ashley present, forget about the time issue. You got six hours and you really don't have six productive hours. We have a lot of presentations that are currently scheduled and there's others that may want to talk. We haven't begun to talk about the six models. We haven't begun to address the criteria. We haven't begun to talk about how we're going to debate upon the series six models. I'm really concerned.

And everybody's got their on lives they're trying to lead here. I'm very concerned about how we're going to make that work. So I'm going to put this right up on the agenda for the Steering Committee. And we're going to get the feedback back to you and obviously we're looking for your health and input to try to identify this.

When all said and done, we may have to schedule a couple more days to really debate some of these issues and people may have

to see if they can make this calendar work for that, we're going to try and avoid that if all possible, David.

MR. KOEHLER: Just to refresh my own memory. These meetings are primarily again to hear presentations.

MR. CARVALHO: Which meetings?

MR. KOEHLER: The ones on the back of the schedule.

MR. CARVALHO: Ones on the back of the schedule -- the meetings will start to become a combination of hearings and presentations that haven't yet been addressed. And presentations of plans and discussions and model Task Force members on how to evaluate, decide what you submit, et cetera. What the Steering Committee meeting will be about and when this is done is exactly how to schedule that out.

DR. LUBIN-JOHNSON: I just want to submit first of all I would hope that since the times of our meetings is going to double starting in May. That would accommodate, you know, some more time for a presentation and be also discussion. And two if the Steering Committee decides to add

anymore meeting dates, please do not add any before May the 23rd because we already have four days of meetings between April 21 and May the 23rd.

MR. LERNER: We will certainly pay attention to that.

DR. LUBIN-JOHNSON: Yes.

MR. LERNER: Plus this doesn't accommodate the Steering Committee's meetings which have to follow these. So we're right with you.

DR. LUBIN-JOHNSON: Okay. And I would even say preferably June the 1st hoping that the legislator is totally done and the other two members of the -- well, three members of the legislator will be able to participate in the meeting.

MR. SMITHMIER: And if I may to your point about time available for the presenters, I don't know if we do but I think we should do everything we can do to let the folks know how much we have already. You know we don't need anyone reciting anymore stats to us about current circumstances in Illinois, the country, we know all that.

And I think to the degree that we

can coach them to make their point. I don't know that we need to be lobbied and we have to get some of that periodically. But get to your point what do you believe in. What do you think would work. What have you seen work, the very practical kind of things.

MR. LERNER: Sure. Good discussion.

DR. LUBIN-JOHNSON: One more real important question. Ashley, sorry that you're leaving but, David, who is replacing her.

MR. CARVALHO: We're working on that. We have some things that we're working on that I can't be more specific on just quite yet.

DR. LUBIN-JOHNSON: We'll look for an e-mail from you in the future.

MR. CARVALHO: Or from him or her.

MR. LERNER: Any other comments from either Ashley or David about what's coming up? Other business or new business from the Task Force members? Other business from the head of the audience. Hearing none do I have a motion to adjourn.

DR. LUBIN-JOHNSON: So move.

MR. LERNER: Thank you very much. Have a

great day.

(Whereupon, further proceedings in said cause were adjourned.)

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STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)

CHARMAINE PUGH, being first duly sworn, on oath says that she is a court reporter doing business in the City of Chicago; and that she reported in shorthand the proceedings of said hearing, and that the foregoing is a true and correct transcript of her shorthand notes so taken as aforesaid, and contains the proceedings given at said hearing.

_____

CHARMAINE PUGH, CSR
LIC. NO. 084-003305

SUBSCRIBED AND SWORN TO
before me this_____day
of_____2006.

_____

Notary Public

667598ac-01aa-4a4b-9f47-25814e326e29