ADEQUATE HEALTH CARE TASK FORCE

Wednesday, October 26, 2005

JAMES R. THOMPSON CENTER

9th Floor Room 9-031

Chicago, Illinois 60601

REPORT OF PROCEEDINGS at the hearing of the above-entitled cause before DR. WAYNE LERNER, on the 6th day of October, 2005 at the hour of 11:00 o'clock a.m.

Reported by: CHARMAINE PUGH, CSR

License No.: 084-003305

DR. LERNER: I don't think we can do

anything official in voting because we don't have a quorum yet. We're expecting a quorum but we'll come to meeting whether we're rewarded that the meeting is starting somewhat close on time and so, I suggest that we get started.

My name is Wayne Lerner, I'm from the Rehabilitation Institute of Chicago and did I mention that there is a World Series going on. Because I am a life long White Sox fan. So if I fall asleep a little bit in the middle of this is because last night was very late and I'm emotionally drained. And is there something more important in my life than White Sox, I don't think so but we'll talk about this a little later. Anyway I want to thank you all for coming today and we'll gain -- we'll start by 7:00 o'clock tonight so we'll be out of here real early.

Let me call to order but start to go around the room and ask people to introduce themselves, Ashley.

MS. WALTER: I'm Ashley Walter, I'm with the Illinois Department of Public Health.

DR. JONES: Good morning I'm Mike Jones, I'm with the Illinois Department of Public Health.

MS. DAVIS: I'm Margaret Davis with the Health Care Consortium of Illinois.

DR. MOORE: I'm Jim Moore with the also Health Care Health Assistance.

DR. ROBERTS: Joe Roberts with Kalick and Associates.

DR. CARVALHO: David Carvalho With the Illinois Department of Public Health.

MS. ROTHSTEIN: I'm Ruth Rothstein.

DR. KOEHLER: David Koehler.

DR. BOYD: Kenneth Boyd, Unit Food and commercial representative for Chicago.

MS. MITOFF: Pamela Mitoff, setting in for Ken Robins Illinois Hospital Association.

DR. YOUNG: I'm Quentin Young, health and medicine policy research group representing all the people of Illinois.

DR. PINTEN: Tracy Pinten, Illinois State Medical Society.

DR. EUPIERRE: Peter Eupierre, Illinois State Medical Society.

DR. JONES: Art Jones.

MR. WAGNER: Bob Wagner.

MS. KIRBY: Jan Kirby.

MS. ALTMAN: Stephanie Altman.

DR. LERNER: That's wonderful did we miss anybody? Okay. Let's get it started. We can't approve the meeting minutes so we're going to skip over that. I do have one announcement to

make about membership of the Task Force.

There was one slot on the Task Force that has yet to be filled by the speaker of the house as I recall. And Robyn Gabel who was appointed by Union Jones, has recently resigned from the Task Force. People may know Robyn, I believe has had an opportunity with a remarkable type of research fellowship. And so this one of those once in a lifetime opportunities she has decided to take it and for sake our really admirable work that she's going to do some other work on her own.

I don't believe her position has been filled yet but if it is we don't know who it is. So we will -- as soon as we know that, we will report that out to the Task Force members

and obviously we'll put an alert into the speaker's office and ask him to see if he will fill this lots.

Are there any other announcements or introductory comments?

DR. KOEHLER: Quentin is now taking her spot.

DR. LERNER: Dr. Young, Quentin Young is taking Robyn Gabel's spot as elected by their group on the Steering Committee. So -- and as you all may know, the Steering Committee meets right after the Task Force meeting in order to

keep our -- the ball rolling, so we're thrilled to have Quentin Young with us. We got other people coming. Let me get started. Let's move alone then.

The first thing on the agenda we can take about is IV which is the Public Heath briefing, public hearing briefings about the Public Health. And Ashley has done a nice job of putting together a -- in your packet, handout packet, a list of the different congressional districts where we've had public hearings and who has been there.

And as we have suggested before, I would like to take a few minutes now on the agenda to ask Task Force members who attended these briefings, to give us their input responses, kinds of impressions they have, factual and otherwise. So let me start out with the first congressional district and a number of members of our Steering Committee as well as Task Force members who were there so somebody want to start it off.

DR. KOEHLER: Well, the first one I guess we had some anticipation as to how it as going to work. We were expecting to think that we had a thousand people and we actually had not quite 300. It was --

MS. ROTHSTEIN: It did seem like a thousand.

DR. KOEHLER: No, it didn't -- yes, it was a lot of false hopes here. I think the setting was I think pretty conducive. The acoustics were good. I guess what I was struck by and I got a group that I send out an E-mail after we have the hearing just to kind of let them know the flavor of it.

But I think what was mostly impressive to me was the sincerity and the real live stories that came forward. We know these things. We heard them. We read about them. But to actually have people tell their story, certainly impacted me because these are real people that have real issues here and so -- just kind of impressed upon me the enormity of our job. We got to somehow not only provide hope but do whatever -- something in terms of solution so those are some brief comments.

DR. LERNER: Any other members of the Task Force who were at the first congressional meeting --

MS. ROTHSTEIN: I think -- yes. I'm sorry.

MS. DAVIS: One of the things that it was different things that emerged, the lack of dental care.

DR. LERNER: The lack of -- I'm sorry --

MS. DAVIS: Dental care. And then one of the issues was a model. And healthy Illinois presented a model and they had been consistently coming and I think that would be a model that we

need to -- once we get our researchers done, that we need to look at the model.

The notion of being insured today and not having insured tomorrow, due to a catastrophe like an accident or a loss of a job. And the young people, this whole gap of people getting off their parent's insurance, not quite graduating, not getting the first job and being uninsured during that period of time. That's what I noted series number one.

MS. ROTHSTEIN: I think also a small entrepreneur who could get insurance but couldn't afford the premium because they were so high. And I thought that was kind of critical. We didn't hear enough from those people, we really didn't. I think the point that Quentin made at one of the hearings and he should do it and that's again what we're hearing and why we're not hearing from a broader base so Quentin you can do it better than I can.

DR. YOUNG: We talk about --

DR. JONES: Dr. Young, could you speak up

just a little bit.

MR. YOUNG: No.

DR. LERNER: She needs it and I need it so that's okay. All right. Any other comments from anybody who went to the first congressional district, Pam?

MS. MITOFF: I think I would echo everyone's comments but something I found frustrating is someone who has been involved in insurance and legislative issues for more years than I could claim. Is that on at least several occasions, there were programs or alternatives that you just wanted to jump up and say, did you know about this.

And I think one of the things I would like to see if there is some way for us to kind of close the loop on some of these, is to at least be able to provide some information or feedback to folks when there is something that will help them now as opposed to waiting for whatever our deliberations ultimately arrive at.

DR. LERNER: That is a really good idea. In our institution we do town hall meetings, we collect questions from people and post the answers. And so maybe we can think about how we can use the web site as a way of providing public

access to the kinds of issues that are raised in any of the congressional district public hearings. And that way, everybody in the state can benefit from access to information, it's a good suggestion. Other comments?

Now, let me move on to congressional district number four. There were a number of members of our group there, David again and Ruth and Quentin from the Steering Committee Jim Duffett was there, any comments?

DR. KOEHLER: This was a more challenging one. First of all we had both in English and Spanish. I think the booth in the back that they set up was for the translation. We were all going to wear headphones and have it simultaneous like the U.N. But by the time they got the booth set up and everything ready, we were done.

So we had the translator actually sit at the table with us and as someone was speaking, they would translate in the other language. It was, you know, it wore him out quite frankly but it was good to be offered that. The acoustics were not good and I think that's one of the things we have -- I know it's -- the

logistics of this have been tough but it was --

it was a tougher hearing from that aspect.

But, again, you know the heart and soul of folks coming forth certainly was evident. This touches people, all economic levels, all situations and, you know, it's good for us just to reflect on that. One thing I would like to ask Pam is that if you could make some notes whatever and give us the actual situation of where someone has said something and what -- that might help me to identify with the real, you know, situation that has happen. Because I think that's part of our job is making sure that we have -- you know, access means information, it means knowledge of what is out there, so it would be helpful.

MS. MITROFF: I think once we can get the transcripts then we can go through them and probably between people of the people here on the Task Force we can say, oh, wait here's an approach or whatever.

DR. LERNER: We can do content analysis that's a great. Margaret, you seem to have great notes so --

MS. DAVIS: One of the things being a fanatic that I hadn't heard before, was the issue of women being tied to the insurance of their retired spouse. And not knowing at any time -- living in fear that at any time the company will

retract that retirement insurance. Not having any confidence in this retirement insurance aspect.

DR. LERNER: That's a good point. That's a very good point. We're just giving a review of the public hearings, anybody else want to comment on congressional district number 4.

DR. SMITHMIER: Only one I went to -- just some general commentary, I agree with you Dave there were very heartfelt comments and stories that from people that were important. But I have to tell you as a whole it felt like an orchestrated event to me.

It was interesting to me how many people ended the three-minute statement with, I'm paraphrasing with the line, this is why I think we should have a single pair system. Which sound to me like a lot of people have leaped to a conclusion about an answer before a group like

this. This has been time that it needs to analyze the issue.

I heard lobbying for community health centers which I think were important. But frankly, I think that if everybody has insurance then they have freedom to go where they like to go for there care when it's to community health center or private physician like everybody else.

I think that's really an important thing for people to go where they would like to go. So I listen to the stories of sympathy but I'm not sure that I got anything constructive out of that -- the event that helps the solution.

MS. DAVIS: It was one more thing Wayne that he jarred my memory. There is a large conglomerate of free clients. Clients that are run by people on benevolence and philosophic. And they have -- they're busting at the seams with these free clinics. And they, you know, we spoke to the executive director and we said, well, you know, if this happens, you will be going out of business. And she said gladly, I would love to go out of business. So these free clinics were very, very evident in District 3.

DR. KOEHLER: Were they free clinics or were they federal qualified health centers?

MS. DAVIS: No, they were free clinics.

DR. KOEHLER: They were both there.

DR. SMITHMIER: I think there was one particular lady who spoke about that one clinic and then there were several at the --

MS. ROTHSTEIN: Erie that's right.

DR. KOEHLER: I think that's important for us to just make note of because at some point as we go back and reflect on all of this, we have to think about what is the gap that they're feeling

and is that something where, you know, FUHC's are funded first of all by federal dollars and then there is a formula of how you use mostly the Medicaid dollars on accelerated reimbursement rate to help fund data on the board of our FQAC in Peoria. That's something that needs to enter into a discussion down the road.

DR. LERNER: David.

DR. CARVALHO: As a sedge way although I'm going to need to cut it off, one of the things that we're going to be bringing to the Steering Committee this afternoon to bring back to the

Task Force at the following meeting, is a sequence of presentations over the coming several months on several different themes.

And one of the themes will be the safety net and it's curved, configuration, what is it. How is it held together, because that is a very important piece for you to understand. What is out there. How does it remain out there. How does it finance and how is it stretched. So all of that will be end of the day of one of the Task Force meetings.

DR. LERNER: Are there any other comments from congressional district number four, Jim?

DR. DUFFETT: I thought there was going to be a presentation and each of those other than

the first one from public health on. And I know that one was a little strange because of the translation wasn't set up. But I think that would still be a very, very important thing for the Department to do before you chair so people would have an understanding of what this whole process is all about.

DR. CARVALHO: And I notice that in the minutes as well. There was sort of an ad hoc

division made at the first hearing, that given the number of people who wanted to testify and the fact that by limiting testimony to three minutes, we were de facto saying no more than 60 people were going to be able to testify, that consuming what would in effect be ten people's opportunity within the 30 minutes -- and I was part of that decision. We didn't -- we had -- look like three or 400 people in the audience. We had no idea how many people were going to testify. As it turned out it was fine but we didn't know looking at the crowd.

DR. LERNER: Yes, but that doesn't take away from the fact that even if we get a five minute overview --

DR. CARVALHO: Well, they did have a fact sheet that was I felt pretty thorough.

DR. LERNER: Somebody would just go over it bring attention it. I think is a good point.

Anything else from district number four. All right. Let me move to congressional district number seven. Jim, you were there Ken Smithmier was there.

DR. SMITHMIER: I didn't make that

meeting.

DR. LERNER: Okay. You didn't make it? Dr. Young chaired it. Jim, anything special?

DR. DUFFETT: No, other than when is the appropriate time just to raise some of the concerns that I've raised with folks of the timing and even, you know, maybe even the makeup of the hearing presentations that we had talked about before. So I don't know if that fits under here or if that fits in another part.

DR. LERNER: I'd leave that to the end of the agenda.

DR. YOUNG: I will I think all three and a couple of observations some are self-evidence but it was noted. The congressional districts was not drawn with this task force in mind. If you look they're ludicrous and you know why they are the way they are. There is some times -- but most of times those were critical decision. So I make the instruction that we go to each congressional district probably the only way to go but on the other hand, there is no unity.

MS. ROTHSTEIN: I'm not sure that was official.

DR. YOUNG: I think labor should be there. Also absent and, of course, captured with industry and the insurance world and aside from members of this committee to be sure so I would like us to think -- make it more meaningful. The other one generalized point I made is, we have to have it make it more meaningful in a public educational way.

By that, I mean, we should make a serious effort to get every elected official in that district to be aware of this and come and obviously it's great to have Congress people and state reps, but even aldermen and county commissioners. I think that would add some creditability for ultimate deliberations. And finally, I think we can do a better job on the media. Seems to me we been gone long enough that certainly the public interest radio station WBEZ should get the updates from Wayne what this committee is doing and how it's proceeding and be aware of our subsequent activity. Thank you.

DR. LERNER: Thank you.

DR. KOEHLER: Can I just make a comment on that.

DR. LERNER: Sure.

DR. KOEHLER: See I think the hearings are going to have a very different flavor when we move Downstate because -- just thinking about when you have it in Peoria, that's going to be a big event where in Chicago it may not be that big a news. But when you come to Downstate and places, I know that we're going to get a very cross section of the community and certainly news media will cover it a much different way. I don't know how you solve that problem in Chicago.

MS. DAVIS: The seventh congressional district I share the concerns with Dr. Young. The elected officials -- I think the staff are sending letters. However, because we are holding them on a time when they are in Congress, they have not been able to be there but like with Bob Rush and Danny Davis, I personally talked to them and Danny Davis was able to send his chief of staff there.

I contacted the commissioners in those two districts. And each of them did not send anyone nor did they come. But there should be some overture by Eric Whittaker to president

Stroeger, to the legislative black caucus of the

state, telling them about the importance of these events. At the seventh congressional district, I was concerned about hearing from breast health advocates. And there seems to be a severe fragmentation of services for breast cancer patients.

One doctor got up and spoke of her referring a patient to the safety net hospital at Stroeger which would -- definitely a suspicious cancer of the breast. having her sit for three days waiting for a diagnostic test, only to be upstaged by a more urgent surgical situation. And so that woman 70 years old sat for three days, five hours each day and never not served.

DR. LERNER: This was a woman who was uninsured?

MS. DAVIS: This was a woman who was using county safety net services. She did allude to her -- but she's 70 so she should have medicare.

DR. LERNER: Well, that's any point.

MS. DAVIS: Right.

DR. LERNER: So there is an issue here not only access to insurance -- I'm not being

critical.

MS. DAVIS: Right.

DR. LERNER: There is an issue here with access to insurance and charges that our tasks force has got, and there is obviously a series of

issues that have to do with the delivery system.

MS. DAVIS: That's it.

DR. LERNER: I don't think it's our job to fix Stroeger Hospital in setting up their triage system. Although, I know this lady to my left did a good job of that. I just want us to separate that.

MS. DAVIS: Right.

DR. LERNER: Okay.

MS. DAVIS: But that was the issue because not only did she speak to it, someone else spoke to the unavailability of diagnostic mammograms for low or no insured people.

DR. LERNER: Yes, I think you're raising a really great issue though that has to do with that.

DR. DAVIS: And then another area was the Chicago Department of Public Health and they alluded to that they're going to have a safety

net. We're going to have a presentation by safety net providers. I realize that both Stroeger and Chicago Department of Public Health are under undo stress, and the question of capacity came up.

But an interesting thing came from one of the nurse managers -- administrators at Stroeger. And she was saying if we do our job

right with the insurance by all, will we be looking at the need for safety net providers. How will we address Stroeger's need. How would we address the Chicago Department of Public Health. You know, will we make recommendations to carve out dollars for the Public Health and safety net infrastructure and so I thought that was good.

And the last one was some cosmetic types of things for poor people. One lady got up and testified that she had severe heavy breasts that was causing her severe back problems. But she could not get services because she was without insurance and nobody looks at those cosmetic issues for poor people.

DR. LERNER: Yes, if they're insured and

it's a medical condition then I know it's covered. But if they're not insured, that's a different problem.

MS. DAVIS: Right.

DR. LERNER: Jim.

DR. DUFFETT: Just overall hearing the depth of the testimony that people gave and variations that they gave and their willingness to, you know, come up to a microphone and be nervous but be able to tell their story. And I think those have a lot of meaning and in assess many that people made a lot of great work that we

have before us to try to solve it.

DR. LERNER: Great.

MS. DAVIS: Last was, you know, we imagine that HIV client are serviced through various Federal and State funding cycles. But one person who was impacted with HIV AIDS, talked about now having to have his formulary altered whereas he was on some medication. Now, the safety net provider doesn't offer that. And so we all know that we've changed those type of drugs you get into a lot of problems. So that was an interesting thing. So we assume that those

people are covered but certain aspects of that is not being met.

DR. LERNER: Got it. Any other comments on this congressional district or any -- some of your comments about any of the three? I really appreciate the Task Force members not only attending but bringing back their observations. And the Steering Committee will take these and I know there are several other comments that people have been making about the public hearings and we'll address those during this hearing committee. We'll leave time on the agenda to talk a little bit about embracing the issues that we might have.

So I really appreciate that. I

think it's very worthwhile that we take time at this meeting to hear it and have everybody at least virtue sense, appreciate what was going on in the hearings. Now, we've got some members who came and guests who came. We have started so we need to see if they're introduce themselves. Dr. Barbato.

MR. BARBATO: Present.

DR. LERNER: Dr. Barbato is the CEO of

Loyola Medical Center. Who else just came in? Anybody on this side?

MS. VEGA: Sue Vega with the Legal Medical Center.

MS. LUBIN-JOHNSON: Dr. Niva Lubin-Johnson member of the Task Force.

DR. LERNER: Jim, did you introduce yourself?

MR. DUFFETT: I'm not sure. Jim Duffett with the campaign for Better Health Care.

DR. LERNER: Did I get everybody?

MS. BRESLER: Catherine Bresler, Trust Mark Insurance Company Task Force member.

DR. LERNER: I understand that we now have a forum so I would like to entertain a motion to approve the meeting minutes of September 14 of 2005, would somebody move it.

MR. DUFFETT: So moved.

DR. LERNER: Second.

MR. YOUNG: Aye.

DR. LERNER: Any additions or corrections that anybody would like to make to the minutes. Hearing none all in favor please say aye.

THE MEMBERS: Aye.

DR. LERNER: Any oppose nay? It passes, great. Just a remainder anybody whose got phones, black bears, pagers, World Series alerts, please put them on vibrate or turn them off so that we can have a meeting going forward. I for one happen to have a newly blossoming hearing apparent, which I'm very proud of because I work in a field for disability. And I have a hard time hearing things so I want to make sure everybody's got that. Let's move along. Presentations, Mike Jones.

DR. JONES: Well, good morning everybody. I have the happy tasks today of welcoming a couple of our sister agencies to come to us and help us with our knowledge building progress. As you recall on September 14th, we provided some slides, some overviews, some reading materials to start building some knowledge about this large universe of activity we have to engage in.

Today we have a representative from the Comprehensive Health Insurance program of Illinois Jan Kirby and we have a

representative from the division of insurance Bob Wagner. And Jan and Bob are here to inform us about their programs, help us understand the nature of what they do and the services they provide to the State of Illinois.

And they will also entertain your questions as we try to build our knowledge and understand this complicated stuff we have to work on. So Jan has -- I have just volunteered Jan to go first. And she will be followed by Bob. Jan, thank you.

MS. KIRBY: I promise first off not to say every word that's in this slide. It's looks kind of voluminous. What I had hoped to do today is to give -- couple of you heard these before probably recognize the slide. Bear with me there is a little new information in here. But I wanted to give you enough information about CHIP that not only would you hear what I have to say today, but in my answers some additional questions you have as you pursue your task at hand.

And it will encompass just a covering of our mission, a little bit about our history, some financial information where we're kind of unusual in that, we are a provider of

health care benefits coverage but were designed to operate in the red. Which is a different perspective than those insurance carriers have. And we're different than the entitlement programs too and so that -- we really are kind in the middle there.

So also how many people are in the program today? What kind of -- what other programs that we have. And then there's some pretty detailed information about eligibility and benefits that we can skim over. I'll answer questions for you but I thought you might want to have it in your libraries as we proceed.

The CHIP program has a two-fold commission. It was originally set up to provide access to health care benefit coverage to people who had the resources to pay for that coverage but couldn't get it because of health conditions.

It was designed as a very small -- it addressed, a small, kind of a small need of a niche solution to a market problem and that was the first mission. Subsequent to that, our mission has expanded under the health insurance portability and countability act. We became the

portability mechanism from group to individual

coverage.

People who lose group coverage they have a right under federal law to get an individual plan of some kind. In Illinois, the alternative mechanism was used as CHIP and that's what we sort of -- in addition to that and that was in '97. In 19 -- in 2003, we actually also moved that mission a little bit further in that we're a qualified health plan for the Trade Act, which is a tax credit program and there is a little more information later on about that.

Just for your information, CHIP became an entity in 1987 legislatively. First policies were issued in 1989. At that time we were the 15th state to have a program so it was certainly not one of those programs that didn't have some -- Illinois had some basis to go by by looking at what had happened in other states and now there are 33 states.

Some of that there was kind of a ballooning of the number as the HIPAA law passed and there needed to be an alternative mechanism sort of in the states. And so we saw kind of

some growth at that point.

Illinois was the first state to pledge general revenue funds for the funding of our uninsurable pool. We still do use general revenue funds, many states have moved away from

that mechanism but Illinois still does use general revenue funds to support that pool. And then we have a separate industry assessment that supports the other pool. A total of 46,000 people have been -- they are in or have been in and out of CHIP.

So if you think of it we got really two basic pools going on and they -- the benefits are the same but the revenue -- the funding is totally different and the criteria for getting in the programs are different.

Section seven is what we call a traditional pool and section seven is just a statutory paragraph, you can kind of weather to those things over the years, it really doesn't mean that much. But it's the pool for people who haven't had any insurance, can't buy it because of health conditions and they have the money to pay the premium and so that's our section seven

pool.

The premiums are set at an average charge by insurers in the market. Insurance companies make their premiums based upon anticipated loses, reserves a little margin for operations and profit. Well, our premiums are based upon what the industry is charging. So it's -- we don't charge based upon our losses and

you'll see what the results of that is, the deficit we operate in.

For calender year of 2004, the total premium collected was $34.5 million. The average premium was $5,846, that's across Chicago to Cairo from zero to age 65 basically. So there is a lot of range in there but that was the average. The section 15 pool which is the HIPAA pool if you think about that as this pool that came into being as the result of the Federal Act, is funded by premiums and the section seven has the premium element too, they both have premiums that we collect. But there is a insurance industry assessment that supports the section for team pool.

The premiums there are still set.

I mean, they're based upon what industry is charging. The Board historically has seen a little lesser -- the claim volume have been a little lighter on the section 15 pool but that's converging right now we're seen, we're almost there. And if you wonder why one is at 143 percent and one was at 135 percent of market, that's really just because of that impact that, you know, divergence which is beginning to go away. So I wouldn't be surprised if you see some attention to that.

In the section 15 pool, we

collected premium about -- in the 64.4 million. And that average premium for that pool was 6,170. Now, if you think about back on the other number, 5846 was the section seven pool and they're at 143 percent. The section 15 pool was at 6170 and they're at a lower percentage. You know why that might be -- well, our population is older. Our population is a little bit older in that section 15 pool, premiums are age based so that's why that average pushes up even though it's kind of --

DR. LERNER: Do you want questions now or

do you want us to hold them?

MS. KIRBY: No, any time. Go for it.

DR. LERNER: Well, I just have one because I'm intrigued by those two slides. I was trying to determine whether the premiums that were set at the 143 percent are a proxy for if you will experience rating or community rating of approaches. Because if the average charge comparable coverage is a proxy for if you will the overall experience of that pool of people who are in there, then would these -- the set premiums change every year, would they change as utilization goes on as --

MS. KIRBY: It's not based on utilization at all.

DR. LERNER: Okay. What's it based on?

MS. KIRBY: It's based upon what the industry is charging. What the insurance industry --

DR. LERNER: The views to charge is the proxy for utilization then it doesn't become that?

MS. KIRBY: Yes.

DR. LERNER: Okay.

MS. KIRBY: And that is -- but our -- because our pool is a higher user of health care services than the average healthy pool. We are a pool. Our pool of people that have health conditions, even in the section 15 pool it's a higher -- so if we were to charge premium based upon utilization of services, it would be --

MS. ROTHSTEIN: Do you know what it would be if you were to do that?

DR. LERNER: Yes. The next slide which shows the financial information would show you that and the basics. If you look at the bottom line here is the plan deficit section seven is the traditional uninsurable pool. Section 15 is the assessment -- so we would have to collect that much more premium and to get, you know, to get to that -- the $52 million total is our deficit. That's the amount that it cost us to run the pool in excess of the premium we select.

DR. LERNER: The reason it picks up on both of these comments, the reason I raised my point is that listening to the review from the public hearings, our toughest job I think of the Tasks Force will be to determine the criteria

against which we will evaluate the models that are being presented before us and the trade-offs that have to be made as a result of that. So traumatically you know the roof is now raised and what we talked about experience. Experience rating versus committee rating -- I don't want to get into the efficiency of the delivery system because that's not the issue in my mind. The issue is on what basis do the estimate costs and on what basis do the estimate benefit. And what you saying is that this program has a true cost of $52 million more than in the premiums that are earned otherwise in the system.

MS. KIRBY: That is true and keeping in mind it is not representative if you took a picture of the whole population.

DR. LERNER: Correct.

MS. KIRBY: It's heavier loaded on the end of people who have health conditions.

DR. LERNER: Correct.

MS. KIRBY: And age wise, that come with and you'll see later, our age distribution is at

a higher age so our population is a little older, is a little more expensive to provide health care

for. And those are all -- so our population is not truly representative of the hold picture you're looking at I don't think.

DR. LERNER: Got it.

DR. JONES: What percentage of family coverage versus single coverage?

MS. KIRBY: I don't know that but I can tell you out of the 16,000 people we have, we have about 900 kids.

DR. JONES: Most of those premiums are --

MS. KIRBY: Well, yes, that is an individual premium. I didn't understand the question. It is an individual premium. We have families collected together for premium purposes and they get a little discount. But we place everybody in an individual premium. They have an individual coverage.

DR. KOEHLER: Do you know how many people this represents, does this say?

MS. KIRBY: Yes, that's later on. This is -- this 52 is 16,000 something. We're right at -- those numbers are lagging that's 1231 numbers and our total population is at 1606 right now so

just to be clear.

DR. SMITHMIER: Do you take all people regardless of any preexisting conditions?

MS. KIRBY: Yes.

DR. LERNER: You got ten more slides, right?

MS. KIRBY: Yes, a lot of it -- that's okay though we'll just get through them. The next slide has to do with claims and I just wanted -- this is kind of interesting, we're in a bit of a transition CHIP because if you -- and it's probably easier to see in your printed material. On the far left-hand we have a plan two which has been a plan that we've hand since really almost the beginning of the program, for persons who are in Medicare as a result of disability.

Because of the Medicare program now offering prescription drugs, albeit some argument about that, I'm not going to go into that. But there is a prescription drug benefit, it is a very real benefit for the Medicare people and the CHIP board made the decision to eliminate prescription drug coverage for that plan too.

And what I would like you to

looked at are these numbers -- look at the relationship between the prescription drug coverage. This is a thousand people. There is six million. This is the other 4,000 or 4500 people in the program.

So that -- the plan two coverage we were very heavily in the prescription drug benefit. And -- but now with the Medicare plan with the Medicare part D, it's going to reduce the premium for those people about 70 percent. I mean, it really -- it should be a pretty good benefit and we did analyze it from that perspective. And that -- I thought this was interesting too from your perspective. The distribution of what we pay the most for in and broken down by plan.

DR. KOEHLER: The difference in the plan is the plan design some have more?

MS. KIRBY: No, the plans are the same pretty much, except the plan two is the Medicare plan. The plan three and five and I'll cover that too I'm very similar in benefit. Let's get through the next couple of slides and get to

that.

I already mentioned that we have 16,000 people totally. The traditional -- the original pool is capped because it is supported by general revenue funds, so we have a cap of

5950. That's what the Board believes we can provide, that's the number of people we can provide coverage for based upon the appropriation given.

Section 15 there is no cap because we have the ability to assess the appropriate amount to get to that funding level. And then 10,000 out of the 16,000 are in our HIPAA pool. When I started with CHIP, you know, the traditional pool had 4,000 and the HIPAA pool had a thousand and nobody knew where it was going to go right away and they watched it. And pretty soon it flipped upside down and now the HIPAA pool is really the lions share of what we have. Down here, this little number if you just keep that number is mind, I'm going to talk to you about the tax credit program, the TAA program as we move along.

DR. SMITHMIER: You could avoid the cap if

you priced at a nondeficit producing premium rate?

MS. KIRBY: Right. In fact, we are -- in that section seven pool and this is not in the material, when we have more people that want coverage than we have room, a waiting list develops, people are qualified meaning they looked at all the material, we know they will

qualify and when an opening -- when somebody comes out, we put somebody else in.

Right now there is no waiting list. There hasn't been for almost a year. One of the -- one of the contemplations is maybe the premium is now at a point where we are seeing some of what you just described. That if you do price the product based upon the actual losses, it will not be as nearly as many people -- the demand the program.

DR. BOYD: Do you know what that premium would be --

MS. KIRBY: I don't know.

DR. BOYD -- with the number of people that are there?

MR. WAGNER: Well, if you crunch the

numbers.

MS. KIRBY: If you take the $52 million deficit and you spread it over 16,000 people, that will give you kind of -- some kind of a number.

DR. SMITHMIER: About three thousand persons per year, right?

MS. KIRBY: Right.

DR. LERNER: Excuse me, we have a Court Reporter here.

MS. KIRBY: Any other questions? The next three slides are just a -- they represent the age

distribution and I wanted just to point out to you that 41 percent of the section seven and 15 percent or 47 percent of the section 15, are persons between the age of 45 and 55.

That's are big constituency. Those are people that develop health problems. As you age, believe it or not you get sicker and you retire early or you know your reemployment opportunities are not what they are, I mean, those are all issues and the focus in our state over the last couple of weeks has been with regard to kids and that's a real important issue.

But there is a big, there is a big chunk of 55 to 65 out there that are not in that equation and that don't have coverage.

That's another -- that's the section 15. This one is interesting from the standpoint it just shows that we have more women than men by a fairly significant, you know, it's not a negligible issue. That speaks somewhat to your -- the question you raised upon women who are retirees -- who's husband's have retired and they're getting the retiree coverage.

When sometimes that retiree recoverage goes away and the spouse who has been the worker is Medicare eligible. But a lot of times as you mentioned, the woman is not and

that's I think that's where we see this disproportional you know, more women than men is that historically the husband has been older and gets Medicare before the woman and if the retiree plan is not available, things like that but I think those are factors.

DR. LERNER: Did you have a question?

DR. SMITHMIER: If I can just come back to the good question that you raised really about

what that premium price difference is because I think we ought to have that clearly in the minutes and if my math is right, you've got 16,000 lives and you got about a $50 million deficit. And you're talking about around $3100 per life per year, increase in premium.

DR. KOEHLER: $3155.

DR. SMITHMIER: Yes, it's about 3100, 3200. And, again, if my math is right I just think it's important for us to kind of think about that and say okay here's at least one example where if you were trying to keep it, budget neutral, this is about your premium cost per life per year for and admittedly though higher acuity population.

MS. KIRBY: Exactly. You would want to make sure you qualify that.

DR. SMITHMIER: So you might represent the top end let's say of real life cost on a per life

basis. Again, if I think that's right, I just think we hold that somewhere to make sure we hold that somewhere in our recording of the minutes.

DR. LERNER: Yes, that and -- what it obviously does is it adds to the premiums that

are currently earning and then you got a total premium cost, at least at that stage of the game.

DR. KOEHLER: Actual premium cost would be around $750 a month.

MS. KIRBY: It's different in southern Illinois than it is -- I mean, there is a range that would have to be addressed and I think it would --

MS. ROTHSTEIN: And it would change. And it would change as well.

MS. KIRBY: And it would change as -- yes, exactly. And our premiums change we reevaluate that twice a year and there is usually an increase, it has been kind of modest in the last kind of years.

DR. LERNER: But I still have a problem. We'll get to this one -- there is a difference between premiums charged, cost of service, utilization and the resulting affects on the person and on the health care industry. And at some point when you done the economic modeling, you got to bring all those variables into play.

Because by using the average of the premiums earned, we got other things in there besides

utilization, there is no difference than hospital cost --

MS. KIRBY: You do have some administrative costs I think --

DR. LERNER: Of course.

MS. KIRBY: Let's see.

DR. LERNER: I don't want to take away from your presentation I just didn't -- Task Force here could be aware --

MS. KIRBY: If you look back at that slide, you'll see what our administrative cost is right here. This is -- it's in that number so we can tell you what those costs are.

DR. LERNER: Good.

MS. DAKER: This section is much more representative of the population. As you look at demographics, do you know where people fall with respect to where they are on the federal poverty level as applying into section 15?

MS. KIRBY: No, I don't. We do -- and I don't do this so I'm not going to say very much about it but we do, are involved in a joint project with the Department of Public Aid, to survey our section seven people, not the section

15 but I believe we survey just the section seven because of -- there's a federal match under the family care program. And so we do actually get some information regarding income in the context of that project.

MS. DAKER: The reason I'm bringing this up is just because the premium is so high 133, 143, so the demographics buying into this bill must be very different than what we're trying to address.

DR. LERNER: Yes, it's real clear that as you're thinking about a population that we're trying to cover, there are going to be different cohorts. And in each of these cohorts there are certain utilization conclusions and those will have certain charges associated with this. So we need to -- it's like listening to the people that you saw. We need to put into our minds, not the solution but the problems that are arising on how we can evaluate those problems from economic modeling that's gone before.

MS. DAVIS: She jarred my memory when she had one slide that said a population of 55 to 65. A man testified of being in that gap and how

there was no insurance for his gap.

DR. LERNER: Got it. Thank you. Go ahead, Jan.

MS. KIRBY: Let's see. This is somewhat information, a little bit becomes reviewing as we've answered questions. So we do have two pools that's kind of a review. There is three separate plans. In plan two being the Medicare plan, plan three being the traditional CHIP and -- that's not really anything we need to hang on to. It is important to know that under the two of our plans -- we do take anybody regardless of health. In the traditional pool there is a six month preexisting condition to waiting period.

People who come to us from HIPAA-CHIP -- in the HIPAA pool, whether they come as a TAA person or not, they come from just having had insurance. And if you talk, if you've ever gone without auto insurance or anything, if you spend some time uninsured whether it's health, auto or anything, your premium is going to be higher because and statistically, actuarially you are more expensive

because you probably haven't dealt with everything.

And so these pools -- these people are coming right in from over coverage and it is the law but there is an actuarial foundation for

that as well.

DR. LUBIN-JOHNSON: Can I ask a quick question about something on the slide?

MS. KIRBY: Sure.

DR. LUBIN-JOHNSON: You're saying because of Medicare part D that after January 1st, CHIP will no longer cost any plan?

MS. KIRBY: No, just that plan. Just the Medicare plan.

DR. LUBIN-JOHNSON: Okay. Plan two.

MS. KIRBY: Just because of our plan two, our Medicare plan.

DR. LUBIN-JOHNSON: And what are -- those person are -- what do they do for prescription billing if they are not in Medicare --

MS. KIRBY: We're sending out information to them and encouraging them to come sit or signing up for Medicare part D.

DR. LERNER: And people in plan two are

Medicare beneficiary?

MS. KIRBY: They are Medicare beneficiaries. Our plan two people are already in Medicare.

DR. LUBIN-JOHNSON: So they're doing this as a secondary?

MS. KIRBY: They're using it in -- people who are on Medicare because of disability, don't

have the same access to Medicare supplement coverage that people who reach the age of 65 do. In fact, there is very little available. I think there is only like three plans that write a disability plan for Medicare disabled people. And those are -- those aren't in guaranteed issue, you have to qualify.

DR. LUBIN-JOHNSON: So this plan two mostly for disable --

MS. KIRBY: It's all disable.

DR. LUBIN-JOHNSON: Those on kidney dialysis?

MS. KIRBY: Those will be included. We have the hemodialyses, yes, that is a big part of our population, HIV AIDS, some diabetic, you know, heart disease. You know, those are the

kinds of -- those are the people that have been disabled for 24 months and get Medicare.

DR. LUBIN-JOHNSON: Thank you.

DR. KOEHLER: So the people in other plans that are nonmedicare plans, their prescription drugs are covered as part of the plan?

MS. KIRBY: Yes. We'll go over that real quick here. This is eligibility. I don't want to go through the whole thing. What CHIP has always been and this is kind of a key term as you're viewing the whole range of insurance, CHIP has always been the insurer of last result. It's

has been priced that way.

It has been set up not to be competitive with the insurance products in the market and as a result, we -- these people in section seven have to prove that they have -- they're uninsurable. Or they can qualify because they have -- they have a plan but it's more costly than CHIP, and we do let people in that circumstance. But generally speaking, they prove that they have a health condition in the traditional CHIP pool.

In the other pools this -- and

then there are people who have concern conditions we call presumptive conditions that mean they can get coverage without the declamation. So there is a list of our presumptive conditions there. The HIPAA-CHIP which is the pool that came about as result of the federal law, it is the industry supported pool. I would like to keep that tied together because we really have a lot of different purposes.

People that have been insured for 18 months or more, and they've most recently had group insurance under the federal law, are guaranteed access to individual coverage in each state. Illinois chose the CHIP pool to do it. Some states said market insurance industry you

have to have a plan that you take anybody into regardless of their health and that was when it was done through the volunteer market. Illinois used it's CHIP pool to provide that mechanism. You can't have access to any other group coverage, you have to let them exhaust continuation whether it state or Cobra and that's the eligibility on the HIPAA pool.

DR. KOEHLER: You have to exhaust your

Cobra before you can do that?

MS. KIRBY: Yes.

DR. KOEHLER: What if Cobra is second?

MS. KIRBY: Then you can come in under the pool that allows you access because you have a higher premium. But you do have the preexisting condition there, so it's a weighty decision. Most of the time I've seen a few Cobra premiums higher than ours not very many. Most of the time the Cobra premium is going to be lower, sometimes a little bit -- not very often have I seen it much higher.

DR. LUBIN-JOHNSON: I would say it's happened to patients, affected Cobra payment and what we heard of the testimony Cobras probably running half of what the CHIP premium is running.

MS. KIRBY: Yes, I think that's probably not -- yes, and what we see it ranges but you're right. The trade act Governor

Blagojevich signed legislation in 2003, that made CHIP a qualify state option plan. For people who are dislocated workers because of unfair trade practices or whatever tried practices.

People who lose their insurance

because they've been laid off because there plant moved to like the Gale -- in Galesburg Maytag was a recent big one -- moved to Mexico with that plant they had in Galesburg, that was a TAA certified event.

That means that the Federal Government is going to pay 65 percent of the premium for those people as long as they are in a, they're getting their unemployment compensation which can be a couple of years if they're in a training program. So that's where -- when we came in if there was no Cobra or the Cobra was more expensive than ours, they could use CHIP to gain that tax credit. But in Illinois that's the option, you have your Cobra or your CHIP premium, CHIP has the options to get the tax bill. It's worked really well. And that's what the puzzling part to us, we have only 391 people enrolled. And at the outside of that program, the Federal government identified 12,000 potential people because it includes the people that's getting a pension from the PVGC.

So with the United -- I think maybe with the United Pension Fund going into the

PVGC and as they're premiums go up on the retirement plan, I imagine we'll see some of that, I don't how we wouldn't. But it just depends on how long they can afford to get premium. And then this is the eligibility. It's much like the HIPAA in that it has -- you have to have had coverage at an employer. You can't have gone too long without coverage. But you do have to have a certification because it's the taxpayer program.

This has been a new thing for us that some I've talked to before may have seen or may not have seen. As a part of this trade act when they created a tax credit, the Federal government also established some grants to be used for high risk health pools, that's how it's defined under the federal law. They gave -- there were two or three ways you could collect money from the feds or operations. The first one was an emergency grant funding to get some start up money for your TAA pool which we did get some of that we got 127,000 plus on that.

The other grant was to fund losses. It was to coverage part of the losses

the pool experienced. In Illinois in the first year of the program that's the single largest grant of any state in the national at $8 million. What that meant was, we were able -- it was divided up so that some of it went to losses and some of it went to premium relief. But we were able to cut premiums in our -- everybody in our section 15 pool got a 6.1 percent reduction in premium in '05, that's going to be 7.18 in '06 calender year because of this federal grant.

And then that -- one other little grant we were able to get was to allow people to collect money so they didn't have to pay their first couple months up front on that. The tax credit mechanism actually takes a couple months to get going. We found some people were not able to get the coverage because they couldn't pay at a hundred percent for two months.

The Federal government applied for that grant and got a grant to fund that 65 percent until that whole mechanism got rolling. And then there is now before Congress a proposal to continue that granting process for several more years. And it seems to be moving

forward but it's not signed yet so we don't know

what's going to happen to that.

The next slides are about benefits, and I want go into a lot of detail. The plan -- the CHIP plan is a PPO plan. We have a plan administrator who we every five years we recontact with the plan administrator, the current one is the Blue Cross and Blue Shield so their PPO network is our PPO network.

In the choice of deductible, 500, 1000, 1525 and 5000. There is no deductible for prescription drugs. So we do cover prescription drugs we're always paying 80/20 on those. The out of pocket limit for our participants is they paid a deductible on everything but -- they pay their deductible and $1500 out of their pocket and they repay a hundred percent in the rest of the calender year.

I think if you look across industry terms the $1500 may be -- it's been there for awhile and it's a fairly good number. There is also an out of pocket limit on those prescription drugs and the lifetime maximum is a million dollar. The next -- I'm not going to go

through the next slides but it is for your information. This is real detailed attention given to exactly what we cover. And I thought you might want that just for future -- it's basically we pay everything but vision and dental

pretty much, transplants are included.

This slide just tells you -- as a result of this this usually happens -- you may come across someone in your own personal circle who needs CHIP. They always do provide kind of this is how you do it. If you need access to CHIP this is how you do it, you fill out an application, they are now available on line to print or you can complete them on line. You have to meet the criteria you don't back date coverage like an insurance company would. You can't bind coverage today and my underwriting happened and then the coverage go back to the binding page. So that's kind of -- I'd just like to give that to you so people kind of know where to again.

And then the next slide just gives you our information, go ahead. And you can read that but the CHIP web site is available and it has -- and you might as you're working through

this, you can go to the CHIP web site and you can plug in HIPAA plan five Chicago, age and hit the calculator and it will tell you the full range it's pretty -- it's interactive.

So as your studying your issues it's real issue -- it's real easy to do. It's much easier to do, and then one more. Here's our numbers. You can reach me at that told toll free

numbers and that's how you get in touch with us.

DR. LERNER: Ms. Kirby, this was excellent are there any questions?

MS. KIRBY: Any questions remaining?

DR. LERNER: Margaret.

MS. DAVIS: I was wondering after three years rejection drugs are not covered under medicare for transplant people, would they be eligible for CHIP?

MS. KIRBY: If it's not covered by Medicare, yes. I mean, they're probably -- if they're three years post transplant, the chances are they are not disabled anymore. In a lot of cases and they would be in the program that would have coverage for those, yes.

MS. DAVIS: : Okay.

DR. LERNER: Jim.

DR. DUFFETT: I don't have my calculator. Dave may have calculated this already but what is the administrative cost for this program?

MS. KIRBY: I don't know the percentage.

MR. WAGNER: If you look on the sheets I think the evidence up $6 million. And if you run that just against claims, claims are $145. So your running at far less than a six percent cost, that's enormously less than the industry standards.

And there is lot of talent on this

staff at CHIP that's an interesting phenomenon. The Board is public private combination, the attorney general is represent on the CHIP award. Legislative leaders are represented. The industry is represented, the disabled community his represented the insurance agency on and on and the staff.

She just mentioned this web site there, I mean, is just a lot of talent there, there IT guy has got everything up there on the web. It's very easy to use very interactive stuff runs through their system, it's just a very

efficient operation. And then the administrative who crossed and basically does the back office claim stuff. So this staff doesn't crunch all the claims and all of that, that's what you hire the --

DR. LUBIN-JOHNSON: Are they included in the total administrative --

MR. WAGNER: Yes.

DR. SMITHMIER: I have the same question. It's six percent on your income it's four percent of your claim is basically what it turns out the way it's being calculated.

MS. MITROFF: I was just reading a study recently more of an extract to me. Heavy duty financial stuff is a little bit beyond my kin but

they were talking about the administrative expense to Medicare and some of the observations in the studies were, when you look at the dollars those really do not represent the total dollars because what people are working for the Federal Government there is other resources that come into play.

So I think this is interesting to talk about this from the administrative numbers

but I would posit that they really don't represent the total administrative expense for the plan because there are other resources that come from the fact that this is a state program and all of those dollars are probably not allocated in those numbers.

DR. SMITHMIER: True or not?

MS. KIRBY: With the exception of payroll everything is done. I would say that's true from the perspective of payroll but everything else we have our own stuff. We have our own computer. We have our own staff. We don't -- we contract out on minor piece on we had a prescription drug consultation. We contract out for audit purposes but that's included in the numbers. So the only thing that we use and being advantage from being a state agency is we have payroll for 30 people.

DR. SMITHMIER: You mean the payment of payroll not the --

MS. KIRBY: Not the payroll itself, yes, I'm sorry. It's the actually processing of the payroll.

DR. LERNER: The point that Pam is making and just need to be put on the table is that when

we look at different programs that are funded in different ways to make sure that we're looking at true cost -- because any kind of contributions will skew one way or the other to cause to the program. It's no different than my comment about the premium issues.

MS. KIRBY: And if you wanted it calculated --

DR. LERNER: Average of earned premiums you got all kinds of other stuff in there far beyond just the utilization of the other services.

MS. KIRBY: One full-time person could do so if you wanted to back out or you wanted to add to it to try to kind of get a truer number of $25,000 to $30,000 --

DR. LERNER: So bottom line on that one regardless of how you do it, the administrative cost is really low and the premium cost are really high, you're looking at the population that you survey. I mean, so you have to really think about what it is that you're looking at

here. Any other comments or questions?

MS. DAKER: One comment and correct me if

I'm wrong here. The most important thing in this pool is the size of the discount that you guys are getting Blue Cross and Blue Shield as opposed to add men or anything else. Blue Cross Blue Shield is administering the products. The size of the discounts that these populations received is tremendous as opposed to may be another insurance company.

MS. KIRBY: Yes, we do get significant discounts and that's a part of the bidding process and we're about to enter into another one.

DR. LERNER: But on the other side of it, correct me if I'm wrong, people are involved in the Blue Cross PPO providers, doctors and hospital and clinicians and -- they're are going to get the PPO rates.

MS. KIRBY: Yes, they don't know whether they're with CHIP or another group.

DR. LERNER: Of course, the cost is being borne unduly by some of the providers in this sense because the way the premium is constructed. Anything else?

DR. BARBATO: All right. Just a couple of

definition questions again. The premium on which the CHIP premium are based an average of all insurers, all individually insurers in the state from uninsured.

MS. KIRBY: We do a survey twice a year and compare apples to apples, we don't look at group premium written. We look -- we do a policy survey, the number of policies -- individual policies written that are similar to CHIP. We have a couple of riders of individual coverage that aren't in the assessment pool or in that survey because they write a POS plan or HMO.

So we do look at -- we look at -- we look apples to apples. We look at what is in the private market that is similar to the coverage CHIP provides. And we look at what they are charging for premium. And then that premium is loaded based upon how much of the market each carrier has.

It's no secret to everybody that Blue Cross and Blue Shield of Illinois writes more individual coverage than any carrier. They have about 63 percent of the individual market. So their premiums are weighted, higher than less

say American Family Wisconsin has a lower number

of policies, and that's how we do it.

DR. BARBATO: And the last question, the multiple of that average has been the same for long period of time.

MS. KIRBY: Yes, the law says we can charge from 125 to 150 percent. We have to be at least 125 and not more than 150 percent of the market. That number has come from kind of a philosophic I don't know position the Board has held that it is expected to be a deficit operating pool.

And so right now premiums are covering about 60 and they go fluctuate. But at the end of last year, I think we were at 70 percent over the life of the pool, premiums had covered about 70 percent of the cost of operation, 60 to 70 percent it has gone up lately.

DR. LERNER: Any other questions, David.

DR. CARVALHO: Is the premium to the individual is it 143 percent of what the premiums to a similarly situated individual or is it averaged across the whole group. So if I'm 35

and I got metastatic cancer and my charge 143 percent of what the average person is 35 to metastatic cancer.

MS. KIRBY: Yes, it is age rated. Your getting passed my actuarial expertise but I

believe --

DR. BARBATO: I think he's asking a different question.

DR. CARVALHO: It's not severity rated.

MS. KIRBY: It's not severity rated. No, I'm sorry. It's age rated and that's where -- yes, but it's not severity rated.

DR. LERNER: It's very interesting that is you think other proxies might can use but that's good not. Ms. Kirby, you did a great job, thank you very much. It has given us a lot to think about which I think we ought to think about during a break. So I suggest that we get back together 12:00 o'clock Tee minus seven hours before the World Series comes on.

(Whereupon, a short break was taken.)

DR. LERNER: Okay. The meeting is back to order. And we have another set of press

relations, Mike.

DR. JONES: Well, first thank you, Jan, that was a very good and thorough presentation. Now, we will hear from Bob Wagner who will talk from the decision of insurance perspective, probably talk quite a bit more globally but he has a lot to tell us.

MR. WAGNER: Thank you, Mike. And can I

begin by offering Greg's apologies for not being at the meeting today he's with the NAIC which is the National Association of Insurance Commissioners. Where several state commissioners get together and try to iron out problems and insurance issues that occur across the state lines. And it is for that very important meeting that he's not here today. But he very much looks forward to his and this Task Force continue the efforts and look forward to providing whatever assistance that we can offer of individual insurance whenever and however needed.

DR. LERNER: Bob, can I ask you if you'd mind standing up because without microphones people are not --

MR. WAGNER: Sure, I'd be happy to. You

want me to be here in the middle. There are four different topics of -- the brief overview of the insurance marketplace here in Illinois. Talk about ERISA a little bit what that animal is what's kind of legal and also business and practical foundations are. A couple of Federal proposals that are out there right now one of which is called the Smart Act the other which is called AHP's or association of health plans.

And then finally to conclude with a description of both the history, and current activities of the state planning grant and as you

all know it was part of the funding or at least some of federal dollars have come in to support this group through that planning grant.

The Illinois insurance marketplace we had in 2000, 34 individual companies writing individual health insurance, in 2005 we have 42. On the small group side, we had 54 companies in 2001 and 51 companies now. Those numbers by the way on the small group side, probably on both are a little distorted because of how we count companies that they might, two or three companies type of thing. So the reality is probably closer

to 20 or 25 if you cut through all the holding company stuff and so forth.

And that -- when looked at compared to other states, Illinois is not in too bad a shape from a commercial insurance marketplace. That is a function of a lot of things, but it very much can be a function of the public policies adopted by the states. I can think of one state that adopted with a variety of public policies respecting health insurance that obviously seemed to be a good idea at the time and the result of which they have now one carrier writing health insurance in Illinois or in that state.

So in general we have a pretty

vibrant health insurance, commercial health insurance marketplace. These are 2003 numbers we ranked -- Illinois ranked 17 among the 50 states for person covered by employer coverage, that's about 59 percent. During 15 out of the 50 states with respect to individual coverage, that's about five percent of our marketplace. And, again, that's -- those are 2003 numbers. Some statistics on the reduction of employer sponsored

health plans by significant --

DR. SMITHMIER: This percentage is that the Illinois nonmedicare population or the total state population that you just described. You said 59 percent have employer based insurance. I assume it's 59 percent of the Illinois citizens after Medicare eligibles were taken out; do you know offhand?

MR. WAGNER: I think that that number is 59 percent of those that would otherwise -- that are employed.

MR. SMITHMIER: Okay. That would otherwise be a commercial marketplace.

MR. WAGNER: How many of those people are recovering.

DR. LERNER: Can you make your notes available to us so we can pass it out.

MR. WAGNER: Sure, I will do that. Again, just a few statistics on that employer sponsored

coverage. The -- that is dropping of course so that -- because I think everybody in this room knows, it's a general nationwide phenomenon of gradual and reduction in employee sponsored health plans.

Illinois is hanging in there pretty well. The national average on the individual for individuals losing employee sponsored coverage was 2.8 -- I'm sorry, that's the Illinois number of 2.8 and the loss nationally is like four percent, 4.1 actually. Percentage dropped for individuals gaining health insurance, gaining individual coverage was a .4 percent drop nationally -- gaining nationally the gain is two percent.

So I didn't say either one of those very well, the bottom line is that we are losing employee sponsored group plans more slowly than the national average and we are gaining in the individual market just a little bit more rapidly than nationally.

This is -- it's really important because as was raised earlier on the retiree side, the 55 to 64 percent, I was just at a reference last week it's a huge problem. But the employers employing continuing to offer retiree health in that 55 to 64 age band is dropping and

the number crunchers, the experts in these areas just see that as continuing.

So that's -- yes, that's basically where we are. It's a pretty -- it's a pretty sound -- it lead us to today commercial health insurance market in Illinois. And we hang in there pretty well if you add in everybody, the ERISA plans and so forth, we're right about dead center Illinois.

So that's the health insurance marketplace in general the -- another aspect of that of course is ERISA. ERISA stands for employee retirement income security act that was passed by Congress in 1974 and it was about pensions. That's what the law was mainly about because many in this room will recall a lot of problems, mismanagement and other problems in the pension, private pension system in the United States in the early mid 70s.

Actually in the late 60s it took Congress seven years, I didn't realize that. Doing more homework here they started working on that bill in 1967 and they finally got it passed in 1974. Obviously problems in the private pension system still exist today. It did have even though it's a pension and statute it also

covers welfare plans, or welfare benefit plans with is French for health insurance.

That's a bit remarkable because that's about the only spot where the United States where the Federal Government has much to do with insurance. And in general insurance is regulated at the state level, not even in general it is regulated at the state level. Except for ERISA which is regulated to the extent that it is by the United States Department of Labor.

There are both benefits and draw backs to ERISA plans. ERISA plans essentially are self-funded plans. It is used a lot and really is a substantial part of this -- especially employee sponsored health insurance arena. It is used by large employers a whole lot when they got the resources to do. Xerox caterpillar, IBM, they will basically sell funds, self-finance their own health insurance for their for employee.

Some are so large, that they don't even buy stop laws or reinsurance -- smaller plans and smaller by 200 employees, 500 employees, a thousand employees and some smaller

plans, they will almost always buy what's called

stop laws. That is to say they will fund the deal up to a certain level and then they're going to kick it to real insurance company to take care of the extraordinary losses on the flatten it out, a little bit of control for that risk, it can be a good plan. It can be a way for employers to save money.

So -- and there are some very good ERISA plans out there operating again at the company level and handled by TPAs or third-party administrators that kind of do the back office claims work. So it can be and is an important part of the marketplace.

As an insurance regulator, we worry about that quite a bit for a number of reasons. First is that because ERISA plans are regulated by the Federal GOVERNMENT, state laws are superceded or preempted in considerable terms to that extent. What that mean is we the state insurance regulators -- well, the first thing is that your benefit plan doesn't have to abide by all of the Illinois laws specifically the mandates.

All of the things that we in Illinois have determined through our elected representatives to be important to cover, well, you don't have to do that if you're an ERISA plan. That's of course one of the ways that

ERISA saves money is because the benefit plans can be different that way or more flexible.

We are -- pardon me. As insurance regulators less able to regulate the financial solvency of these plans. Indeed we can't really regulate them at all and that's one of the key things that as insurance regulators we do. Insurance companies are coming in here and the Met Life says tell you what, you pay me $1,000 today and I'll be there for you 30 years from now to pay this debt benefit. And it's our job to make sure they got enough money in the bank to actually that that's what insurance is about. We cannot do that with the ERISA plan. And we can't help people that's the other thing.

I'm sorry, the other thing that we do at the insurance division is our consumer people pick up the phone and answer thousands of calls a year trying to help people deal with

problems that they have with their insurance company. And people call us and they say okay I've got this problem, my insurance company isn't covered and after a few questions we pretty quickly learn that they're in a ERISA plan and we say nothing we can do, call the United States Department of Labor. That's a tough call to get through.

So it's another regulatory concern at least with the ERISA phenomenon. And it sounds like I'm beating up on them a bit as -- again, I have to say with my biases of insurance regulator. The other problem with ERISA plans is sometimes you get bad players doing it. And gives everybody a black eye. You know, they get into the deal, they collect a whole bunch of premiums and they head to Tijuana and it happens all the time. And there is very little that we as state insurance regulators can do it about it. So if you say ERISA to an insurance regulator, they get nervous and that's not entirely fair because again there are some good programs and it is at least a partial -- it is a player in the issues that are before this task force.

MS. MITROFF: That comment you just made anything more along the line that he was in that comment. I think ERISA plans a little bit of a different framework.

MR. WAGNER: That's a good point, ma'am, yes, your right. A good ERISA plan can work real well for individual companies. The instant you start aggregating risks, the moment you start pulling disparate companies together or whatever it is so that my business is insured, your business is insured and your business and self-worth, if you don't have the financial

solvency that's where you get into so-called meetings. Multiple employer welfare arrangements it's a federal statutory term, even those can be all right.

But if you're a bona fide A association and that sort of thing what you get though those is a fly by night guy that sets up the air breathing association, thousands, hundreds of dollars, millions of dollars are paid in to the guy sitting here with a desk and a phone and we just take it in and they're gone and it's a problem. But it also can be a solution if

done well. Anyway, that's ERISA in a nutshell.

DR. DUFFETT: A couple of questions. When you're talking about some of the bad players, I mean, do you have an idea of how many entities are self-insured. And of those entities what percentage a year you know do you see problems not only them going under because of maybe they don't have a stop gap insurance option and something happens and then they can't afford it or ones that are just leasing.

MR. WAGNER: Both good questions and in general the answer is no. We don't have good statistics on that. It's real hard -- it's real hard for the government to note things when it doesn't get stuffed filed or whatever because our

best sense is that upwards of 40 or 50 percent of the health insurance marketplace is occupied by this ERISA phenomenon.

Again, many of them do just fine and been doing just fine for ten or 20 years. The truly bad players are the exception of course rather than the rule. It's just that when they happen, it's an enormous problem. I mean, a family has gotten out lots of money out of their

wallets. When they're sick, they drum up two or $300,000 in health insurance. And what they think is health insurance and they're not, so it's a problem.

MR. ROBERTS: Jim, maybe I can comment on that being someone who deals with those plans on a regular basis. The plans that we service from the insurance side, we don't have a large number of problems. I would accolade your comments in that really it's the exception not the rule on the ERISA basis. And the majority of those plans are saving their consumers a considerable amount of money by going self insured.

MR. DUFFETT: Just as follow-up not -- I guess this would be a fair indicator but I suspect that you categorize the phone calls that you do get on your consumer help line. And I just wondered if there is a number out there or get us a number on all those people that call how

they're related to insurance and that percentage that is with self-insured.

Again, I don't think that is going to be a fair indicator but it would be just interesting. And the last point -- question I

want to raise and I can get some information to Ashley is that I know in California SP2 was legislation they had out there that succeeded in working around the ERISA issue in California. And was legal and even though through referendum it was overturned but I can get that information out to people.

MR. WAGNER: Great we can try to take a look at that complaint ratio. I don't know whether or not they keep it that way but I'll certainly take a look at it.

MS. MITROFF: Can I have one other comment on ERISA because I think you focus on financial language versus your bag. But for many of the employers that look at going with a plan let's say a ERISA plan than an insurance plan, one of the things that they accomplish and one of their main goals, is that they can continuity of coverage across the country.

So if you're an employer that's in multiple states and you want to provide one plan for your employees, the only way that you can

achieve that is to go with the self-funded plan, because otherwise you do run into the varying

state requirements whether they're mandates or other requirements.

So while it's usually financially motivated, it is also frequently because they want to have a continuity of coverage and have more control over the rules. And at the same time, it's not the wild west either because the feds do have significant rules regarding claims, payments, appeals, processes, filing of information, there is a lot of disclosure information, but it's just -- doesn't in a different venue.

And then you also sold yourself short in that when it comes to questions about plans that are not real plans like with me was -- many times the departments of insurance across the country including ours, has that -- once they uncover that information, they're participants in trying to make sure that those bad actors are out of the system. And so they actually are resourced frequently for the broker community, the insurance community and the consumer community to make sure that that information is out and available and someone calling in saying I

just heard about this great deal from Joe Schmo insurance, the department may indeed and have already know and say Joe Schmo insurance is not a qualified company.

DR. LERNER: Thank you, Pat.

MR. WAGNER: I'll go on to the federal proposals there's two. The big bigger of federal proposals out there with respect to health insurance, marketplace, regulations so forth in general. One of which is called the Smart Act. It stands for state modernization and regulatory transparency act.

MS. BRESLER: One more time.

MR. WAGNER: It is the state modernization and regulatory transparency. First thing to say is it's not even a bill yet. There is nothing that has been introduced in Congress at this point on it. In general, it is a very lengthy and complex piece of legislation or proposed legislation. 17 different titles covering a broad range of insurance regulatory issues, including producer licensing, producer it's our turn from agents, company licensing, commercial and personal rate supervision.

Reinsurance, surplus lines insurance on and on.

Lots of -- covers a very broad spectrum of the insurance regulatory arena.

In each case, it basically provides that states are to adopt a federal standard on how to do, how to regulate in those different areas. And if the state doesn't do that within a given time frame, then the Federal standard will preempt or take control of or just substitute for the individual state regulatory an legal requirements.

There are some as you might imagine -- this is -- there is a tension for your background between the idea of having a federal regulator and the idea of continuing to regulate the insurance industry at the state level. The insurance industry has been regulated at the state level since Ben Franklin cranked up his fire insurance company a long time ago.

And the essential rationale for that is that the kinds of insurance issues that occur in Illinois with respect to the flooding of the Mississippi or crux or insurance issues in Cook County are different from wind damage issues

in the state of Florida, earthquakes in the state of California, that sort of thing with the -- the insurance has a lot of local aspects and that's where it came out, that's where it came from.

In 2005, the insurance -- some in

the insurance industry are concerned that this state based regulatory system is nothing but -- it's just a pain in the neck and they are just trying to do the insurance business cheaply as they can so they can keep premiums down and not have to satisfy all the different state regulations along the way. The Europeans see our United State system of state base regulation as a trade barrier, plan and simple, it's just a plan in the neck. They can't do that -- so there is a lot of tension there.

I say that because I can articulate a few regulatory concerns of the state regulators across the country with respect to the Smart Act, among those are that it negatively impacts state regulatory authority to supervise all lines of insurance, that it creates some confusion, some regulatory confusion if we try to shutdown that that perpetrator of the me world,

whatever we take regulatory action that could be reviewed at the Federal level.

And finally, I guess just in some, a lot of the concerns that the Smart Act tends to or is trying to address the state regulators through the national associates of insurance commissioners are trying to get together and solve a lot of those problems to try to make the

industry more efficient, allow it to do business across state lines in a more sensible way, so that's the Smart Act as it's a bit --

DR. KOEHLER: It's being pushed by industry primarily?

MR. WAGNER: Some would suggest that.

DR. KOEHLER: And who is picking it up, I mean, where is the support.

MR. WAGNER: Representative Oxley. It says -- Bill, I think you've cited from Ohio he's the main player behind it. There is a lot of conversation about it but at this point there is no -- they're is no bill that's been introduced in Congress.

DR. BRESLER: If I may and I think some of the impetus for the Smart Act really came from

the life industry in their attempt to try and compete with banks now being able to sell insurance. And since the banks are otherwise federally regulated, I think the life insurance industry saw some impediments to getting their products to market and there was a real effort on their part to have uniformity on the federal level.

I think the health insurance industry is really if not split, is not so supportive of this federal initiative. We appreciate the ability to be regulated and have

relationships with our state representatives and state regulators and really kind of afraid of system of federal regulation. So there is a lot of discussion surrounding it.

DR. JONES: Did you mention there was some element of an opportunity for state action immunity within the provision. So if Illinois did something, they could avoid certain federal regulations.

MR. WAGNER: Yes, that's if -- right, Mike, if Illinois -- if the Illinois general assembly adopts the federal standard then you're

okay. It's basically a job. It's not usual, there's a number of other federal statutes in the banking arena in terms of handling check and so forth. What the Congress will say -- you can do it anyway you want but here is our standards and if you don't do it that way our standards apply.

Sometimes that's fine and it helps the banking system or it helps commerce. In other cases some would say, yes, but what you're doing is you're taking out some things that we care about a lot here in Illinois, some consumer protection and that's the tension.

DR. LERNER: Go ahead, please.

MR. WAGNER: Association health plan is the other one. The associated health plans

are -- it's a federal proposal. This is a bill to allow bona fide associations to essentially pool they're risk. Well, they can do it on a fully funded basis or self-funded basis. You have to have been an association in the past or real association rather than like the air breathers that I'm facetiously referring to.

In other words, rather than just creating an associates to create your insurance

project. The concerns -- I'm just going to skip a lot. The concerns with the AHP legislation of the federal level is not the similiar and the kinds of concerns that we've already talked about in the ERISA context and in the Smart context. And that is a concern about financial solvency. A concern about overriding state requirements, consumer protection requirements, benefits and that sort of thing.

Main thing is there is no guaranteed fun -- basically the insurance industry -- when insurance company fails, the insurance industry picks up the tab. So if your company goes down because it's been mismanaged or whatever and it's a commercial insurance company, rest of the industry get assessed and pays that and I get my claims pay, there is no such mechanism for these guys.

Now, there's is something in the

Federal law that purports to address that but there is just not enough money. So there is some similar regulatory concerns there. The advantage which kind of gets me to a point I skipped over a little bit, has to do with small groups.

And that's a big part I think of this Task Force's concern. Small groups are a problem because of the economics. If I got ten people in a small group and I charge each one of them $500 bucks a month $6,000 a year, that's $60,000 in premium I'm getting from that ten person's small Group. One person gets moderately sick. I'm not even talking about a transplant I'm talking about surgery, whatever, doctor you're going to run through that $60,000 in a big hurry, maybe too weeks.

So the economics it's just a troublesome group from a concept from a financial standpoint. So the idea then of taking this small group and this small group and this small group and aggregating them into larger groups is a pretty attractive intellectually and financially it makes some sense, that's what the HP legislation is trying to do. And indeed we're trying to look at some things here in Illinois but are along the same lines.

The problem is as soon as you get

people that aren't related to themselves,
insuring and I've got my small business and each

one of us has their small business and also all my guys are sick and so you're assessed, you're assessed, you're assessed. Ten of thousands of dollars to pick up because my guys got sick, all a sudden you say I don't want to do that.

And the next thing you know if your people are healthy and mine are not, well, you know what, then we got to raise premiums for whole association health plan and what are you going to do, it's called the desk spiral. But, you know, the healthy groups get out and you got the sick groups in there, that's the problem. So that -- I think at once the idea of aggregating the small group plans is attractive but it has to be done very quickly certainly from the financial --

DR. LERNER: I still say that the thing about what Bob's been presenting and we'll get copies of it, the take aways are still not so much the federalism issues, the Federal or state but the issues are -- the distributions of the cost for utilization and the distribution of who is going to support those costs.

And I don't want to go back to

history but whether they go back to community rating, community rate within groups, now that's really some of the issues that we're going to be dealing with here economics to economics. We know that there is going to be astute population. Now, the question is how do we help people get access to health insurance without killing the rest of the effort here.

MS. DAVIS: Two people at the hearing were in support of this model. It was a contractor at Rush who worked for three years. He had had a hernia prepare and because of his precondition, he was denied insurance and he was calling for an association --

DR. LERNER: No doubt in my mind. No doubt in my mind. I can understand that totally. I want to be able to cut this thing we got a couple other things to go onto. Are there any things other than your presentation you want to bring to our attention because if that's it we're going to get hard copies.

MR. WAGNER: Well, I was going to talk about state planning grant I can wait for another meeting if you want to.

DR. LERNER: If you can do it quickly.

MR. WAGNER: All right. I'll try to do that. The state planning grant began several years ago. It is a -- it's just what the name says. It is a Federal grant that funds state program to try to plan for, research, figure out what's going on in the health insurance marked place in Illinois and figure out ways to get -- develop plans, strategies, policy options not at all dissimilar from the kind of things this Task Force is working on. But not necessarily to set up particular -- but to develop policy options as opposed to getting plans on the street.

That planning grant I just want you to know, try to cut through it fast, has done a ton of research on the areas. We got three binders full of information. Mike and the Department of Public Health very activity early on. We crunch some numbers about who is uninsured who is not uninsured. What small employer -- why people -- is 50 buck enough? Would you pay $100 for health insurance, how much?

We went through a lot of that

stuff. We took a look at the name plan, we took a look at helping New York, we took a look at Connecticut reinsurance model so just kind of cut to that. There is just a lot of home that's been done that we look forward to it and when the Task

Force would like to see it.

A lot of information about the topic of the Task Force has worked on and is working on. The only other comment I can make is what it's doing right now. It's got three pilot projects going. One that's almost on the street, again, we're not supposed to do that. All the planning grant is supposed to do is plan stuff not actually get health insurance to somebody and indeed the federal law says you can't do that. All we can do is plan. But what we've done is to try to support local efforts at the local level and we have one almost on the street in the metro east area that's generated by the local community, local hospitals, doctors and insurance, small business and so forth and try to figure out how we can do this. It's a three share model that's being use into that, but it's kind of complicated and that depends on Federal

Government approving where the Medicaid dollars go. But there are some interesting things there again that we can share with you about another project just getting underway in the very various southern tip of the state involving three counties and another one in Fulton County but they're just getting going.

So those are two basic parts of

the planning grant. One a lot of research that we've done and continued to do. And the second is to actually try out some models and get them on the street and see how it works, so that information is available to you.

DR. LERNER: I really do appreciate that. Our idea is to make these representations regularly for the Task Force meetings not to become experts but to file it into a reference area and then come back to it later on as we start to get into the issues of models and criteria and cost and benefits. I really do appreciate you taking this time. Are there any questions?

DR. SMITHMIER: Just one comment. The last things you mentioned about Connecticut,

New York the homework they've done, that's valuable for to us here.

DR. LERNER: Absolutely.

DR. SMITHMIER: I vote we find the time to get you or whoever back and tell us all that. I think that's critical information.

DR. LERNER: That and then the points about the online community in light. We're providing a flavor of these things at these meetings but we're going to be providing substance either online or in hard copy to you. So that you have that and then of course the

agencies ICHIP and part business insurance and the others, this isn't the one shot with us they are accessible to us as we go forward for additional comments, questions and information. Other comments or questions? Thank you very much we appreciate it.

Let me go to the rest of the agenda VI Task Force Committee updates, we kind of done that with David. That was just to let you know that there's a vacancy new vacancies. That Robyn Gabel opening and the one that's still sitting with the speakers office -- the RP

update?

DR. CARVALHO: We need a few more approval from some other agencies within state government and comments. And we also put in our business days I think it's called CMS, so that should be -- that should be out very soon. Depending on other agencies. I don't like to give a date but it should be very good.

DR. LERNER: What will that do to our time frame?

DR. CARVALHO: Well, we're late from getting the -- we weren't in a position right yet to ask the research entry to research anything anyways so the -- still should be fine.

DR. LERNER: If we run out of time we'll

just put on the consultants back anyway so that will work out just fine. Any other questions on the RP other questions? Can I get a systems update, Mike.

DR. JONES: First I would like to offer the floor to Ashley. You have a couple things you want to say.

MS. WALTER: I actually just wanted to remind everyone about the special meetings that

are taking place on the 3rd and the 4th, those are sponsored by the health and disability advocates and Stephanie Altman is actually here today if you have any specific questions.

But I have included the agendas for those two programs as well as the meeting notice that has more of the who, what, when, where information. So if you're available and you haven't signed up yet, you do need to actually register for the meeting that is on the 3rd which is the Medicaid leadership group summit but there is still space available and Stephanie actually wants to --

MS. ALTMAN: I should just say if you could just E-mail us and let us know that you're coming just for lunch we -- you know, when you sit down and feed 200 people or 175. But thank you very much this is going to be a great combined third and fourth meeting. The only

other thing is on the third we also have some additional state and county speakers and Dr. Steve Saunders from the state. We'll talk about All Kids and in Cook County Wendy Mark and Dr. Daniel Winfield addressed the group on what's

going on with the county and their role in the uninsured and the Federal issues that are going to affect them so thank you so much.

DR. KOEHLER: What happened on the 4th then.

DR. CARVALHO: Actually, I was going to anticipate your question. The third of the program at the medical leadership group was already putting together and that's what he's indicating from and you're invited to come. And we noticed it up at the meeting so that there is no open meeting that issue about you want them to be able to talking about health care.

The fourth is the agenda that was specifically put together for us using as the raw material the experts that they were bringing into town anyway. So, again, it was an agenda put together based on the experts that were available not in this instance an attempt to do A to Z presentation on Medicaid and that one we are noticing up at the meeting of the Task Force as well.

DR. KOEHLER: Where is that at?

DR. CARVALHO: The tour?

DR. LERNER: The Civic Opera Building and that's sponsored by the Michael Reese Health Trust.

DR. ALTMAN: As is our summit.

DR. LERNER: As is your summit.

MS. DAVIS: Do you have your E-mail address?

DR. ALTMAN: Ashley sent out the RSUP but I can give you my card as well.

MS. WALTER: It's also in your folder for meeting notice for the November 3rd meeting, it's on the back side.

DR. ALTMAN: And don't worry about filling out the card, if you just E-mail me your name, I'll get all your other information make sure -- they're is no cost for the program, thank you.

DR. LERNER: Okay. So Ashley --

MS. WALTER: That's all I had to say.

DR. LERNER: We're really thrilled with the health trust has allowed this to take place, it's a remarkable asset resource and clearly to the extent the community organizations or other businesses and other organizations are able to help us get smarter about this it's really great.

So I encourage you to attend as much as you can, Mike.

DR. JONES: I would like to mention the state coverage initiatives project that we are trying to schedule a special day of learning for everybody is -- are negotiations with them are moving forward. We will be talking about this in the Steering Committee meeting but we need to make some decisions on venue and some scheduling decisions and, but I just wanted to remind you that will be coming up. I believe Debra Shaley will be coming to talk to us. And I believe Alan Well will be back in town and he'll talk to us at that event also trying so we're trying to lineup a good group of speakers. If you don't --

DR. LUBIN-JOHNSON: This is for what event?

DR. JONES: The state coverage initiatives project in Washington has agreed to bring in some speakers and pay they're travel and lodging expenses, who have certain expertise related to the work we have to do. And we've been negotiating with them to schedule that event so --

DR. LUBIN-JOHNSON: Is this going to be

something different from the past summit that was proposed before.

DR. JONES: This is precisely the Health Summit. We're just not -- we're not going to call it a summit anymore.

DR. LERNER: We're looking at dates now. The Steering Committee will be reviewing that because the SCIs asked for some potential change and dates.

DR. KOEHLER: So it's not on the 18th?

MS. WALTER: We're not sure yet it will be discussed with the Steering Committee.

DR. JONES: And if I could -- in the interest of time I'll jump right ahead to the next agenda item. The web site as you know is up it was launched on October 13th as a link to the Governor's home page. You can find it on our home page, the agency's home page or you can go directly to this site and look at it and encourage it and I'll pass the torch back to you.

DR. LERNER: Any questions about agenda items eight, nine or ten?

DR. LUBIN-JOHNSON: Let me ask for

clarity. So I understand that the Steering Committee will decide about the date and inform us today?

DR. LERNER: Yes.

DR. LUBIN-JOHNSON: And then that will be

E-mailed to us?

DR. LERNER: Today.

DR. LUBIN-JOHNSON: Okay. Thank you.

MS. WALTER: We haven't gone over number ten yet.

DR. LERNER: Sorry.

MS. WALTER: That's okay. I just wanted to give everyone a quick update. We ran into a couple of snags with creating your accounts for the online community but we have that straightened out now. And I have been keeping tabs of all the articles and other documents that have been sent to me. So I have those -- I've started to organize those and those should be up rather soon.

As soon as your accounts are created, I'll be sending you each an E-mail with your log in information and telling you how to access the site and we'll just keep moving

forward and adding articles and I'll be sending weekly or biweekly summaries to remind you to go check it out to let you know what's been posted and to also provide you with an abstract or summary of what has been posted.

DR. LERNER: Thank you very much.

MS. WALTER: No problem.

DR. LERNER: Keep going, Ashley.

MS. WALTER: Travel voucher. At the last meeting you all received a guidance on how to complete the travel voucher. But it had been requested that you all receive a hypothetical completed travel voucher, so there is now an example for you in your folders.

So hopefully this will help. And then on the reverse side there is actually even a more detailed version and this is just to show you what Tracy and Steve did in our Springfield office kind of go through and do. So if you feel able you can go ahead and do the comments and line up the line items on your entry with the comments from the box.

But if you don't feel that you can do that at this point, send it down and Tracy and

Steve will be in touch with you to make sure that they get everything straightened out. Just a couple of items and I'll go ahead and send this to everyone as well. Please use your home address where -- in box number two where it says traveler's name and address.

And as well you should be using your residence as your headquarters which is I believe box six. You have to submit receipts for any item that's more than ten dollars. Make sure that you keep a copy of that receipt so send in your original but keep photocopies for yourself.

Hotel receipts must show zero balance. So sometimes if you just have expressed checkout, it still shows that you have a balance left to pay at the hotel. You need to actually make sure you go through the whole checkout process and get that zeroed out bill.

The other thing is that staff will work out the perdiems, it kind of tricky and so Steve and Tracy just ask that although you have the guidance to do that that they'll just calculate that for you.

Other than that it's pretty

straight forward. If there is something that you know looks weird on your travel voucher just explain it. So for instance if you traveled from your home site to a meeting and then went somewhere else and you're expensing that to someone else so it looks like you only made a one way trip, explain that because otherwise Steve and Tracy will try to follow-up with you and want to know how you got home.

DR. LERNER: There's some things you shouldn't talk about.

MS. WALTER: So other than that that pretty much covers it but I'll be sure to send out these highlights to everyone as well.

DR. LERNER: On behalf of Ashley, I just

want to remain you to turn in your time sheets.

MS. WALTER: Yes, please.

DR. LERNER: We have -- you are obviously within the regulation of the state and certain things we have to abide by. Ashley, are there any other issues like this we ought to bring before the group --

MS. WALTER: Just make sure you signed in today other than that I think we're okay.

DR. DUFFETT: Do you know what -- any idea when the testimony will be up on --

DR. LERNER: Jim, I can't hear you.

DR. DUFFETT: The testimony that -- for each of the hearings when it's going to be up --

MS. WALTER: I believe we get the transcripts ten business days after the hearing.

DR. DUFFETT: Okay.

MS. WALTER: Other than that, it goes to our RT department and since we really haven't had to do it yet, I don't know what the process is and what the time takes there. Because they do have to turn it into a PDF and then figure out how to post it.

There are also some issues that they're trying to work out about who owns the transcript, if it's Eastwood-Stein, the transcribing company or if it us. Whether will we do -- read only on the web site, will people

be able to save and print or what kind of rights we have with that. So as soon as that's figured out, it will be up.

DR. LERNER: In terms of other business there too that I know that have been brought to

my attention, I would like to raise them at this time. Ken Smithmeir called me or E-mailed me and said that the All Kids program that's been announced by the Governor, what's it about, how does it affect the work that we're doing, et cetera, et cetera, et cetera.

And I've asked David if he could do some background for us on that and then Jim Duffett had a couple of issues that he wanted to raise with regard to public hearings and some other administrative details and some other issues we'll leave some time for it.

I had hoped to get out of here by one but I think we're going to be real close to today. So -- I know that we're supposed to go to 1:30 but I want to be respectful of your time.

MR. WAGNER: Thank you. As many of you have -- if any of you have read the newspaper or watched TV or been on the street you know that the Governor has proposed a program called All Kids which essentially wraps around all the programs that the state currently has and fills

all the gaps for people who are not eligible for those programs, providing an opportunity to sign

up for a program to provide health insurance for children.

As you probably know, over the last several years the State has provided Medicaid and added kids care. On top of that expanded the ranks of -- for kid care. It's also ICHIP, there are some children in ICHIP. And so they're substantial number of children who one way or another are covered and of course people that are covered currently through their families.

But there is approximately 250,000 or so children in Illinois currently who are not covered, some of those are children who are eligible for existing program and not enrolled and some of them are not eligible for existing programs or whose families have not having been to them to private insurance. And so All Kids would provide -- I'm skipping through these slides they were prepared by they Governor's office, they provide a template. All Kids provides a sort of fill in the gap. The percentage of uninsured children around the state varies, is seen on this slide and you can skip

that slide. Most of these are slides about why is good to have kids have insurance.

But what I wanted to do is go to the slide with the schedule, that one -- yes. The program would provide for a premium based insurance availability to people whose family income is over $40,000. $40,000 is roughly 200 percent of poverty and Kid Care currently covers people under 40 percent of the poverty.

The premium would be sliding key scale but it would be eligible for folks in all the income categories of over $40,000. Applications would be made in a number of ways which are on the next slide. The legislator is considering this now, there are issues about the specifics. There are issues about the funding. The funding has been designated to come from savings from people of case management, existing Medicaid program they're is lot of questions about that.

But the specific thing that I heard asked and want to address was, you know how does this impact the work and the Tasks Force. And from the tasks force of courses perspective

if you at the range of what is out there to be

addressed with is all the people who are uninsured. Or do not have access to adequate HEALTH care. Now, while the All Kids initiative is terrific and will extend coverage to all children, it is the smallest slightest of the uninsured and the cheapest to cover slice of the uninsured.

So if anyone on the Task Force who was worried that this took a substantial chunk out of what you had to do, it is does not, it takes the smallest number in terms of the demographic slice and the cheapest number. Leaving you a financial number of uninsured to be concerned about and substantial cost for doing it.

The All Kids proposal is -- the timeline is going to be any necessary authorizing to be considered in the veto session which is basically over the next couple of weeks. So the Task Force will know the fate of that legislation by the time of it's next meeting. Then the process of implementation but that's a process involving the Department of Health and health

care and family services. And in fact at our next meeting we are hoping to have a presentation similar to the presentation we received today from ICHIP insurance on the Medicaid program generally both the chair and various members have

alluded to the fact that the Medicaid as it currently exist is an important thing for you all to be familiar with as you do the work of Task Force.

And so what we are hoping is the HFS representatives will be available for that meeting to talk with you both about Medicaid generally and the outfit the program. As can you imagine they are quite busy today and that's why they were not able to make their presentation today, they are down in Springfield.

DR. LERNER: Any question about the outfit program?

DR. SMITHMIER: Well, nobody can oppose the goal. I don't oppose the goal obviously or I wouldn't spend the time I'm spending here but I'm hundred percent opposed to the method that this proposal represents. Which to me is a continuation of historical piecemeal approach to

the issues of the uninsured. And so if -- and this is what I said to Wayne, if this is that -- if this is what the Governor and perhaps the legislator thinks is the right approach, then I would just prefer that they de authorize this committee, save a million bucks and save everybody our time. And just continue, you know, dealing with the next piece that they fine.

Because if they do fine 45 or $50 million in savings and then a year from now we finish our work, what if we find a really good and what we think is a broader based use for 45 or $50 million bucks, well, it's gone.

And it's gone to this program just like any other pot of money will be gone to some other program. You know when I agreed to serve in this group, one of the pledges, maybe the main pledge I made to myself, is that I would keep my mind ideologically open to any set of solutions that we might come up with that will address this issue for everybody in the state.

And I hope that the group would take that approach. And I think you can only do that, you can only come to a reasonable set of

solutions. If you spend the time that today represented for us and listening to different kinds of people talk about things that exist that maybe didn't know about or didn't understand or perhaps things -- people are thinking about making exist that you described about in your conversation.

And then you can come up with, Wayne, what I think you have alluded to what are the salient pieces of the comprehensive plan that might benefit everyone. And frankly, I think this proposal flies in the face of it. And so I

will tell you I think I said this to Wayne as well, I am already publicly opposing this, I've done it with the editorial board of our newspaper and I will continue to. I just think it flies right in the face of the concept and I believed the philosophy under which this Task was created.

DR. LERNER: Thanks, Ken, any other comments?

DR. LUBIN-JOHNSON: I think I take a different somewhat ideological approach to you and I appreciate your comments and your concerns. I guess I take the approach that he is the

Governor that's the legislator and it's -- and we have to -- and whatever happens happens.

And we have to create a plan out of whatever remains of the uninsured population in Illinois. And if it's that problematic for you to express your views about it to this point, then perhaps you have to consider is it worthwhile being here or not and that's the choice you have to make for you.

I think that we're on this tasks force to try to help all of us to come up with a with solution for all of the uninsured in Illinois, no matter what. No matter if it floats no matter if it doesn't float and I think that's what our purpose is. It was created out of, you

know, legislator from the legislator. And we were appointed by those entities to do the work for the state that's in that field.

And it very well may be up and running because we're done with our work because my understanding the intent is that this be up and running July 1st of next year.

DR. SMITHMIER: I don't think that my serving on this and this group and opposing that

are philosophical, opposites for the reasons I stated. So I think I can still serve constructive role on this committee. But still critically analyze and evaluate political proposals like this one and see in my mind whether or not they fit with the original intent of the legislation behind this in my opinion they don't.

DR. LUBIN-JOHNSON: And you're right you can and I'm not saying that you shouldn't and you don't have anything to contribute. I'm here because I got appointed by someone to do the job to help uninsured in Illinois not to debate what may or may not be a political issue.

DR. LERNER: Well, the bottom line of this -- excuse me. The bottom line on this one and I appreciate both of your perspectives, is that when push comes to shove, we look at the cost of covering one and seven people are clearly

uninsured and pick up the pieces of the other one and seven who are on Medicaid one way or the other. And look -- and at trying to buy continuous coverage and access and to continuous care.

Any fragmented effort that rips resources out of the system is number one going to be problematic and number two a roll down hill typically to people who are already picking up a lot of those resources right now are either doctors and hospitals and insurance companies, employer and business, et cetera. So many of us were disconcerted when this was announced at the very least. The very least somebody should have called us up from the Governor's office and said by the way this is coming and you shouldn't even be surprised by it.

So separate apart where we -- either of us feel it's political issue or it's not, we could debate that, not long but we could. The issue is how does that impact the work that we're doing is a critical issue. And I think what we have to do now is keep our eyes on this one when that forum to set up -- take an opinion on this one, do we have to respond to it. But when we're done and we're doing the modeling of the consulting firm and we're looking at a gap

which damn well well exist between what it's going to cost to care for these people and what

it's going to take in order to pay for it. Then we may have to go back to the Governor and say it it's times to have a little session with us.

Because I have to tell you something in another state where I worked we did that. And the difference in the approach was the Governor put together a Task Force just like this but the Governor is ruling to bring his state to objectives and sit with us and walk through the issues and talk through both political agendas both economic -- and I'm just hoping that the current administration --

DR. LUBIN-JOHNSON: And what state was that --

DR. LERNER: Missouri.

DR. LUBIN-JOHNSON: And when?

DR. LERNER: About ten years ago.

DR. KOEHLER: I just want to -- just a comment. I hope we don't think that there are certain things off limits. I guess going back to David's comment. I mean, I guess I have the expectation at least the hope that we can look at comprehensive health care and that we're not just dealing with kind of little pieces. I mean, are

we piecemealing this thing ourselves. Is there anything that's not on the table. I mean, is there that something more restricted from talking about or doing?

DR. LERNER: We can talk about things but --

DR. CARVALHO: I guess I am a little puzzled by viewing this as piecemeal because right now if this hadn't happen, we would right now have a dedicated program and an ICHIP program and a several other programs to deal with pieces. And if came up with a comprehensive plan, it would in all likelihood impact all of those things and include recommendations. You wouldn't take all those as fixed in stone and your just doing everything else. So now there is one more piece which will be if it's passed to All Kids and you will have precisely the same issue --

DR. KOEHLER: And because of that comment that's exactly where I would hope we were going. I don't -- I mean, let's understand the political season we're in. I don't think it changes our scope or our work one way or another.

DR. LERNER: Catherine.

DR. BRESLER: To the points that I have

been hearing. I think it's going to be very important going back to what Pam mentioned before there are a number of state programs. We're already in -- not that we got them identified right here in front of us now. But I think it will be important in continuing this work that we do identify all those programs and look at the gaps.

David spoke about the All Kids program and that there are many of these uninsured children now who are eligible for that program who are not involved. And so maximize the, you know, the available system and maybe part of your effort is to bring those more to the public's attention.

And I think it can be a comprehensive -- I appreciate Ken's comment and it would have been nice to know that this was in the hopper so to speak. But the fact is it's here as are remember of other programs and I think it's just going to be important for us to get the statistics and get the information out there. And that I really anticipate that that is

going to be part of the solution their existing programs.

MS. ROTHSTEIN: Yes, I think that as well. And I understand where Ken is coming from. True, I think this is another piece. I think the more

troublesome part of this thing was that you have set up a Task Force legislatively and then you have a responsibility and Government has a responsibility to the task force. Task force has a responsibility to the Governor and the legislator.

And I think to get up in the morning and see this in the newspapers and not to even understand it. And David even with your presentation, nobody really understands it. We just say oh goody. I love David but --

DR. CARVALHO: I can do the half hour presentation.

MS. ROTHSTEIN: I think the fact is that the Governor and legislator and the Governor specifically need to understand that there is a task force, he has a responsibility for it.

DR. LERNER: Any other comment on this? The sum of all of these conversations is that

this program like any other program that would be brought forth during our deliberations will be put on the table. We'll put all the pieces together and hopefully the way we put the puzzle together will present a prettier picture than the current picture that exist within the state of Illinois politics recognized and politics aside.

Jim, you had some issues you

wanted to raise. You just want to alert the task force quickly.

DR. DUFFETT: Well, actually I would say yesterday was great at the senate public hearing that this issue was raised and the context of Ken's comments and some of your comments to Catherine. And I think it goes to the larger issue of how far do we publicize this process that we're participating in and committing a lot of time to.

I definitely want to really commend all the hard work that Public Health are doing. The issue I want to raise is the timing of these public hearings and the concern that I know is definitely growing with barely a week notice when these public hearings are happening

or even less than a week's notice when the next hearing maybe next Wednesday is going to be.

And unfortunately we don't have a budget to deal with media and of ways of trying to get the word out there. And I guess the fear that I have is as we're constantly trying to figure out where can we find a venue to have this at and just to process it, it takes to confirm a location or have a location to be concerned and to be cancelled on and to find something else is that we definitely don't want this process to be look as nonpublic.

And that there wasn't enough effort to get the word out to the public when these hearings are going to take place. So I guess our concern or my concern is that I would hate to have a public hearing with at least 30 days notice to the locations of where -- and maybe it could be different. I'm just throwing up 30 days notice that we have a location where it's happening. If we have to change a location from Oak Park to another location we have, you know, at least 30-days notice to let people know that that venue has been changed.

And I don't know because there's a million and one things the staff at public health are trying to do and they're doing it very well in getting the web site and all the stuff going up is -- what kind of creativity can we all do and even the different departments can do to try to get the word out that is hearing is coming up. And so I guess I throw that issue on the table and also really throw out on the table I really feel the hearings next week should be unfortunately postponed because it just is not enough time to be able to get the word out there.

I understand we're under a timeline crunch on this and I surely don't want to say that we move those hearings to May we can

move them maybe into further months down the road. But even down in May and I don't want to discredit what that testimony that we would hear at LaGrange and Homewood would be.

I have a feeling by the time we reach those hearings, we're probably going to be still hearing about 90 percent of the same issues. And so I don't think it's going to have a major impact on something new that's going to

hit us. So I just kind of want to stop there and hear other people's feeling about that.

DR. LERNER: Jim is -- sent us an E-mail about the Steering Committee and it was my expectation that as soon as adjourn this meeting the Steering Committee goes back into operation. Margaret.

MS. DAVIS: The only thing I would like to support Mr. Duffett's comments because I know in Homewood they are moving -- the south land is moving into regional planning. And they are having they're summit on November -- I mean, October 31st on November 1st. To talk about how do they want to see their Health care system in the south suburban area, and that information could be forthcoming to us.

But the biggest thing is we have a very extensive Cook County Department of Public Health System and they want to mobilize their

clients and I have not been able to tell them where in Homewood we're going to have it. And so they can't do the mobilization tragedy by next week in order to get their clients who are very much wanting to testify.

DR. LERNER: David.

DR. CARVALHO: Ask any of you. What is the down side of postponing it. Are there other groups that are ready to go that would maybe and --

MR. DUFFETT: I don't think anyone knows about it.

DR. CARVALHO: Is there any down side, Ashley.

MS. WALTER: You find a couple of contracts for venues. This is all a legal process and so that's part of what takes so long. All of these venues have causes to indemnify themselves and so that the state does not hold them harmless. And so we have contracts going back and forth between their legal department and our legal department. And so we do have contract outstanding so likely we would still have to pay for the venues if we didn't postpone.

DR. LERNER: Did you have -- Mike, did you have a comment.

DR. JONES: No.

DR. LERNER: The hearing committee and then the Task Force ask us to do is to set in

stone dates for hearing so that information would be disseminated to people that there would be a hearing and that the venue might be changed and in fact the venues have changed in some instances so I guess I'm puzzled a little.

This is a testimony gathering process. I know that there is other ways that this process can be and is being used by others and that is great. But this is principally a testimony gathering process. And if you bring 600 people to a meeting or 75 people to a meeting, we only have the time to hear testimony from 60.

And so -- and we've almost fully occupied -- we did fully occupy the time at first hearing. And almost fully occupied the time at the second hearing. The third hearing somewhat less. But at the end of the day, you are only going to be able to take worldly testimony from perhaps a thousand people over the course of all these hearings. And I guess only isn't the right word to use. But it's not the only mechanism for taking testimony from people. We are also talking testimony by E-mail, we're taking

testimony in written form and so -- Dr. Lerner said we can talk more about the logistics and what thresholds you would like us to use.

But I need to remind you we're operating at your direction and no individual on this Task Force can call us and tell us to move a meeting only the Steering Committee can tell us to change a date. You gave us the authority to move a venue and in one instance is we exercised it. But I'm sorry we couldn't respond to request to move hearing dates because that's not a staff function, Dr. Lubin-Johnson.

DR. LUBIN-JOHNSON: I guess when I gave that when I voted, you know, that this was a process that we would use, I did not think that we were going to get to me not going whether the hearing for seventh congressional district was going to be exact location or week before.

I honestly thought that we have the dates and, you know, the locations will roll off pretty quickly. But I think the point that you raised as a speech then why it needs to be a 30-day window. If the time is being taken up with contracts having to go back and forth and

against other bureaucratic maneuvers that we

don't -- we didn't know about when we said okay to doing it this way.

I think we were operating in the dark to some extent about what the process was really going to entail. You know I called her weekly about location of those areas that I'm interested in going to that are part of my community. And you know and don't know and find out part of the process of notification either goes to IDPH's press person. Well, you know, in my community the drum beats come from a couple of places. One, the church and two locally publicized newspapers.

And both of those go to print on Wednesday for Thursday distribution or Sunday distribution. So if this -- if the second congressional district hearing goes on as planned next week as is right now, that is the last hearing where that will be located in a predominantly African-American district in this state. And I would say that in terms of getting significant numbers there, they're going to be SOL for lack after better description.

And that's going to be very unfortunate because the first one, you know, short timely noted, last week a change in venue and I'm sure people were upset on the west side of Chicago and the western suburbs that have

large African-American population about not being able to participate because of transportation issues.

So I would hope that the Steering Committee would look at this seriously and look at what now that we now a bit more about what the process entails, you know that we can move on -- moved forward from that. And I would say I can look at other venues in the second district if we lose that one next week or maybe it's not going to be an issue next week.

DR. CARVALHO: I'm don't mean to be feisty. But if everybody knows that it's not a given Wednesday subject to it's location, you've dedicated that Wednesday and whether you go on the blue line going outbound or going inbound it's right on public transportation. So I don't understand what the -- you know, other than maybe 400 people, nobody is going to be able to walk to

these things everybody is going to have to get on the El or drive. And if they drive two miles that way they can drive two miles that way. If they can take the El two miles that way, they can take the El two miles this way.

Someone even suggested that we had moved it from Oak Park to County Hospital because we were trying to due favors for the Cook County

Bureau of Health Services officials. I wish people would stop putting so much into this. It was simply a question that somebody had given us the Oak Park Village Hall's location, it turns out Oak Park didn't rent out their village hall. So we looked for a venue in the middle of the district and I know people I can call at County on a moments notice and ask for a very big room and made it available to us.

DR. LERNER: Joe.

DR. ROBERTS: I just want to count it from a Steering Committee perspective. In our first meeting as a full group we were pushed very hard to move that timeline up. To make it happen to make all these hearings happen as quickly as possible. And as a Steering Committee, we had a

great amount of debate about -- of the amount of time that we needed to allow to get these hearings on board.

We decided that as a Steering Committee, that we would then take that recommendation based upon the input that we got -- I got 50 letters from a variety of different groups state asking me to step the timeline up.

I was the one wanting to hold that back. Well, we're stuck. I think at this point you've identified what we wanted to do as a group

and as a Steering Committee that that's the calender that we have to give the staff the ability to work with and I agree. I think that opportunities are set and we need to go from there.

DR. LERNER: Tony.

DR. BARBATO: Certainly don't want to make this unduly complicated. I do want to add one other dimension to this question from my perspective. Not understanding all of the political issues that need to be addressed, I do understand that this is a public process and the

public hearings are a necessary piece of this project.

Unless clear about what it is that as a task force, the relationship of what comes out of these public hearings to the work product of this group is going to be, and that bears on the question of appropriate timeliness of the public hearings. And if any of us here in course of the public hearings, things that surprise us about the inadequacies of the health system that's currently in place relationship of Medicaid to the uninsured, I'll find that shocking.

The bigger question for me is what's the public airing or public hearing

process to whatever it is that this task force decides to recommend. And what are the opportunities for the public to weigh in on that issue. Getting a list of testimonials about what's broken, what doesn't work, what's in effective, what's not good use of resources, that list of -- that list of sins has been put together over and over and over again.

The question for me is does

that -- does this process of public hearings have any role to pay in what the work product of this -- is it going to add to what the work product of this Task Force is, thank you.

DR. LERNER: Thank you, Tony. Jim.

DR. DUFFETT: I think I like your point. I think that's a really valid point and I think there's also -- as we discussed the September 14th meeting about the idea of the hearing whether it's an hour of public testimony. An hour of more targeted testimony, because I think it also would really be very helpful for whoever is out there to be giving more concrete testimony.

I think we talked maybe going to five minutes or ten minutes with a handful of people to educate the public too about many of these different issues that we're talking. So it isn't just a gripe session that this ends up

happening. And although I think we're all learning more, that there's a little more substance there and I know that that had been a couple different levels of discussions here.

Let me be really clear it isn't

about having us bring 400 people or 600 people to this thing, you know. If 50 people show up or 25 people show up, I think the real issue is having people have enough time to really know that there is a hearing in the location of that hearing.

I apologize, however, it is framed about making it convenient for folks at Cook County, that was my, that was my thing that I stated, so I'll put that on the record there. It was no disrespect at all to the Cook County people at all. But there were 20 to 30 people in Oak Park that were planning on coming and for whatever reason, they decided that they weren't going to jump on whatever their mass transportation is to drive into it.

And I guess all I'm saying is that, you know, right we got all those states and I'm solid. And I hope the staff person if there is a staff person the Public Health has hired to line this out because I can only imagine the craziness that Ashley and you guys are going through to do it.

I'll give up my perdiem on my travel thing today to pay for whatever the fee is

to be able to do that if we can get into that. I really do think that it is important for two things. One is to give the public enough notice when a public hearing is happen because I want the chamber there. I want the insurance.

Quentin, you talked about getting other people to be able to be at that table to be able to testify. And I think as you mentioned doctor too, I would like to see not just people complaining but I would like to see you guys come to some of those hearings. That I know, it would take away from your meeting to be able to talk a little more about CHIP and whether it's a ten minute thing so that there is also an educational process that we can provide as much as we can to the public.

DR. LERNER: All right. I want to close --

DR. LUBIN-JOHNSON: Can I make one other comment.

DR. LERNER: I really want to close this off.

DR. LUBIN-JOHNSON: It's not about people coming and giving testimony about the hearings,

it is also about letting them know that this process is going on and it exist. People do not know. I can't tell you how many people I encounter every day who do not know. And getting more time to get the hearings publicized, allowing the public to know that we exist, this legislation exist, this task force exist and the hearing exist.

DR. LERNER: That gives me, and I don't mean to be snide about this, but who was at the Governor's presentation yesterday --

MS. DAKER: I was.

DR. DUFFETT: I was at the --

DR. LERNER: I just want to know something. When he was talking about All Kids, did he mention the Adequate Health Care task force.

DR. DUFFETT: Unfortunately not and we --

DR. LERNER: Okay. That's all. Thank you. Thank you. Are there any other issues before the Task Force?

MS. MITROFF: Can I just -- it's not about the timing because I think some of that stuff is

going to take care of itself. But one thing that

was mentioned -- when people are testifying, if there is anyway, especially when we get close to that magic 60 number in some venues which I suspect will happen, if we can somehow screen to make sure that we're hearing from people who are in that district.

DR. LERNER: Right. And perhaps who haven't testified before so you're getting new voices in here.

MS. MITROFF: Because I'm concerned that in some areas in particular, there may be specific regional issues that could get lost if we don't have some method to try to make sure --

MS. DAVIS: And one -- to support what Pamela is saying is that, we've got a Tinley Park Mental Health System that's getting ready to be dismantled in the south suburban area. Mentally ill people are just running from place to place and that's a big issue there.

DR. LERNER: I agree. And I'm very concerned that the same people or the same groups who have testified at multiple hearings will lose the opportunity to hear voices. Okay. Everybody

take a deep breath.

DR. BOYD: I just want to say I agree with Pam but I think that's also why we need public notice out ahead of time, so we don't get the same can response or -- earlier when he came into

the meeting he heard the same people giving the same -- they all entered their response on the same thing.

That's not a public hearing. You want to hear from everybody just different public, it's get the notice out to the general public so we hear from the general public. Not the can group that's going to come in and bus 50 or 60 people but the general public and that's what we should do.

DR. LERNER: Okay. Everybody take a deep breath keep our eyes on the mention which is every document that Ashley sends us. I want you to put it underneath your pillows and remember that in just a few hours we hope to have a real big winner. Can I have a motion for adjournment.

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

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_____2005.

_____

Notary Public