STATE OF ILLINOIS

ADEQUATE HEALTH CARE TASK FORCE

HELD SEPTEMBER 26, 2006

9:30 A.M.

160 NORTH LASALLE STREET

CHICAGO, ILLINOIS

Reported by: Tonja R. Bowman, C.S.R.

and

Donna T. Wadlington, C.S.R.

ADEQUATE TASK FORCE MEMBERS:

DR. WAYNE LERNER - CHAIR
DAVE KOEHLER - CO-CHAIR
DR. NIVA LUBIN-JOHNSON
KEN SMITHMIER
KEN ROBBINS
KEN DUFFETT
SEN. DONNE TROTTER
J. TERRY DOOLING
COLLEEN KANNADAY
PAMELA MITROFF
MIKE MURPHY
JOE ROBERTS
MARGARET DAVIS
DR. ANTHONY BARBATO
DR. QUENTIN YOUNG
RUTH ROTHSTEIN
DR. CRAIG BACKS
JAN DAKER
PAT JONES
REP. ELIZABETH COULSON

ADEQUATE TASK FORCE MEMBERS: (CONTINUED)

TIM CARRIGAN
GREG SMITH
SEN. IRIS MARTINEZ

ALSO PRESENT:
DAVID CARVALHO, IDPH
ANN MARIE MURPHY
RALPH SCHUBERT
CATHERINE BRESLER, IDHS
TRACEY PRINTEN, ISMS

NAVIGANT:
GWYNN DAVIDSON
CATHERINE SRECKOVICH

LYNN TAYLOR - MATHEMATICA POLICY RESEARCH

P-R-O-C-E-E-D-I-N-G-S

MR. KOEHLER: Call the meeting to order. We have a quorum here. Good morning. Why don't we start as we do customarily, go around the room and give our names. Tim, why don't you start that down there.

MR. CARRIGAN: Timothy Carrigan, University of Illinois Medical Center.

MR. KOEHLER: You got to speak up real loud so Tonja can hear us.

MR. CARRIGAN: Tim Carrigan, University of Illinois Medical Center.

MR. SMITHMIER: Ken Smithmier, Decatur Memorial Hospital.

MR. ROBBINS: Ken Robbins, Illinois Hospital Association.

MR. DOOLING: Terry Dooling, C.J. Schlosser and Company.

MS. DAKER: Jane Daker, United Congregations of Metro-East.

MR. DUFFETT: Jim Duffett, Campaign for Better Health Care.

MS. MITROFF: Pam Mitroff, Pam Mitroff Consulting.

MS. BRESLER: Catherine Bresler, Trust Market Insurance Company.

MR. MURPHY: Mike Murphy, the WellPoint Company.

MR. ROBERTS: Joe Roberts, Caywood and Associates.

MR. KOEHLER: Dave Koehler, Peoria Labor Management.

MR. CARVALHO: David Carvalho from the Illinois Department of Public Health.

And in Dr. Lerner's absence, I want to remind everybody to turn their cells phones off, please.

MS. ROTHSTEIN: Ruth Rothstein, Retired Chief of Bureau of Health for the County.

DR. YOUNG: Quentin Young, Physicians for the National Health Program.

MS. DAVIS: Margaret Davis, Health Care Consortium of Illinois.

DR. BARBATO: Tony Barbato, Loyola University Medical Center.

MR. BOYD: Ken Boyd, United Food and Commercial Workers Union.

MR. SCHUBERT: Ralph Schubert, Illinois Department of Human Services.
DR. BACKS: Craig Backs, Illinois State Medical Society.
MS. PRINTEN: Tracey Printen, Illinois State Medical Society.
MR. SMITH: Greg Smith, Group Marketing Services.
DR. JONES: Art Jones, Lawndale Christian Health Center.
MS. SRECKOVICH: Catherine Srekovich, Navigant Consulting.
MS. TAYLOR: Lynn Taylor, Mathematica Policy Research.
MS. DAVIDSON: Gwynn Davidson, Navigant Consulting.
MR. KOEHLER: Okay. We are going to --
SENATOR TROTTER: State Senator Donne Trotter, 17th District.
MR. KOEHLER: Let's go around the room in the audience. Need to be very clear. So -- I am sorry. Niva.
DR. LUBIN-JOHNSON: Dr. Niva

Lubin-Johnson, Prairie State Medical Society.

(AUDIENCE MEMBERS INTRODUCED THEMSELVES)

MR. KOEHLER: Anybody else?

(NO RESPONSE.)

MR. KOEHLER: Thank you.

Dr. Lerner is going to be absent for a little while this morning. He had a funeral to attend, so he will join us when he can.

Look at the agenda today. We do not have minutes from August 15th. But if everyone has had a chance to look at the July 25th minutes, we have a motion to approve for any changes?

MS. BRESLER: I have a question. Thank you.

In looking at these and trying to do some review of some of the last few meetings I noticed that -- You just referred to them as "minutes," which is kind of what I thought of these as. And in looking at it, they really are just meeting summaries, these are not meeting minutes.

MR. KOEHLER: That is a summary.

MS. BRESLER: In addition, we have a court reporter here at every meeting. The last meeting was a rather full discussion with many votes and many numbers. And in trying to prepare for this meeting, wanting to look at that, I can't find the transcripts. And I am wondering when and if we will have access to those, and when and if there will be actual meeting minutes provided. Because, obviously, we are getting to a very critical point here where we are being called to vote on some very critical issues. And I don't feel that I have enough background or detail to be able to make some kind of informed decisions at this point.

MR. CARVALHO: You are correct that what we have been approving have been -- what you have been approving have been meeting summaries. Because you have a transcript, we do not prepare minutes. Minutes will serve the same function as the transcript. So the transcript serves the Open Meetings Act requirement of the record of the meeting.

The meeting summary is provided

because it's less unwieldy than a transcript and more convenient to someone who is just trying to scan and get a summary of what occurred at the meeting.

We prepare the meeting summaries off of the transcripts, which is why sometimes there is a delay in getting you the summaries, because until we get the transcripts, we don't prepare the summaries.

We have on site a copy of the transcript, so we can refer back to it if there is something in particular you or the Task Force want reference to. The transcripts and the meeting summaries as they are accumulated all go up on the website as well.

Now, there are several transcripts where there's still some issues of corrections, from the prior transcription service. And that's why some meetings earlier in the year aren't on the website. But as of now it's the summaries and the transcripts that are being prepared to memorialize activity.

MS. BRESLER: Well, we haven't been able to find the transcripts on the website. We

may be looking in the wrong place. So if you can help us out with that, that will be great.

MR. CARVALHO: Some of them aren't up.

MS. BRESLER: We haven't been able to find any.

MR. CARVALHO: They are there if you go to right page. I have got -- Elissa?

MS. BRESLER: August 15th date.

MR. CARVALHO: One from August 15th. In particular, there have been some questions about what exactly was the motion that was made towards the end of the meeting and what was the roll call. I have the roll call. And then the transcript should have the motion. But you know, at such time that that becomes relevant for discussion, we will refer to it.

MS. BRESLER: Okay.

DR. LUBIN-JOHNSON: Well, pertaining to transcripts also, I sent an e-mail to both you and Dave and Mike asking for ten copies of the transcript to be available at this meeting, because of the issues I had concerning the motion where there was actually placement on the consensus items also. And so -- and I didn't

get a response. So I question, you know -- I wonder, if that e-mail had been received by either of you. And obviously, you know, there is only one copy of the transcript. I just had a concern. I would like to see the transcript.

MR. CARVALHO: Neither of us got that e-mail. Sorry.

DR. LUBIN-JOHNSON: Okay.

MR. KOEHLER: We do have one copy of the transcript here, though, from the last meeting?

MR. CARVALHO: Yes.

DR. LUBIN-JOHNSON: I would like to see it.

MR. KOEHLER: Does anybody else have trouble getting the transcript off the website?

(NO RESPONSE.)

MR. KOEHLER: Maybe we should ask for some help towards the end of the meeting concerning that.

I misspoke at the --

Is there a motion to approve the meeting summary of July 25th?

MR. SMITH: So moved.
MR. KOEHLER: Is there a second?
COMMISSIONER TROTTER: Misspelled my name.
MR. KOEHLER: Well, we need to change that.
SENATOR TROTTER: That's not my sister. Talking about in the summary itself.
MR. KOEHLER: Let's make that change, with our apologies, Senator. With that correction made, all in favor say aye.
(CHORUS OF AYES.)
MR. KOEHLER: Any opposed?
(NO RESPONSE.)
MR. KOEHLER: All right. We are going to get into the actual meat of the meeting here, and that is to ask Navigant to take us through what was sent to us this week.
DR. LUBIN-JOHNSON: Mr. Chair.
MR. KOEHLER: Yes.
DR. LUBIN-JOHNSON: I would like to -- I guess I would ask, and I would like to make a motion to adjust the agenda. There are several that were asked questions about the -- what was

sent to us that there was no response -- actually, the response was that the questions would be dealt with on Tuesday. And because of the short time of when we received the materials, I believe it would be more appropriate for those who did ask questions to Navigant, and submitted questions to Navigant, be given the answers to those questions first before we proceed into what's scheduled to be a two-hour discussion -- or presentation of a model that we have been asked to digest in a short period of time.

I think it would help with not asking so many questions during the presentation if those persons who submitted questions to them beforehand were allowed to get those questions answered first.

MR. KOEHLER: Who is it that submitted questions?

DR. LUBIN-JOHNSON: From what I understand, there were several persons that had asked questions before.

MR. KOEHLER: Who did you receive questions from?

MS. DAVIDSON: We received questions from Mr. Duffett. And we have gone through those questions. We received them last night. And we have pinpointed in our presentation this morning to address them as we are talking about the topics so we can give the background to them. Some of them involved insurance market changes and some of the contractors, hopefully where we can give a background leading up to that answer. So that was our plan, but we can adjust it.

MR. KOEHLER: Who else submitted questions?

MS. DAVIDSON: We didn't receive any others.

DR. LUBIN-JOHNSON: You didn't receive anything else? Are we going to take two hours (inaudible)?

MS. DAVIDSON: I think, yes. Well, we can go through this per (inaudible). We were kind of (inaudible) two hours instead of walk through so you understand that people have been trying to digest. So we wanted to make sure to provide the explanation to help people do that.

But we are at your convenience.

MR. KOEHLER: Is that a right --

Personally I want to see a full explanation, because I find it a bit confusing. It may just be me.

DR. LUBIN-JOHNSON: No. I mean, if those are questions that are going to be answered during the presentation, that's fine. But, for the record, I find it somewhat disconcerting that in five weeks we got a plan in five days to digest. And it seems like we got a lot more material in a shorter amount of time, with our last meeting. And I thought that the work was less -- that we received what we needed, so that leaves probably at least two weeks' notice and not five days' notice.

So, for the record, I am concerned about that, and I was just wondering if our time is best being spent by once again being here with material received on short notice. We did this two months ago and here we are at the same place again. And everyone is a volunteer here and have other things that they have to do. And for this to happen twice, you

know, as the saying goes, fool me once shame on you, fool me twice shame on me. You know, I just don't understand that.

MR. KOEHLER: Your concern is noted, since this is a verbatim transcript. But I'm not sure what else we can do with this at this point.

MR. CARVALHO: Navigant was given the assignment of distributing this material last Wednesday by the Steering Committee, and distributed the material last Wednesday. So I'm not sure why you're casting aspersions on Navigant's work. They did exactly what they were asked to do. The Steering Committee asked them to distribute the material during the meeting last Wednesday.

DR. LUBIN-JOHNSON: I guess I was not aware that the Steering Committee gave them the okay when we have less than a week's time to digest materials.

MR. ROBERTS: There needs to be some clarification. The Steering Committee asked for the first cost benefit, that Navigant make that information available during that meeting. It

was Wednesday that we asked for it.

DR. LUBIN-JOHNSON: Thank you, Joe. Thank you.

MR. KOEHLER: All right. Any other discussion?

DR. YOUNG: Just a quick one. Important to me. It's the use of the term "consensus." The problem I have with that is that we do agree to negotiations, we do it all the time. And of course this is what happens, a popularity contest, strong or lesser support. And as we move toward transmission simply to the Legislature, I think it's best to indicate that's what it was, it wasn't a consensus.

MR. KOEHLER: We could probably address that once we get ready to do the signatures.

DR. YOUNG: Noted now. Silence might give the impression of consent.

MR. KOEHLER: Sure. Understood.

MR. MURPHY: Just to echo the same sentiment on consensus, I think those of us who I think at this date may be numb by the fact that a lot of things that we were concerned

about be part of this fell off the rails months and months ago. So, though I would agree with Dr. Quentin, I think they've come to that realization more recently. We have come to that realization quite sometime ago.

MR. KOEHLER: All right. Any other comments?

(NO RESPONSE.)

MR. KOEHLER: Let's proceed with the order of the day then. We will ask Navigant to take us through what they have presented.

Gwynn.

MS. DAVIDSON: What I would like to start -- We are going to basically walk through the materials that are in front of you. And just to sort of bring us to the first step, our task at the end of the last meeting was to modify the hybrid model that was in front of the Task Force and adjust it to concentrate on the high consensus items that were identified at that meeting, and then to bring in any moderate consensus items to help achieve the goals of the Task Force and the high consensus items. So that was our focus as we looked at my final

hybrid.

And we looked at modifying it, we wanted to provide as much information as possible, so we broke out the results into two tiers. Tier 1 essentially has -- focuses on the high consensus items but does not achieve a complete -- sort of a full level of coverage. So we brought that in knowing that that was one of the Health Care Justice Act Goals. We brought in the employer assessment and the individual mandate to bring up that coverage level. And that's what happens in tier 2.

So we have -- You can view that as, you know, looking at tier 1 all by itself or looking at tier 2, which really encompasses tier 1 and tier 2.

We wanted you to be able to see the impact of putting those policies on top of a coverage approach. We thought that that might be useful information for you to help make decisions around.

Then as we were going through the modifications to the hybrid, we developed an option A and an option B. And basically under

our option A, additional coverage options are presented to the uninsured population through carriers in the market now.

We thought that it might be helpful to see a lower-cost option that also helps spread risk and support its safety net providers. And to that goal, we developed option B, which basically allows insurance carriers to offer this product that is subsidized by the State, to help increase insurance coverage, but then also has a State-insured plan that also provides that premium assistance. And that does lower the cost somewhat.

Again, we felt clearly it's up to the Task Force what option to take; but we wanted to present you with as many options and information as possible as to how that might play out.

And we understand that there are a variety of ways to achieve the high consensus goals. And we have put together these recommendations sort of to our --

Let me move this so you can see.

(PAUSE.)

(Senator Iris Martinez joined the proceedings.)

MS. DAVIDSON: May be things you would like to change. There's more than one way to achieve some of these goals. And we understand that.

So on that note, if you turn to page 3 of that report, you will see a table that lists high, moderate and low consensus items. And what we are going to do over the next hour and-a-half is to walk through the components of the model, walk through the graphics of this report, walk through the cost and coverage numbers.

But just to give a brief sort of --

MR. KOEHLER: One second.

Does everybody have a copy?

MR. MURPHY: I do not have a copy.

MR. KOEHLER: Are there extra copies of these?

MS. DAVIDSON: We just sort of want to

touch on -- and I'm going to go through this in more detail at the end -- touch on how this modified hybrid achieves this high consensus item. And I'll just speak very briefly to some very general differences between today's hybrid and the hybrid presented to you on August 15th.

So, on the high consensus items we have state-refundable tax credits and premium assistance. And I am sort of jumping --

Well, let me just go from top to bottom. Might be better.

We have, as we did in the original hybrid, a very strong (inaudible) component where we are providing premium assistance to various individuals up to 400 percent of the federal poverty level. So that's how we address that high consensus item.

We have Medicaid and SCHIP expansions and relatable that maximizes federal Medicaid funds. And we do include expansions to Medicaid and SCHIP to maximize those federal funds here as we had done in the original hybrid.

Long-term care partnerships

recently (inaudible because of loud coughing) allowed the original hybrid.

Strategies for spreading risk. We have a variety of changes to the insurance market that we think help to do that. And we are going to talk through that a little bit more. And we also have various ways that uninsured people can obtain coverage by pooling their risk.

For reinsurance, the original hybrid did not contain a reinsurance component. This one does.

We have included a provision about adequate and timely payment to Medicaid providers, and ways to address the adequate supply and distribution of providers.

We continue to have the main option available under the strategy be a comprehensive commercial package. So that's how we address the comprehensive benefit package. And we aren't showing any reductions to the current Medicaid and SCHIP packages.

We support employer commitment to health insurance by providing premium assistance

in a modified hybrid. We also have a special component -- a special part of the hybrid that helps target small low-wage employers. And we try to encourage them to take up coverage.

MR. ROBBINS: Do we need to wait until the end --

MR. KOEHLER: Well, if you have a question of clarification, why don't you go ahead and ask it. If it's a substantial part let's wait and address those again later.

MR. ROBBINS: Could you define employee commitment -- employer commitment? What is that? Is that a mandate?

MS. DAVIDSON: No, it is not a mandate, although there is an employer assessment in the second tier.

By employer commitment we are saying we want to support employers in providing health insurance to their employees.

And then in terms of minimizing all costs not related to the direct provision of health care, including administrative costs and cost recovery for fraud and abuse, we have brought in a variety of provisions through the

oversight body of this model. And we have also looked at ways to reduce administrative costs that we talk about in opposition B. But as well as limiting -- looking at approaches to try -- not eliminate, but reduce the administrative cost of health insurance carriers.

MS. MITROFF: Did you do anything about administrative costs of providers at all?

MS. DAVIDSON: We have providers reporting their costs I believe through IHRT, but we don't have something that's specifically directed at the administrative costs directly.

So we wanted to just sort of lay the land and sort of be able to draw these aspects of this modified hybrid to high consensus items.

And on page 4 you have a table that talks about some of the major differences between the original and the modified hybrid. I don't want to focus on this too much, but I would like to just draw out some of the critical differences.

In the original hybrid you had a sort of standard package being available to you,

sort of a newly-covered population, as being a high deductible plan that was a health savings account compatible. That was a low consensus item to the Task Force. So we did away with that. And we have now a sort of standard product that is not a high deductible product, and that's not health savings account compatible.

In the first tier of the modified hybrid we now say that if you have an offer of coverage that you are taking up, and you are -- through your employer, you are under 400 percent of the federal poverty level, we will not offer premium assistance to you, in the first tier. In the second tier, once the individual mandate comes in, you may.

And we recognize that that is an equity issue. We implemented that over concerns for costs, and recognizing that -- In tier 2 that does not exist. Done away with. But under the original hybrid that provision didn't exist. If you were receiving coverage or not -- If you were taking up coverage or not taking up coverage through your employer, you were under a

certain FPL, you would get premium assistance. So that's also a change.

In the original hybrid we had a no reinsurance component. And in this one we do. We will talk in little more detail about that. I know one of your questions related to that program.

For the benefit package the scope of service remains unchanged. But as I have mentioned, the high deductible component of it did.

We continue to include an individual mandate and an employer assessment. However, those don't go into effect -- those only go into effect in tier 2. We don't have those in tier 1.

For public expansions, the original hybrid that, let's cover childless adults through Medicaid, and let's try to capture federal funds through Medicaid for that population, when we thought through it, we thought that it -- thought it might be very unlikely for the State to be able to achieve the cost savings in its current Medicaid population

to cover that new population of childless adults.

So we decided that, to be more conservative in our estimate, we would say that that would be population covered through the Medicaid program but funded only by State funds. That's also changed.

For administration we have what is called the Illinois Health Education Referral Center, an administrative body; and that in the first hybrid did not have a public board that serves a governing recommendation function. In this version of the hybrid it does.

We also have added some fraud and abuse provisions in this hybrid, under what we'll call IHRT during the meeting that -- this administrative body.

MR. ROBBINS: Clarification question.

MR. KOEHLER: Yeah.

MR. ROBBINS: Are these different fraud and abuse considerations than those already involved in either the Medicaid program or the Illinois Department of Insurance?

MS. DAVIDSON: If they are already

currently existing?

MR. ROBBINS: I know in Medicaid there are fraud and abuse protection activities.

I assume also in the Illinois Division of Insurance that there are as well.

Are these different from or in addition to those?

MS. DAVIDSON: In addition to those. In addition to those. These are --

These are having IHRT look at fraud and abuse technologies and activities in the private sector and thinking about how to apply those to public programs, as well as if the Task Force were to go with option B going to -- to apply it to those as well.

DR. BARBATO: Could you be more specific about the difference between employer assessment and employer mandate?

MS. DAVIDSON: Sure. We have chosen the word employer assessment because -- or that term because what we are saying is that all employers must pay -- with the exception of employers that are under 25, must pay an assessment -- a health care assessment fee.

They may receive a credit against that fee if they offer certain levels of coverage currently to their employees. And that's that sort of broad-based approach to defining that assessment what we think would help the State avoid some of the legal challenges that other states have encountered with employer -- deemed as employer mandates.

MR. MURPHY: In looking at the cost, is that the $4 billion figure that you talked about in the presentation?

MS. DAVIDSON: Employer assessment fee.

MS. TAYLOR: 1.4. I will specifically point it out when we get to that part of the presentation.

MS. DAVIDSON: And those assessments are meant to offset -- to go towards the cost of these premiums.

So we are going to go through some of the exhibits you have in front of you. So this is on page 5 of your report, sort of a general overview as we have been talking about, you have an IHRT here, your administrative body

and oversight board, and you have various insurance market changes to spread risk and reduce administrative costs. And that's sort of the umbrella over which this change occurs.

We have a variety of new coverage options. The covering parent from 185 to 200 percent of the FPL is something that we had in the original hybrid. It is -- We say that it is SCHIP-funded, but we believe the State can achieve that by doing one of two things, one is by finding existing savings in the Medicaid population to cover this new population. The other option would be to use income disregards for the Medicaid population to cover more low-income parents. We think that that is a possibility. I know we have talked in the report about there being extensive discussions needed with CMS to do that. And, Jim, this was one of your questions, but many states have used income disregards to cover more low-income parents. Why would we think extensive discussions would be necessary with the federal government? We believe that a lot has happened in the past few years. The federal government

is a lot more cautious about what they will approve. And we think that it is best said that this is a risk area; that we think that the state could do this, but we don't want to say that it's a sure thing.

DR. BACKS: Income disregard, that terminology to me means --

MS. DAVIDSON: It means that to qualify for Medicaid the state will say, well, we're going to disregard a certain portion of your income, we are not going to count it, so essentially you would meet our poverty -- the guidelines, the eligibility guidelines to qualify for coverage, because we are not going to count some of your income. Disregard --

DR. BACKS: Can you give an example of what type of income might be disregarded?

MS. DAVIDSON: The state will pay $300 on it. They might say $600, $800. There are other ways to do it as well. I think that some states have actually said they will disregard assets in addition. But basically you disregard a certain amount of income up to the point where you're essentially extending coverage up to a

certain federal poverty level.

MR. ROBBINS: One other question. Wasn't entirely sure when you talked about expanding -- I think you said expanding the SCHIP program to make more money available.

Could you just elaborate on that a little bit?

MS. DAVIDSON: Yes. Yes. Illinois currently is, as you just said, is spending all of its SCHIP allotment; and our understanding, continuing to do so. So once you go beyond the federal government SCHIP allotment, you have to pay for that cost of care, often with state-only funds.

Low income parents are covered under a -- large portion of them are covered under SCHIP funds. What we are saying is we're going to extend that higher up to 2 percent.

MS. TAYLOR: If the lowest income parents receive match at Medicaid rates, and by including more Medicaid rates it can free up current SCHIP spending from that allotment for what we perceive to be purposes that move more towards expanding coverage --

MS. DAVIDSON: So you essentially have an allotment that's capped, and you're saying you're going to bring in more parents. So essentially you use some of your parents that's covered under that allotment into Medicaid through these income disregards.

The other new coverage options are your childless adults paid for up to a hundred percent of federal poverty level paid for by Medicaid.

We continue to have the various Medicaid expansions for disabled populations that we have had in the original hybrid.

Then we provide premium assistance up to 400 percent of the federal poverty level, with a special provision to support small low-wage firms. And Lynn is going to talk in detail about that in just a little bit.

Within that we have this option A and this option B. So under option A, all carriers offer this comprehensive standard plan that people would access through premium assistance. And under opposition B carriers can

still do that, but you'd also have a state self-insured plan that would provide that support.

And the reason we brought in that option B is we felt that it helped the state achieve high consensus items, such as lower administrative costs and pooling risks, and supporting safety net providers. And the reason I say that option B supports safety net providers is that this state self-insured plan will be built on the Medicaid provider network.

MR. ROBBINS: Including payment levels at Medicaid rates?

MS. DAVIDSON: That's a good point. No, it's not.

MS. PRINTEN: It's a smidge higher.

MR. ROBBINS: Oh, 105 percent, based on Medicaid rates.

MS. DAVIDSON: That's right. So what we are saying is that under -- and this isn't here in this slide. But we are including a 6 percent total Medicaid increase to providers.

Across the board I think it would be an issue of great debate and analysis to

determine how to allocate that to different provider groups. But that you would increase under tier 1, the payments by 3 percent, and then based on quality indicators at the additional 3 percent after that. And what we are saying is that this state self-insured plan would be 105 percent of those rates. So if there are increased rates, it would be 105 percent of those increased rates.

MR. ROBBINS: In what -- See if I phrase this correctly.

Every state has an upper payment limit that applies to its Medicaid program.

To the extent that Illinois is already bumping up, and it might shortly be bumping up against that upper payment limit under its current arrangements, does the expansion of the Medicaid programs that you propose have any -- is it (inaudible) in any way by that consideration of the upper payment limit amount?

MS. DAVIDSON: It would -- You would have to target your increase to --

You'd have to look at your

providers across the spectrum in the Medicaid program. And if there are providers that are bumping up against their upper payment limits, you wouldn't be able to pay them more and get federal match for it. So you would have to --

MR. ROBBINS: I don't think it's a question of paying them more.

As Dr. Murphy here -- perhaps somebody else might know the answer to this, it's the total sum of spending, is it not, not just paying more for any particular provider?

So if you added a lot of people to the rolls not presently on the rolls, that could create a problem with your upper payment limit, depending on what the mathematics are; am I correct?

MS. SRECKOVICH: Right. There is no specific adjustment in the model to take right now.

MR. KOEHLER: David has a question.

MR. CARVALHO: Let me try to help out on this too.

Upper payment limit is a calculation that says look at the people you are

serving in Medicaid, you can't spend more if you use Medicare principals. But it's not an absolute number, it's a number based on the people you are serving. So it seems that if you are adding people, your limit goes up.

MR. ROBBINS: Thank you. That helps.

MR. CARVALHO: Depending on what people you are adding, what is a covered category that the federal government would match for. But I think there is that flexibility in there.

MS. TAYLOR: And then making one other consideration that we also have -- well, I guess we'll get into that in a little more detail. But a lot of populations that may be going to Medicaid providers who actually aren't getting federal match. So for them, when you look at the overall increase in case load for these providers, there are some people that aren't impacting that calculation because they in fact don't get federal match.

MR. ROBBINS: Thank you.

MS. DAVIDSON: So these new coverage options that are layered over the (inaudible)

state public programs to (inaudible) coverage and individual market takeout.

The funding sources of all of these options are federal and state Medicaid and SCHIP funds; employer and employee premium payments; additional state tax revenues, which is a moderate consensus item, would be necessary to fund this.

And then, you know, through tier 2 you have monies coming in through your employer assessment, then also from --

We have not counted in our modeling the penalties assessed through the individual mandate, because we feel that's a very -- unfair to both funding streams, but you would have some type of funding (inaudible) couldn't be complying with your individual mandate.

And we are going to go on and talk a little bit more about the differences between your option A and your option B. And I will turn this over to Lynn to walk through.

You have a question here?

DR. JONES: Taking into account that

there may be -- will have less tax revenue from the county, if everybody becomes insured right now (inaudible) lot of tax revenue. Could you count that?

MR. KOEHLER: It's hard to hear that question.

DR. JONES: Well, if this comes through, you also would have less -- you also potentially would have a county -- the county would have automatic tax revenue for health care, which would not -- that would leave you with much less. You could even say, well, that offsets some of this.

Did you take that into consideration at all?

MS. TAYLOR: Well, we have not taken it into consideration in the sense that we estimated what those total funds were, and showed that if we were to net them out of sort of a residual left for the state to pay, how much the balance would be. However, I think we all believe that ideally those would be captured in some way. Might even be through indirect mechanism. Maybe your county income tax'll go

down. I am not sure. Because the county is paying for less uncompensated care.

But, on the other hand, there is, you know --

We are trying to spread the burden evenly across all the residents of the state. So those funds that are freed up are -- maybe people who are previously uninsured and now contributing to their premium could see that, you know, maybe it came through that mechanism.

I think it's something to -- in the final version of the proposal to the legislature that you would want to keep track of and say, how did you account for those funds.

DR. JONES: Well, for that matter, the providers also. You're sort of going to have external resources too because everyone will be covered. So what happens to those providers, you keep them; or what's going on?

MS. TAYLOR: There's a number of ways that could be approached. I think that we don't specifically -- in this proposal we do detail how this happens, we are capturing those types

of funds. You know, that's something we can look into.

MS. DAVIDSON: I think in the tier 2 when you have coverage of the uninsured growing -- excuse me -- covered of the insured growing so quickly, you would anticipate that you wouldn't need as much as those funds; and that, for example, your hospital with disproportionate share funds may not -- sort of mechanism to distribute those might need to be adjusted. I think that's where the state might want to start consider looking at those types of sources redirecting them potentially in cases where funds usually using those expand part of the coverage expansions to fund parts of those.

MS. TAYLOR: And other states that I have looked at, I think those tend to be the bulk of the uncompensated care funds going from the state, are those issuing --

This exhibit number 2, does everybody have that in front of them? This is a lot of the same information that Gwynn just presented to you, but it is a little bit confusing because we have provided several

options. This is in essence a different way to look at that same information. And what we tried to do was distinguish between the features of our proposal, which don't change as you go between tier 1 and tier 2 and as you go between option A and option B. And those are listed at the top of the chart.

Basically, the function of IHRT; the fact that we are offering premium assistance to individuals up to 400 percent of poverty is subject to some other constraints which I will get into. But there is a premium assistance program in place.

There are public program expansions that don't change as you go across the options. And there are certain insurance market changes that don't change, and there are others that do. The ones that don't change are a limit on medical trend for your guaranteed issued products, and the voluntary reinsurance pool, which I am going to talk about in a lot more detail in a few slides.

What does differ between the scenarios, which you might want to keep track

of, is, under option A, as Gwynn has already mentioned, the product that we are offering the premium assistance for is a commercially-provided -- Carriers are required to offer this product on a guaranteed issue basis both to their individual -- if they offer it in the individual market, they must offer it there. If they offer it in a smaller market, they must offer it there. And it is -- It uses commercial providers.

As you will see when we get to the cost analysis, it's a more expensive product compared to option B. And we just wanted you to have some alternatives in front of you.

Under option B there are two products that qualify for premium assistance. One is a state self-insured plan that uses Medicaid providers, and it uses the enhanced Medicaid rates that Gwynn mentioned, 105 percent of the higher rates that we are already proposing. We put this in place because it's been our experience that often the types of people that we are trying to get the premium assistance to are actually often going to these

types of providers already. They are already being seen by the FQHC as an uncompensated care payment or a self-pay patient.

In addition, one of our high consensus items was that we limited administrative costs. And this was one of the ways that you could achieve that high consensus item.

Lastly, between increasing demand and enhancing the payment rates, we are hoping to also achieve the high consensus item that strengthens the safety net provider network.

In addition to this -- And this has the exact same plan design. What is different between A and B is the provider network that's being used.

In addition, the cost to the person receiving premium assistance is actually the same between A and B. It's the cost to the state that differs.

MS. MITROFF: The state-funded premium assistance that you are talking about, that's 400 percent of federal poverty level?

MS. TAYLOR: The assistance is

available up to 400 percent.

MS. MITROFF: What is that in real numbers? Because 400 percent poverty level is probably --

MS. TAYLOR: Well, that depends on your family size.

MS. MITROFF: Family of four might be what?

MS. TAYLOR: I'd hate to hazard a guess.

MR. ROBBINS: $80,000.

MS. MITROFF: I thought it was $80,000.

MS. TAYLOR: I don't think it was that high, but you could be right.

MS. MITROFF: It is.

DR. JONES: 400 percent.

MS. TAYLOR: This is a sliding scale. I don't know if we have mentioned that, so I will look it up. I don't doubt what you said, but I have something I can look up during the break and make sure that is what it is.

So the other thing under option B still in tier 1 is that carriers are permitted

to voluntarily offer a comprehensive guaranteed issued product in the individual market or in the small group market. And if they do so, the premium assistance can be applied to that product as well; but they are not required to do so, as they are in option A.

Now, these last two bullets don't differ between A and B, but they only apply to tier 1. And this is --

We do have -- as we did in the last hybrid, we do have some compression of the minimum premium and the maximum premium that you are allowed to charge for a given product within a geographic area. And the spread cannot be -- Highest premium charge cannot be more than 135 percent of the base (inaudible). And carriers in the individual and small group market are limited to a medical loss ratio of 80 percent, when they go to have their rates approved upon renewal. These two features change as you go to tier 2. Tier 2, just as a reminder, features individual mandate in an effort to achieve greater coverage.

With individual mandate in place,

and additional coverage in place, and presumably lower risk of offering products in these markets, we reduce the rate spread by 5 percent down to 130 and we increase the minimum loss ratio up to 85 percent.

Lastly, tier 2 features the employer assessment that Gwynn already described. All these features are the same between A and B. And these products -- and the products in A and B continue to be offered down in tier 2.

Does that help? Do people feel clear about how 1A through 2B vary?

MR. KOEHLER: Catherine.

MS. BRESLER: I've got a couple of questions. And I am very confused at this point.

One of the comments you made earlier on is about how these options demonstrate that administrative costs are contained. I have no -- I mean I wrote it down as you were saying it, but I have no idea --

MS. TAYLOR: How we achieve that consensus item?

MS. BRESLER: Right, with these.
MS. TAYLOR: Well, there are two features that address that consensus item. Common to all scenarios is the limit on medical loss ratio.
MS. BRESLER: We're talking about administrative costs. You said it helps contain administrative costs. What you are talking about is limiting price, you are not talking about administrative costs?
It seems to me that this is not addressing the cost of providing care.
MS. TAYLOR: Right.
MS. BRESLER: Or the cost of providing coverage. So how is it that limiting rates contains administrative costs.
MS. TAYLOR: Well, the rate -- the bans, that is not intended to contain administrative costs, it is the medical loss ratio that is intended to address administrative costs. Because in the analysis that we provided last time, for carriers in the individual market, we had carriers with administrative loss ratios of, you know, 661 and 65 and so on, which

seems like their profit and admin. is higher than it needs to be.

MS. BRESLER: Loss ratio is --

MS. TAYLOR: Is not what you are spending on medical care.

DR. BACKS: 80 percent. 80 percent of dollars go to care.

MS. BRESLER: Right.

MS. TAYLOR: So the balance --

MS. BRESLER: Doesn't go to administrative cost.

MS. TAYLOR: No. If you -- The flip side of saying you are restricted to an 85 percent medical loss ratio is to say your nonmedical -- the nonmedical care component of your premium cannot exceed 15 percent.

So the percent of your premium that is not going for medical care cannot exceed 20 percent in the case of tier 1 and cannot exceed 15 percent in the case of tier 2. So that was intended to address that consensus item. Okay? Does that not make sense?

MS. BRESLER: It doesn't make sense, but not because --

MR. ROBBINS: Could I just ask --
MS. TAYLOR: All right.
MR. ROBBINS: Go through that again, what the rationale is for the difference between 80 percent in tier 1 and 85 percent in tier 2.
MS. TAYLOR: Well, the rationale is, in tier 2 we have achieved very high rates of coverage. And we believe that that should make costs more predictable and that carriers can be held to a more restrictive standard, because the rates of coverage across the state are so high.
MR. KOEHLER: Joe. You have the next question.
MR. ROBERTS: One of my ongoing concerns is -- I raised it last month and I will raise it again: If you continue to limit the private insurance market by doing these types of things, has there been any conversations with the major carriers here in Illinois about the willingness to offer these types of products, or are they just going to bail on the state? And then we are left with -- in a situation where you have a none-competitive situation where two or three carriers can jack up the price

significantly. That's a major concern as you look at the east coast models that have been put into place where the premiums are five to six times higher what we pay here in Illinois.

MS. TAYLOR: Those are -- It's a valid concern. We do not want a solution that causes carriers to leave the state. I think we can all agree on that.

The fact that significant premium subsidies are being offered creates a demand that is not now available to the carriers.

MR. ROBERTS: Has there been any discussion with any of the carriers?

MS. TAYLOR: It's my impression that it's not even appropriate for us to discuss this with the carriers. I think that's something for the Task Force to discuss; and the function of these stakeholder forums.

DR. JONES: The employer who currently is providing insurance for his employees, would he have the option of switching over to state-insured plans spanning through that?

MS. TAYLOR: Only if they are a small low-rate employer.

DR. JONES: Couldn't they say this is more attractive -- this is a more attractive product, you know; without the subsidies it's still more attractive; 3 percent administrative costs instead of 15 to 20 percent administrative costs, I want to have my employees with this insurance, which would also go along with this? They going to leave the market and still have -- If it turned out to be the best options to compete, and if they can't compete, then have a lower cost program that covers everybody --

MR. ROBERTS: But there's no guarantee it's now by a lower cost program.

DR. JONES: The administrative costs of 3 percent to pay into paying Medicaid rates plus 3 or 6 percent.

MS. TAYLOR: Well, I think there are probably practical limits on how many people you can -- these providers can serve, even with all the incentives that we put in place under the proposal, such as increased timeliness of payments, enhanced payment rates.

You would probably have to do more if you vastly increase the number of people

being served by the Medicaid providers.

DR. JONES: All of the (inaudible) providers will join if they have to, because if they don't, they'll lose most of the patients, incentive for them to join program, start to move.

MR. KOEHLER: Let me break in here. I think that gets into a substantial area where we need to do more research. So the point is noted, and we need to review that further.

MS. TAYLOR: Thank you.

MR. KOEHLER: How do you define geographic area?

MS. TAYLOR: It would be the same geographic areas currently being used.

MR. ROBERTS: You don't have community rating.

MS. TAYLOR: Pardon?

MR. ROBERTS: You don't have community rating.

MS. DAVIDSON: You don't -- I apologize. So there aren't any in place right now?

MR. ROBERTS: Not in Illinois don't

have community rating.

MS. DAVIDSON: No, I know you don't have community rating. I thought there were geographic areas that factored into determination of --

DR. LUBIN-JOHNSON: ZIP code.

MS. TAYLOR: It would be an aggregation. It would be something larger than a ZIP code, but designed to reflect, obviously, the prevailing practice costs in that geographic area.

MR. KOEHLER: This is an area where we again have to kind of come back maybe after lunch and address some issues that we see as needing some more research, ongoing discussion. But for the purpose of the presentation here, let's move on. I think another question to clarify --

MS. TAYLOR: You would not want them to --

You would --

I think the point here was you don't want enforcement to be used on the cost geographic areas because the cost of goods from

carriers differs too much across the board.

MR. KOEHLER: Doctor.

DR. BARBATO: Just as a question of definition. The enhanced Medicaid rates relate to which Medicaid rates, base rates, DISH rates, add-on rates, all of the above? Makes a difference.

MS. DAVIDSON: I don't think that. I think that given where DISH payments stand, I think if you will apply it to the base rate (inaudible) that some providers are receiving, so that we would --

I think what the state would want to do is look at that aggregate increase and then decide how best to direct that to different provider groups. That's not something that was specific to here.

MS. SRECKOVICH: Add to that hospital, all kinds of different add-on rates. And I think all of that would need to be rate-considered, in light of, you know, I think any proposed increases, and with the loss of some disproportionate share of allocations to the hospital, the whole scenario needs to be

evaluated.

States that have made these kind of changes have gone back and started from scratch -- not exactly scratch, but have developmental analogy that will go back and re-create kind of compensation levels they have with hospitals in absence of some of the other, you know, DISH and other funds. And that needs to be worked out with CPS either through waiver -- or as part of the waiver or whatever. That is something that needs to be considered.

MS. TAYLOR: Okay.

MS. DAVIDSON: In the exhibit what we are trying to show -- let me just put this away.

What we are showing here are choices available to the individual under the modified hybrid model, another way of presenting the information. So the first questions that an individual could ask themselves, for themselves or their family is: Am I a childless adult who had under 400 percent of the FPL? If yes, can I get a Medicaid light coverage that's state-funded? Am I a low-income parent up to 200 percent of the FPL? If so, I can obtain

family care coverage. And am I disabled?

There would be new Medicaid eligibility categories for disabled populations.

If I am none of these, then I would go into these options: Under tier 1, if I am under 400 percent of the FPL, and I have an employer offer of coverage, and I am taking that coverage up, then I have no change. I don't get premium assistance for that in tier 2.

If I am under 400 percent of the FPL and I am not participating in offer of coverage, and I am not uninsured -- excuse me -- if I am under 400 percent of the FPL and I am employed by a small low-wage firm that has qualifying coverage, I can get premium assistance.

Lynn, do you want to sort of talk through the options from the employer standpoint?

MS. TAYLOR: Sure. So on Exhibit 4, for medium and large employers, and with small employers who do not have a majority of low-wage workers, the only thing that's changed from the employer's perspective is employees in their

firms who are eligible for the coverage, but did not take it up. Can now get premium assistance to help them take up that coverage, under tier 1.

Under tier 2 all employees would be eligible for premium assistance. What's different is, in keeping with the high consensus item of trying to maintain -- I forget how it was worded -- maintain employer commitment and try to increase it, we have a special situation for our small and low-wage employers, which are the most vulnerable employers, in terms of whether or not they even offer it to begin with, and whether or not they will continue to offer in the future.

These employers may offer the product that is eligible for premium assistance whether -- So that would differ between option A and option B. They can contribute as little as 50 percent to the cost of coverage for their employees and they can contribute zero for their dependents. So this is a below market contribution rate that would help make it more affordable to them.

In addition, under option B, if you will recall, the subsidies are set up so that the cost of coverage is the same to the Illinois resident under both option A and B, the post-subsidy cost. But the cost to the small employer under option B will be less, because the product being subsidized is much less costly; and they are paying a percentage of that. They are paying only 50 percent for their employees.

Yes, Ken?

MR. ROBBINS: To be sure that I am clear, on the green and blue blocks, if you had employers who were providing coverage to their employees, and you had some people making $20,000 a year who pay for that insurance, and some who had chosen not to pay, because they couldn't afford or for whatever reason, under this plan only those who previously have not had insurance coverage would get a subsidy; but somebody earning the same amount of money who had taken up the coverage offer would not be subsidized; is that right?

MS. TAYLOR: Under option A that is

correct. That is not a feature that you need to keep. It certainly is a huge equity consideration. But one of the things that the Task Force -- we've seen it wrestled with a little bit, is the cost of these types of programs.

So we wanted to give you an option with a very strong crowd-out feature because it significantly reduces the cost to the state. There's a flip side, which is it's highly inequitable to someone who is similarly situated. I think it's a question for the Task Force, perhaps for this afternoon, how do you want to navigate that thicket.

You have -- Under our option A results you can see generally what it looks like to have that strong crowd-out provision -- I am sorry -- Under tier 1, I should have said.

Under tier 2 you can see what it looks like and what the cost to the State is of not having that strong crowd-out provision.

Now, there is a mandate in place, which means the take-up in costs are a little higher for our employer -- our subsidy of

existing employer coverage, but it's not that different. It still shows you the impact of removing the crowd-out provisions. So everything is on the table.

MR. ROBBINS: I understand that. But I am just curious in terms of thinking that it is -- that's creating that distinction between tier 1 and tier 2.

What was that rationale for treating similarly situated employees in similarly situated companies differently, depending on whether we went to tier 1 or tier 2 option A?

MS. TAYLOR: Cost.

MS. DAVIDSON: But also that we have the individual mandate coming into effect in tier 2, so if everyone needs to have insurance that becomes even more an equitable -- difficult to judge, you know, who shouldn't get that premium assistance. So tier 2 really brings it in.

MS. TAYLOR: But the reason you have an option that even contains that inequity was to look at the cost implications.

MR. ROBERTS: You may have a slide on this. Do you have specifics on what the mandate for the employers are somewhere? What the actual mandate says?

MS. TAYLOR: You mean how is the assessment --

MR. ROBERTS: Yeah. What's their requirement to provide it?

MS. TAYLOR: I think we do. It is actually, I think, the same as last time.

MS. DAVIDSON: Page 28 of the report.

MR. KOEHLER: Is there another question?

MS. TAYLOR: Question over here?

DR. JONES: It's not just an equity issue for employees. You can have two very similar industries: One employer decided they are going to have lower wages and provide health insurance and higher wages and not provide health insurance. All of a sudden that second one gets a competitive edge because he is now offering insurance subsidy for that.

See what I am saying?

MS. TAYLOR: You are saying if -- Our

green and blue blocks --

So you are not talking about small low-wage --

DR. JONES: Right.

MS. TAYLOR: You're saying someone that's previously not offered, they begin to offer; and presumably, all their employees fall under the category of low-wage --

DR. JONES: Subsidy. They are getting help for their employees, where the other one say, well, I'm going to pay a little bit lower to my employees and give them health insurance, that's how I am going to spend my money; don't get insurance.

MS. TAYLOR: Well, I don't think it's highly in equitable. Because the employer is not getting a subsidy. And presumably, if they wanted to offer coverage to their employees, they would be doing so. You know, I don't think we would get a lot of new coverage offerings because their employees are not eligible for a subsidy.

In addition to the employers that are not now offering, only -- not all of

there -- it's highly unlikely that all of their employees would qualify for premium assistance. Some of those employees are getting coverage through their spouse; and that would disqualify them. Some are in public coverage (inaudible) because the cost sharing is lower. So it is the type of employee that is affected by this provision. They tend to be scattered across firms, but never concentrated in a given firm. That's what the research seems to indicate.

DR. JONES: What does Wal-Mart do for its low -- for example, it doesn't provide -- they don't provide insurance for their low income --

MS. TAYLOR: No, they do. They do. But people don't take --

DR. JONES: Don't take it up --

Because all of a sudden, Wal-Mart, their employees are going to be able to access premium. Another company with the same product may have said we're going to make less of a barrier for people, and provide the most cost to their employees, so really is providing more.

MS. TAYLOR: Yes.

DR. JONES: -- not provide much in health insurance.

MS. DAVIDSON: I will sort of put that on sort of the -- to think about as we move forward.

If we go into tier 2 --

MR. KOEHLER: We need to move on. Been here a long time.

Craig.

DR. BACKS: Going from a situation where there are no inequities and creating inequities. There are going to be inequities all throughout the system. So I am a little disturbed.

We're getting too bogged down and focusing on one type of inequity without addressing all the others. That's my observation.

MR. KOEHLER: We're going to move along here.

MS. DAVIDSON: Let me just finish up with what is facing the small employers.

Whether you offer or not, we are

trying to provide a lower cost option to you. And in the case of option B, unlike for the price set facing employees, option B is lower cost to the small low-wage employers.

And I think that covers it.

MS. TAYLOR: At the risk of being shot down, I was going to walk through the changes that we are suggesting be made in the insurance market.

DR. BACKS: I will administer first-aid.

MS. TAYLOR: I will likely need it.

Carriers will have a new requirement that they have to file rates with the State for review and approval.

In order to get that approval, they will have to demonstrate that the new rates achieve whatever the appropriate minimum medical loss ratio is, whether it's 80 or 85, depending on whether you are in 1 or 2.

As before, we have a limit on how high the highest premium for a product in a geographic area -- how much higher it can be over the base rate, or the lowest premium that

is offered. And that's 135 percent in the individual market in tier 1; 130 percent for small groups, and -- whether it's tier 1 or 2; and also 130 percent in tier 2, for individual.

I think I could have said that in a less confusing way.

MS. MITROFF: Well, I guess what I'm confused about, are you saying that currently those limits are not being met?

MS. TAYLOR: Yes. Rates vary by more than 35 or 30 percent in both the small group and the individual markets.

MS. MITROFF: And so you are trying to reign in administrative costs? Did I hear --

MS. TAYLOR: No. This provision is unrelated to administrative costs. This has to do with risk-spreading; trying to meet the consensus items of spreading risk broadly.

MS. MITROFF: So I guess I'm not tracking with how this is spreading risk. Isn't it just dealing with price?

MS. TAYLOR: Well, it has the --

By compressing your rates, the very healthy people are effectively subsidizing

the unhealthy people. Because if you did not have this in place, the spread for a given product in a given geographic area would be much wider.

Like, take the small group. I think the spread permitted right now is 67 percent.

Yeah. Can you confirm that, Jim?

MR. SMITH: Plus or minus 25 percent.

MS. TAYLOR: Plus or minus. And I think that translate into some sort of math to 67 percent.

Without those requirements in place, the spread would be greater.

So a very healthy small group would be charged less. A very unhealthy group would be charged more, but perhaps they couldn't afford the coverage, and be priced out of the market.

So taking that type of approach to rates, compressing it more than it's compressed now, and also bringing it into the individual market.

MS. MITROFF: And this is on all

products, or just on this comprehensive, undefined product?

MS. TAYLOR: This is on all products. So it's within a product and a geographic area.

The lowest premium offered must not be -- well, the highest premium offered must not be more than 135 percent of the lowest premium offered.

MS. BRESLER: It's community rating.

MS. TAYLOR: Well, it is not pure community rating, but it is moving along that spectrum, in an effort to meet the high consensus item of spreading risk broadly.

MR. MURPHY: Just real quickly. I think at the April 9 hearing, we had testimony from a past insurance commissioner and present insurance commissioner, I think in response to question about this exact thing. Seems to indicate that they did not feel what you are suggesting here would have the impact that you describe; as a matter of fact, would have an opposite effect.

You have consultant recommendation disagreeing with those statements

from past and present insurance --

MS. TAYLOR: Was the impact a coverage impact or risk-spreading impact? Specifically which point am I disagreeing to?

MR. MURPHY: I think it had to do with affordability, what actually occurred with rates.

MS. TAYLOR: Well, and this is not an affordability consideration. I don't dispute that this is not addressing affordability. This is specifically to address, consensus item of spreading risk more broadly.

It is a given that if you compress rates, the least -- the most healthy people will pay more and the unhealthy folks will pay less. You know, that is the outcome of this type of approach.

MR. MURPHY: Could you also argue that if you expanded the current rate bans, that more healthy groups would be attracted into the market, thus reduce rates?

MS. TAYLOR: Well, that's the situation we have right now in the individual market. There is no -- There are no bans in

place.

MR. MURPHY: In the small group.

MS. TAYLOR: In the small group, right. If we look at --

Presumably, access is not deemed adequate in the individual market right now, I would assume, based on the fact --

MR. MURPHY: We heard you tell us that.

MS. TAYLOR: I think David probably wants me to move on.

MR. KOEHLER: I do.

DR. BACKS: Ask a clarifying question. I think you just did it, but just to be clear.

When you say "base rate" you are talking about minimum rate?

MS. TAYLOR: The lowest rate.

DR. BACKS: When I hear "base," that could mean you could subtract from that rate based on being healthier than average. So --

MS. TAYLOR: Right.

DR. BACKS: When we say "base," that's minimum?

MS. TAYLOR: Yeah.

DR. BACKS: Minimum to maximum is 35 percent variation. The other way would be 70 percent, plus or minus 35 percent.

MS. TAYLOR: Right.

MR. ROBERTS: That's correct.

MS. TAYLOR: We intend this to be the former.

DR. BACKS: Which?

MS. TAYLOR: "The former" being?

DR. BACKS: The floor?

MS. TAYLOR: The highest rate may not be more than 35 percent of the lowest rate for the same product in the same geographic area.

MR. KOEHLER: Whether we agree or not isn't the issue here. So we need to understand what is being presented.

Any other questions of clarification?

(NO RESPONSE.)

MR. KOEHLER: Let's move on.

MS. TAYLOR: We have a limit on medical trend just for the guaranteed issued products. So this effectively -- if you -- This could mean that there would be some cross-

substantive issue from the nongroup guaranteed issued products over guaranteed issued products.

When we work through this, we envision that for any given carrier, the guaranteed issued products would probably be a minority of their business.

Carriers -- All right. We have --

To address the high consensus item of a reinsurance product, we brought in a voluntary reinsurance program modeled on the NAIC model.

Carriers, this is a -- it is voluntary. If you want, you can pay a premium and reinsure an individual or a small group through this product. The premium that you would pay would not be more than 400 percent of your base rate. You would have to incur -- the carrier would have to incur $5,000 in losses before the reinsurance would kick in.

To the extent that premiums do not cover the reinsurance product, there would be a non-voluntary assessment across all the carriers, to cover the cost of the product. And

the state would operate the reinsurance product. Okay.

And there are a few differences in the provisions related to option A and B.

In option A there is a requirement that carriers who operate in the individual market offer the guaranteed issued comprehensive product to individuals. And if you operate in the small group market, there is a similar requirement. Again, that's under option A. They also must provide individuals and small employers information about this product and about the premium assistance that's available.

Under option B there is no such requirement on carriers; however, they can voluntarily offer a guaranteed issued product that qualifies for premium assistance.

Let me quickly say -- this is one of Jim's questions, is: What is the role of ICHIP in this brave new world?

Our recommendation is that you would continue ICHIP until it was determined that you didn't need it anymore. It sort of

depends on exactly what set of reforms was put in place.

We are introducing things that you could say compete with ICHIP.

Individuals have an option of a guaranteed issued product. And there is a cap on how much they are going to pay for that product, the rate bans that we are talking about putting in place.

So effectively, if you are somebody who might have qualified for ICHIP before, you have another option available to you now. However, we recommend that you keep those options out there for this population, for a while, and just see if their needs are being met. This may beg the question, especially in the tier 2 world: How do you qualify for ICHIP, given that you have to be denied coverage right now to get into ICHIP?

If the only product that you are able to get a quote for is a guaranteed issued product, that's when you become eligible for ICHIP, in this world.

In addition, the reinsurance

program also changes the dynamics a little bit, depending on how many carriers choose to reinsure their product. And that's no more possible possibly offering coverage to these high risk individuals.

Gwynn is bringing up the colored slides they have in front of them.

We were going to spend no more than half hour on these, and conclude for lunch.

I do want to note we have not been able to specifically address some of Mr. Duffett's questions, so I just wanted to make sure that we could circle back to those.

MR. KOEHLER: Okay.

MS. TAYLOR: One thing that you have not asked me about is: What are these subsidies? What does the premium subsidy look like?

When we developed these subsidies -- And you may want to --

I know I just told you to look at the slides, but at the same time, you can look at Exhibit 9 in your handout, which has an illustration of the development of the premium

subsidy schedule.

MS. DAVIDSON: Page 32.

MS. TAYLOR: In developing the subsidy schedule, which has been mentioned, is not quite as generous as our subsidy schedule last time. And it gives the Task Force a few more cost options. We wanted to accomplish a few things. We wanted to ensure that the post-subsidy cost of coverage in the group world was less than the cost of coverage in the nongroup environment. And that is to achieve the high consensus item of maintaining as much employer commitment as possible.

Very small employers, if they --

There have been subsidy programs, more local affairs, where you could get coverage -- a subsidized coverage product, and costing the individual the same, whether it was offered through their employer or they got it as a nongroup. So it's very little incentive for the smaller employers to try to cover their workers because the workers are just as well off in the individual subsidized product. So we wanted a differential in there, to achieve our

high consensus item of employers.

MS. MURPHY: These subsidies are really more general than All Kids?

MS. TAYLOR: Well, it depends. I think that they are less generous below 150 percent. I think in this -- This range, they might be a tad more generous, if you have one kid. If you have more than one kid, All Kids is more generous. If you are at a very high income level All Kids is more generous. So the answer is "it varies." Okay?

MS. MURPHY: It's unlimited? It's per child? And then you got six children --

MS. TAYLOR: Right. You don't get maxed out the way you do in All Kids.

The other objectives we wanted to achieve in the subsidy schedule is we wanted to ensure that a given family did not pay more than a certain percentage of its income, if it chose -- regardless of its family structure and regardless of how many members it insured. And that percent that we chose to start, for the purposes of the modeling results that you are going to look at, was: You did not pay more

than 4 percent of your income to insure your entire family in the group market, and you didn't pay more than 6 percent of your income to insure your entire family in the nongroup market.

Now, if you insure fewer family members, or depending on your configuration, because the way federal poverty level is determined is a non-linear thing, you may actually pay much less than that; but the result is you will not pay more than those two figures. And that is something, obviously, that the Task Force could discuss and adjust, that 4 and that 6 percent.

MS. MITROFF: Where did you come up with that number? That was a question I had as I came through here. Was it something we had discussed?

MS. TAYLOR: Where did we come up with these percentages?

MS. MITROFF: Yeah.

MS. TAYLOR: Well, again, we wanted the differential. There is this sort of SCHIP standard out there that both between the premium

outlay and out-of-pocket cost-sharing, that that should not exceed 5 percent of family income group. So we are kind of centered around that. There is --

You know, if medical cost exceed 7 percent of income, you get a tax deduction. There is no goal standard.

But we are sort of in the area where people start to feel like you are paying too much if you are going above 5 and 7 and so on. So we picked something that was right in the middle there.

MS. MITROFF: But don't you have to relate that to the benefit too?

MS. TAYLOR: In other words, how much they are paying out of pocket?

MS. MITROFF: Well, if you are saying that you are only spending 4 percent of gross income, you are relating that to a benefit plan, aren't you?

MS. TAYLOR: I am looking --

Our standard that we use is that, if you buy the product eligible for subsidy, your post-subsidy premium costs will not exceed

those two thresholds. It could be well below. And it doesn't factor in cost sharing, which is much more --

You know, it's not a high deductible plan such as we had last time. However, for people at very low incomes, the cost sharing could be somewhat onerous, you know, because it's the same cost sharing for everybody.

Right now the cost sharing does not fly with income the way that it did in our old hybrid. Okay?

So the net result of going through this is that the monthly post-subsidy cost of the coverage in 2007 would look like this, just to give you a sense of what these people are paying. And we addressed a little bit with Ann Marie how does this line up with All Kids or Family Kids or KidCare rebate. We looked at all of that, and in some cases -- because we are approaching it differently, we are in the ballpark. But in some cases, All Kids is more generous and in some cases we are -- and what the family -- how many people

you are insuring and where you are in the income stream.

So here are the results. While the number of people covered by the program differs a little bit between option A and B, there is not a large difference. And if that seems surprising, the reason is -- and that's why I haven't shown them separately here -- the reason is that, again, the post-subsidy cost is the same between the two options to Illinois residents. It's the State's costs that were affecting in our option A and our option B.

The reason that varies at all is that small employers are facing different costs between option A and B. And so only in that option do you see higher take-up of the coverage under option B, in the detailed results that are available to you as part of Exhibit 11.

So under tier 1 where there is no mandate in place, there are premium subsidies not quite as generous as last time. We cover about a third of the population. Okay?

Under tier 2 where there is a mandate in place, we think we are going to cover

around 90 percent of the population, very similar to last time.

How many people would be covered under a mandate is subject to, I will admit, some speculation. You know, it depends how well the penalties are enforced, how stiff the penalties are. You could certainly affect that number in how you implement that individual mandate. But as we've seen in the past, you get a big increase in coverage from the mandate.

Yes, Ken?

MR. ROBBINS: Under tier 2 of the lower right-hand corner, currently insured residents covered by the program, does that change between option A and option B under tier 2?

MS. TAYLOR: I think that --

You have again a few more people covered under option B, not a very large number, but a percent or two more.

MR. ROBBINS: So if you used option B, you would actually have a very significant number of people who are currently insured moving to a Medicaid based product; is that

right?

I will debate the wisdom of that later but --

MS. TAYLOR: Under tier 1 I wouldn't call it a large number of currently insureds --

MR. ROBBINS: Under tier 2.

MS. TAYLOR: Okay. Under tier 2, yes, because we have removed crowd-out provisions.

In tier 1 the only currently insured people who can get the premium subsidies are those working for that small low-wage employer, which is why you just see 1 percent there. Sort of one of the goals of tier 1, which was: Have a strong crowd-out provision. What does that look like?

No crowd-out provision under tier 2. You get a lot more currently insured people getting a subsidy.

Have I answered your question, Ken?

MR. ROBBINS: Well, for clarity, there may be a lot more people getting a subsidy, but it would also be a lot more people moving from a commercial insurance product to a Medicaid-based

product.

MS. TAYLOR: Well, much more of that under option A and much more of that under option B.

Most people, as you can see by the 21 percent, under tier 2, option B, keep their current coverage. Their employers are -- we believe they will continue to offer the coverage they have offered. Their workers will continue to take that coverage.

It's only the people who are currently uninsured or in the individual market that may be -- Well, I should say it's only the people who are in the individual market who are faced with this mandate, they can't afford the commercial options and they are the ones that are going in and taking FQHC product.

REPRESENTATIVE COULSON: Could you explain why you make that assumption?

MS. TAYLOR: Which assumption?

REPRESENTATVE COULSON: The assumption that people are going to --

MS. TAYLOR: You mean people with access to affordable coverage?

If they are buying coverage now, and they can afford it, we believe that there is no reason --

REPRESENTATIVE COULSON: That's a relative thing. That's why I am having a problem.

MS. TAYLOR: Well, I think you could say --

Well, don't forget, we have --

Their commercial coverage may be more affordable. So it depends who you are.

But we have more people covered, so there is a little bit less risk in the system. We have limits on medical loss ratios. And if you have employer-sponsored coverage of which we increased it a modest amount, you know, that's pretty affordable coverage, you know, and you have a premium subsidy for it.

So if you are under 400 percent, there is no crowd-out provision in tier 2. So the incentive to go into the FQHCs is pretty low, if you have one of those options, because you have this assistance available.

And we do --

One of the things that it seems like the Task Force may need to do, as you narrow down what you are going to recommend, could be that you need some sensitivity analysis around some of these assumptions.

MR. ROBBINS: By saying that they go into FQHC under option B, is that what they are limited to, under the Medicaid-sponsored program? I thought they could go to any Medicaid provider.

MS. TAYLOR: They can. I was probably using inappropriate shorthand. I think somebody else used it and I started picking it up.

All right. Let me move on before David shoots himself.

So if you were to look at -- We have a new table in Exhibit 11 that we did not have last time. And we tried to show the impact of our different options on subsidy groups -- subpopulations of the uninsured.

In general, the impact of these options is somewhat uniform across, for example, different types of workers.

Where you see some big

differences in tier 1, which is where you are going to see them, because individual mandate is that the biggest reduction in the uninsured, if you look at that exhibit, is among residents that are under -- at or under a hundred percent of the federal poverty level. That is primarily due to our new product -- our new public coverage for the childless adults.

In addition, a nuance is we realized there are some parents who aren't eligible for family care because they are recent immigrants. We are making that population eligible for this product as well, if you are under a hundred percent of poverty. So that's where you get your biggest gain -- or your biggest reduction in the number of uninsured.

Again, under tier 1, your smallest reduction is residents over 400 percent of federal poverty level.

While we have insurance premiums, we do not have access to the premium subsidies, and we do not think that you will see a big increase in the take-up due to insurance markets that are low.

In addition, children do not really have a new coverage option under tier 1 because they have access to coverage through All Kids. So when you look at that chart you will see that our new options are not reducing uninsurance among children. But you have to keep in mind that they have an option in 2007 called All Kids that is providing them with access to coverage.

Now, merely because they were so large to begin with, the largest group of remaining uninsureds are full-time workers, because almost all uninsured people are full-time workers ages 22 to 44; and they are probably childless. So that's kind of the group that remains the largest, even though they have seen a percent in reduction commensurate with some other groups. But they started out being the largest.

Under tier 2 you can again get the impact of the mandate with much higher take-up of the coverages. So it's not going to cost anything. That's the good news.

These costs are lower than the

old hybrid, due to some of these assumptions that we have been describing to you. The total cost, not surprisingly, varies between A and B and 1 and 2. That was one of the major reasons that we offered you these options. This is the cost to the state. It included outlays that are getting matched by federal Medicaid or SCHIP match and none-matched state expenditures.

Option B is much less expensive. Okay?

Now, due to the fact that the coverage that's being subsidized is less expensive for the people getting premium subsidies, the cost for the people in our public program options is the same between option A and B. So it's only a portion of the newly-covered that we can attribute that reduction in cost, or that lower expense.

So we are spending 2,500 for participants down here, and over 3,000 per participant under option A. And under tier 1, if you recall, these are almost all people who are previously uninsured, because we don't have that many insured people coming in.

MS. MURPHY: If you change your numbers to be per newly-insured, which of them vary a lot?

MS. TAYLOR: Well, these numbers here would probably go up slightly. Those numbers are available to you in Exhibit 10? In Exhibit 10. These would go up slightly.

These would go up quite a bit; and the reason is that, under tier 2 we do not have crowd-out provisions; we are covering a lot more people who have coverage now.

So the overall population and the newly covered population don't align as closely as they do here. These numbers are higher on a per-person basis if you only look at those who are newly covered.

Under tier 2 overall, though, whether you look at it on the basis of cost per newly-covered participant or cost per participant overall, the cost under tier 2 go down, because we are -- primarily because we don't have a crowd-out provision for the subsidy of employer-sponsored coverage. We bring in a lot of those people. And the cost per person is

very low, because the employer's still paying their share. The employee still has a share to pay. So the amount is being subsidized. It's quite small, which you can also see in Exhibit 10. And so that's why the per person cost is a lot lower, regardless of what population put it over in tier 2.

MR. ROBBINS: And the difference between tier 2 option A and option B is simply what you are going to pay for that same care; is that right? You are going to pay less?

MS. TAYLOR: Yes, you are paying less, because a portion of the population participating in the new coverage options cost is going to be much less expensive providers than they did compared to option A.

MR. ROBBINS: How do you come to that conclusion?

MS. TAYLOR: You're going to commercial providers, the none-public options. So this is what we call premium assistance.

Under option A you are going to commercial providers. Under option B --

MR. ROBBINS: When you say "provider"

are you talking about insurance companies or care providers?

MS. TAYLOR: Care providers.

MS. DAVIDSON: It's really the issue of what the rates to those providers are based on.

You understand that providers serve a variety of, you know, large --

MS. TAYLOR: Right. Thank you, Gwynn.

MS. DAVIDSON: But the other issue in the option B is that there's lower administrative expenses for the premium assistance, because it's done commensurate through the state, it's not solely on reduction and cost based on provider payments.

MS. TAYLOR: Well, it's that the coverage program is tiered through the state. Because the premium assistance is tiered through the state in both cases.

MR. KOEHLER: I have a question here. Niva had a question here.

DR. LUBIN-JOHNSON: I'm just curious as to why we were presented a tier 1 where the coverage was only 32 percent of the uninsured,

after you heard, although not passed, sentiments expressed the two providers on this task force -- physician providers on this task force sentiments about not dwelling much on options that didn't honor the mandate of the Act?

MS. DAVIDSON: Let me answer that.

MS. TAYLOR: Sure.

MS. DAVIDSON: We felt to achieve that level of coverage you needed to go to your moderate consensus items, the individual mandate and employer assessment. And we felt that because those were moderate consensus items, that we wanted to show the impact of those policies so they could be better discussed.

DR. LUBIN-JOHNSON: So tier 1 was the high consensus policy, and tier 2 includes moderate consensus to get more coverage?

MS. TAYLOR: Right.

MR. KOEHLER: Just a minute. Another question here.

Catherine.

MS. BRESLER: I just want to make sure that I have this straight too.

It appears to me -- and I am way

confused right now. But it appears to me that one of the cost differences between option A and option B is that in option A you are forcing carriers to provide, on a guaranteed issue basis, some comprehensive standard plan, which we have no idea what that looks like. As far as I can tell, there is nothing in here that details what the comprehensive plan looks like. That's option A.

Option B, where the State is putting together some plan that you are presuming is going to cost less to administer, I don't know how you are going to provide subsidies to all these people without it costing anything to administer. But that's your presumption. But it appears to me that the State is not having to comply with this comprehensive benefit package. So the result, as I see it, is that you've got an option A that forces carriers to offer mandate on a guaranteed issue basis an expensive comprehensive medical plan. And the alternative is "or they can go to the state and get a real cheap plan."

MS. TAYLOR: So the scope of covered

services and the cost sharing is exactly the same between the product being offered -- what we call "state self-insured product" and the product that we are requiring the carriers to offer under option A.

We have specifics on that plan design with us, although that is by no means cast in stone. That would obviously be for the Task Force to determine what represented a comprehensive plan, which was one of the high consensus items that it had to be a comprehensive plan. So it is the exact same plan designed with the exact same cost sharing.

If I didn't make that clear, I apologize.

And the reason we assume the administrative costs are lower is that, as we have been using the same assumptions we've been using all along, we believe that administrative costs in the Medicaid program, even accounting for fraud and abuse, are still lower than is achieved by commercial carriers. And so we believe there is a savings there.

MS. BRESLER: And there has been

testimony contrary to your presumption that the administrative cost is lower, number one.

And number 2, my recollection is while we did -- part of the Act did dictate that there were comprehensive medical benefits. And the point is to provide medical coverage. I don't think there was any discussion about a mandated plan of standardized benefits.

I don't think there was -- that discussion ever took place. I think the discussion was comprehensive medical benefits, not a mandated standardized benefit plan.

MS. TAYLOR: Uh-huh.

MR. KOEHLER: Let's move on.

MS. TAYLOR: I think we are on the last side.

I think we've already made this point, which was simply we wanted to show the impact, which gets a little bit diluted at the overall level.

The real difference between options A and B really lies in the cost of state subsidies in the nongroup market, because most of the take-up of this option is going to be in

that market. And so, this is the cost per participant, if you pull that out of Exhibit 10. And I just wanted to show you guys that it's about a 40 percent difference in cost as we modeled it, which includes some controversial assumptions.

MR. ROBBINS: And what percentage of that difference is attributable to lower provider payments versus lower administrative costs, in option B?

MS. TAYLOR: That's a good question. Let me see if I can answer it during lunchtime.

Okay. That's it. David, I am done.

MR. KOEHLER: Questions?

Yes, Mike?

MR. MURPHY: I think it's appropriate to ask, but also in reading the package that is redistributed in a reinsurance component of this, and I think was funded by tax on insurance carriers, is that what is contributing to some of the lower costs inside the state program?

MS. TAYLOR: No. No. The assessment of carriers only goes to fund the voluntary

reinsurance program. It does not fund the subsidies.

MR. KOEHLER: Any questions before we break for lunch?

MS. DAKER: How does this plan that you put together go with the things that we weighted before? Because I was looking at one like wellness, which we had assigned ten points, but I forget the weight.

When I look through here, that's one of the biggest cost cutting things that can happen for a program that keeps people well, as evidenced by the VA program that is successful. But I see little in there about control costs. So how are the weighted things originally still in here? Are they still in that same proportion?

MS. DAVIDSON: This exercise really concentrated on the consensus items as opposed to the different weighted items.

MS. DAKER: But it was in the original items.

MS. DAVIDSON: I would say that for wellness --

Well, I mean, to back up to your question, we haven't done a crosswalk in this document back to those items. Certainly some of them had very high weights. But increases in the provider payment and timeliness are reflected here.

In terms of wellness, I would say that we have expansions of public programs that have the financial components and that, you know, we have supports for preventative care services. The packages are -- the comprehensive package that's subsidized contains preventative services.

MS. DAKER: With the history of the VA that's one of most successful things controlling costs overall, and we still have to afford this. We did weight it very heavily originally. It doesn't seem to be reflective in here; other than if they come in for a regular check-up, that's it. There is nothing to (inaudible) them to do that.

MR. KOEHLER: Niva.

DR. LUBIN-JOHNSON: In reference to the high consensus item of (inaudible) and

distribution of providers, I think when that was agreed to in high -- well, agreed to be in place as an item, my thought, when it was previously discussed, was that there would be some provision in whatever plan to ensure that those who are part of the underrepresented population, persons of color, that there would be some provisions in the plan that would help allow for increase in those numbers, you know, in a state where over 20 percent of the population of persons of color, and we know the persons providing the care, be they physicians, dentists, nurses, pharmacists, physical therapists, or whomever, are probably 5 percent or less of the population. When this was placed originally in as an item, that was the thought behind this also, not just loan payment or some other incentives to serve in underserved areas. It was also by how do you put persons in the pipeline, you know, to serve those populations.

REPRESENTATIVE COULSON: I just want to be real clear on the new state costs, because I'm just finally getting down to the bottom.

This is what it would cost the State of Illinois in our current budget. It does not include the assessments or anything else? Is that accurate?

MS. TAYLOR: Well, in tier 2, where employer assessment is in place, the state cost is net of that assessment. In other words, assuming that assessments were available to you to fund the subsidies and the program in general, this is what extra (inaudible) would have to be found. And it's in --

REPRESENTATIVE COULSON: Tier 1 it's not?

MS. TAYLOR: No, there is no assessment in tier 1.

REPRESENTATIVE COULSON: Basically what you are saying is this is what we would have to find in the state budget in order to do this?

MS. TAYLOR: Correct. I think that is correct.

REPRESENTATVE COULSON: Getting clear.

MR. KOEHLER: Art.

Jim, I'm going to ask if we can

have -- We have two department heads here that want to make a comment as well. So Task Force members first.

Art.

DR. JONES: Look at net impact on providers as a group. Is it zero? And if it is zero, who are the winners? Who are the losers? Are the losers the ones that have a much higher insured population? Who's the winners? Who's the losers? And what's the group provider as a whole? What's the --

MS. TAYLOR: You mean across the whole state?

DR. JONES: Across the whole board, all providers to start with. Is it neutral?

MS. TAYLOR: I think that we are not reducing --

I don't think there is a net reduction in care that is reimbursed through commercial insurance. So that reimbursement stays the same. And there is an increase in care that is covered -- well, it stays the same or higher. It will be higher under option A. And there is a reduction in uncompensated care.

And that made under -- under option A that represents -- it's now being compensated at typical commercial rates.

Under option B some of that care is being compensated at these enhanced Medicaid rates.

MR. KOEHLER: Jim.

MR. DUFFETT: Yes, two things. One is I guess an interesting layout that you did here. I surely was under the impression that what we were going to be getting was going to be something that had high and medium together versus just making like the whole tier 1 thing.

I kind of find that a little disconcerting.

My questions -- the other question is -- and maybe you guys have done this. I apologize. I have not looked on the website. But it'd also be interesting to see, if we do nothing, what happens to the State's budget? What happens to the number of uninsured? What happens to costs overall?

I thought in the contract there was something that you guys were going to

provide us, like what would happen in five years or ten years, in terms of the State of Illinois; in terms of the impact on uncompensated care, the number of uninsured, the growth of the state budget on health care costs, and all that.

Was that something that we are still going to be getting from you guys? Was that in the contract? Do you know or you guys --

MR. KOEHLER: My understanding, we had talked about that.

MR. CARVALHO: Check that at lunch.

MR. DUFFETT: That would be a helpful thing as we are looking at this, to be able to counter. And I am not sure if --

In that context, I know if we did have some form of affordable, accessible health care, I know at least $362 of my automobile insurance would hopefully no longer be there, because I am covering people. And there's all those other side costs that would be interesting for all of us to be able to kind of balance off, you know, the new costs that need to occur, and then other savings that would be there.

MR. KOEHLER: Let's look at that.

And before we break for lunch, we have two department heads here. Michael Gray (phonetic), Department of Insurance, and Ann Marie Murphy.

You had a question?

MS. MURPHY: It related a little bit back to when Niva was talking about only 32 percent, which is a good question, considering that.

It struck me that maybe -- maybe they should answer that partially, that if you take all the things that we all like, or different people find, that it starkly demonstrates that you can't get to a high level of coverage without the second tier; things that we are all a little scared of, which are the mandates. And that actually is a really stark way of putting that you can't get home unfortunately without some stakes.

MS. DAVIDSON: When we did call them tier 1 and tier 2, I think our main goal is we know the individual mandate in employer assessment were sticky topics, and we really

wanted to be able to show the impact of those. We thought that was a useful piece of information. That's why we broke them out. It's certainly not to say that we think you should only implement tier 1. That's really --

I know the way we present it sort of leads you to think: Well, what happens if we were only to implement tier 1? But our objective is really to be able to show you the impact of those additional policies.

MS. SREKOVICH: And when we started this -- We originally started it as a phase in where there would be some initial reform, and as we have described in tier 1, and then a gradual or some -- you know, some kind of step to tier 2 that could be accomplished over a longer period of time, just because of the dollars associated with those implementation of firms.

MR. KOEHLER: Let's break for lunch.

One more question.

MR. ROBERTS: I have a question.

MR. KOEHLER: Mike said he didn't have anything. Anybody else?

Mike.

MR. MURPHY: Quick question for Dr. Murphy. I know she is here on behalf of members of the Governor's cabinet.

Is an employer mandate something that the administration has decided that is one of those unpleasant things we need to --

MS. MURPHY: I don't think any decisions are being made at the Governor's office. All the agencies will consider all the options, and are very interested in the deliberation of the Task Force.

Obviously, as we all know, the Governor has had a longstanding commitment to health care. And now over a half a million more people have health insurance due to our efforts. But we are very interested in listening to all the different viewpoints here.

MR. KOEHLER: Let's break for lunch and come back in 20 minutes.

(A break was taken.)

MR. KOEHLER: Can we reconvene?

I was really hoping at this point to be able to turn the meeting back over to Wayne.

DR. LUBIN-JOHNSON: Psyche. You believed that e-mail, huh?

MR. KOEHLER: I guess let me start with sharing a couple of observations and maybe true confessions here. I am not quite exactly sure how we proceed into this next discussion. Got a lot of things on the table.

I sense that there is -- if not certain anxiety, certain level of frustration, at least some confusion about where we are? And are we making progress? Are we taking step back? Where are we?

Let me just float this out and see if this is a good starting point.

I'd like to go around the room and ask people to just make a brief comment about what has been presented in terms of if this is acceptable to you in any way, shape or form.

Let me put it this way: If this has some possibility of being acceptable to you, what would you like to see changed about either added focus, narrowed, whatever?

It may not be acceptable to you,

and that's fine too. That's your prerogative. But I would like to have Navigant maybe put some of these issues on the Board so we can begin a starting point for our discussion.

Does that make sense? Anybody got a better idea?

MS. MITROFF: I have kind of a question going through this. Maybe I missed something. But we are talking like this is the only proposal out there. And we have not taken any proposals off the table.

I think that gets to Jan's comments earlier that, as I was going through some of this, I was thinking: How does this compare to some of the other proposals that we have been contemplating?

So I think, you know, what I want to bring up is that really nothing is off the table.

MR. KOEHLER: Right. That's a good point. And let me start with my own feelings, just to get this thing rolling. Probably going to go down this side of the table. Fair warning. Going to go around the room here.

But my hope is that we can see this new hybrid area as a place where we can begin to fine-tune something that would be acceptable to most of us. I don't think we are all going to be agreeable a hundred percent on anything that comes out of here, but that we would see something that could be worked or reworked, as a possibility of saying, here, this is -- you know, this is what the majority of the Task Force is putting forward, you know, as a recommendation to study.

Again, this goes to the Legislature. This can be changed in all types of forms. It could be considered in its entirety or whatever. But at least, as we said, we have struggled with some of the difficult issues. There may be some --

All right. I am done.

(Dr. Lerner joined the Proceedings.)

MR. KOEHLER: This is a way that we have tried to grapple with some of the important and even controversial issues surrounding the whole issue of health care. So if there is

anybody to take the heat, let us take the heat, and let the legislators then begin to see what is politically doable. We have got some --

You know, Pam is right. There's other issues that -- other proposals that are still on the table, and, you know, we are going to talk about in the Steering Committee. But certainly some minority reports can come forward as different groups see fit. But at least if there is one -- you know, one general consensus of the group -- or majority of the group but not a consensus that says: Here is our idea. Here is what we think the components are of the comprehensive health care plan.

Personally, I am kind of overwhelmed at the complexity of what I saw today, and I think that what I need is a lot more explanation as to how some of these things got put together.

Because, you know, as I tried to listen to all of you who raised questions about it that really opened up a whole new, you know, avenue of questions for me, you know, especially in terms of some of the numbers that we talked

about.

I hope we are still on task of trying to complete our mission. And I am feeling a little bit like we are becoming kind of strained in this discussion. But -- And I hope it doesn't become heated or personal. I don't think we will do that, because I think we at least understood that we all have a right to our own opinions. But we are all people here trying to do what we think is the right thing. So let's proceed with this discussion.

Wayne, what I am suggesting is we go around the room and we say if this thing is to be at all acceptable to us. And it may not be, but that's one thing we don't know. But if it is to be acceptable to us, what do we think needs to be done to further refine it or enhance it. And that way we make a list of things.

By the end of this discussion some of -- you know, all of us can be thinking about what the logical next step is, because I don't know what the logical next step is.

I guess that, Wayne, you can kind of give some insight.

MS. KANNADY: I guess one item I would comment on that's an area of concern, as I go through the proposals, specific expansion of Medicaid as a hospital that serves large percentage of Medicaid, and given financial challenges the option of expanding Medicaid under the current scenario, is very problematic from the long-term viability perspective for the hospital that I represent.

MR. KOEHLER: Record everybody's comments, just to have them on the board.

MS. DAVIDSON: Medicine I payment issue.

MS. KANNADY: And proposal issue. If you look under option B, expansion of Medicaid, that would be very problematic.

MS. DAVIDSON: Expansion for Medicaid and based on those Medicaid provider rates.

MS. KANNADY: Even what's proposed with the immigrants.

MR. CARRIGAN: In the hospital that provides Medicaid care, then also care to uninsured, one thing that we spend a great deal of time and money on is getting these people

that we see come through our emergency department and clinics up to snuff with hopefully trying to find some federal or state insurance, so to speak. So what we are interested in is one simplicity in terms of the resources we have to put in to getting these people insured, whether it be through Medicaid or some other sort of federal funding, and be the maximum number of people that can be insured. Because that decreases costs to us that we can funnel into other areas such as care or access.

MR. KOEHLER: Again, going to do a synopsis of that.

MS. DAVIDSON: Increase simplicity for hospitals to find coverage options for patients?

MR. CARRIGAN: That's right.

MS. DAVIDSON: And just increase the number of insureds, and overall increase the number of insureds.

MS. TAYLOR: Reduction of uncompensated --

MR. KOEHLER: Ken.

MR. SMITHMIER: Two things, Dave. I

have the same provider sensitivity to Medicaid that was pressed in one specific piece that keeps tugging at me. Maybe it was addressed in the proposal and I just didn't catch it, but: How particularly do we keep small and middle-sized employers in, if they offer insurance now, from dumping that insurance because they see that the chance for their employees to take the Medicaid or the state-funded option is more financially attractive to them? That would be a big issue for us because then we get people moving from commercially insured to Medicaid population. That specific piece --

The second thing, Dave, I feel the same way you do, after this morning. I feel like we have gotten to an incredible level of technical complexity now in this conversation, which on one hand is needed, and at the same time is very difficult for a group this size and this mixed to figure out with accuracy, which is, I think, all we really want. We want to know what the facts are; and then we can make our decisions from there.

And so, when you talk about other pathways, it feels to me that, to the degree that the public meeting law would allow, some subset of this group, representing different constituencies, who are really familiar with the technical complexities of this, if they can get together and hash through some of this and bring it back to you as a group as a whole, that would be beneficial, to me anyway.

MR. KOEHLER: So you are talking about sub-groups without violating the Open Meetings Act that begin to take different pieces of this?

MR. SMITHMIER: Right. Because frequently we were appropriately cut off on topics, or we would have been here all morning on one question; yet many of those questions were very good questions that need to be gotten into in great detail, before this task force knows what's X and what's Y. And absent that, it's hard for anybody to really vote.

MR. KOEHLER: We have tape? Tape these to the walls?

MS. DAVIDSON: Yes.

MR. KOEHLER: Oh, it's a Post-It.

MS. DAVIDSON: I don't think it's a sticky back.

MR. KOEHLER: Cost cutting constituencies.

Ken?

MR. ROBBINS: I think it was a useful process of giving the two tiers in order for you to contrast what is in tier 1 versus what you can achieve in expansion of coverage if you went to a tier 2.

And I think we would be -- I think that it would be appropriate for us to be bold and move toward the more expansive of the approaches. And so I am sort of comfortable with that as a concept.

But there are so many questions underneath that that I think need detailed technical work, whether they be impacts on insurance market, impacts on provider community, impact on the uninsured or underinsured.

What I fear is that the analysis we have seen so far is what I would describe as static analysis rather than dynamic analysis. So, for example, if you simply said, well,

people who are now uninsured and for whom providers get no payment when they treat them would be covered by what I think is inadequate Medicaid payment in the state, that would still be a net improvement for the provider getting something rather than nothing.

But I think experience in other locations shows there is a bit of "If you build it, they will come" effect.

That is to say, if suddenly full coverage is available, it isn't just what we think the impact of what these lower rates would be with the number of people we see right now, based on some modest assumption about their need patterns. But if those need patterns become a whole lot more like the rest of the population, given that they have also probably got a lot of longstanding unmet medical needs, what is the real impact of that kind of reduced payment mechanism likely to be? That's just one example.

I too think that there are a lot of very good technical minds either sitting around this table or could be brought in from

the rest of the concerned parties, who could really give a good scrubbing to a lot of the questions that have been made and others not yet raised, to come back to us at a future date with more of these answers provided. And if there are new questions that get raised in this process, that could then be considered.

So my view would be very much like Ken's. This has been a good exercise -- a very good exercise up to this point. But it's definitely always in the details. And we need more complete understanding of details and consequences of those details.

MR. KOEHLER: Did I hear you say at first you were leaning towards looking further to tier 2 as an example?

MR. ROBBINS: Yes. You can then have an opportunity to sit down and work your way through the implications of what that means for all of the affected parties.

MR. KOEHLER: So I'm hearing you say that the focus on tier 2 as the model, but do the research and the number crunching?

Terry.

MR. DOOLING: I agree with focusing on the tier 2 level. I see some process in where we are going. And I like seeing the increments of cost and coverage that we have looked at today.

The groups that we look at, I would like to achieve this and to achieve more coverage of the uninsured as our main goal, but at the same time protecting our institutions, our carriers and our providers, that they aren't the ones that bear the full cost of this.

I am very concerned about another constituency, that's the employer. And I think this -- The mandate, while I think it's probably necessary to achieve our goal, I think it can't be done in a vacuum. I would like to know the economic impact.

I think there are many employers that are above the small employer level that would fall into serious financial difficulty, with the type of assessment that we are talking about. And I am sure there are numbers available. I think we could use technical input on that.

I would have a hard time voting in favor of employer assessment, if I had no clue as to what the negative impact would be. If we put 50,000 people out of work, we haven't really helped ourselves.

The very simple side of me says maybe this costs several billion dollars; is that right?

If we look at the moral aspect of it, just from the state side, if the State picks up the entire cost on the individuals, the employers -- employees of the state, residents of the state, and what is our realistic likelihood of achieving a tax cut, some sort of general revenue increase to provide this coverage for the residents, what would it cost? I am not saying we are voting to do it, but there is the -- that 3.6 million from the state has to come from somewhere. Hopefully, not from someplace that here is just reducing some state funds to cover other areas.

DR. LERNER: So you are asking whether we need to be dealing with the sources of the support as well as the amount of support?

MR. DOOLING: Yes.
MR. KOEHLER: Jan?
MS. DAKER: Well, taking from Ken's words, "bold," and "build it and they will come," I happened to see this detailed article on the VA and how they turned themselves around in the last ten years where someone who is 65 and older has a 40 percent increase in health, by going to the VA now.

So, think of the economic impact if we could switch this around and focus instead of -- the people we use, if they get sick, instead focus on wellness and look at the economic impact that we would have if our people were productive and well. So that's huge for me.

I think we've really overlooked it because we think of it the other way. Most of the people in the room only see people when they are sick, but we don't look at it the other way.

MR. KOEHLER: Jim.
MR. DUFFETT: Well, we all know the access State of Illinois' temperament: A health

care plan that provide access to full range of preventive, acute and long-term health care services, maintain and improves the quality of care services offered to Illinois residents, and these other criteria. I mean, that is the mission that is before us.

I guess I was taken aback when I first saw this, and was disappointed. But as I was looking at it again this morning around 5:00 and re-reading it; and as we went from tier 1 to tier 2, you know, I guess to some degree the approach that I thought was going to be provided today was much different. But I am a little more relaxed about personally how you guys did the tier 1 and tier 2.

I also felt that August 15th was a very defining day; that -- because I really thought the approach was going to just take the high and the medium and combine them together. And that is what tier 2 does.

While there are many things in tier 2 that I have questions about, and it's like, "Do you throw the baby out with the bath water?" I think some of the comments that Ken

had mentioned too about looking at different components of this, I'm not going to lay out what I see the positives and what I see the negatives are.

But I really do feel that at our last meeting we moved the yard sticks down the football field. And I'm not looking at us reinventing the wheel and going back to square 1. I think we moved beyond that.

I would also think that it's also important to state, I would like to see that report.

I don't know, Dave, if you saw in the contract or not. I thought there was something that some status quo: If we do nothing, what is impact in five years and ten years to the State of Illinois? And also: What are some of the cost savings that we can see?

And again, those may be live numbers. But it would be interesting to see what are those cost savings that we see?

And also I think, as other people alluded to: What are the different income sources to try to come up with that extra

whatever it is, $2 billion or whatever?

And I say that, as I alluded to earlier, there are cost savings that, whether as an individual one has to pay more taxes.

I surely hope that Allstate will reduce my automobile insurance a substantial amount because people in the State of Illinois will have health insurance.

And even though I know other people in the State drive, I think all those factors are going to be really important to balance, as we come up with the final product.

MR. KOEHLER: Pam.

MS. MITROFF: I think this proposal takes us in absolutely the wrong direction, with one exception. It's got long-term care partnerships that's the --

MR. KOEHLER: What?

MS. MITROFF: Long-term care partnership.

MS. ROTHSTEIN: You say that's missing?

MS. MITROFF: No, that's the one part that's in there.

MR. ROTHSTEIN: You like that?
MR. KOEHLER: Catherine.
DR. BARBATO: Another 30 seconds takes us in the wrong direction, implication being that the other direction that it ought to go in what --
MS. MITROFF: I think we are seeing a movement across the nation to get consumers more involved in their health care. We are seeing a strong movement in making Medicaid be more flexible and more responsive to the individual needs. And this proposal does none of that.
MR. KOEHLER: I think it's important to note. Get those on the board.
MR. DUFFETT: I want to be sure I know on my notes too. Maybe there is another sheet.
Was there anything before you had J up there to look at?
MS. DAVIDSON: What are income sources?
MR. DUFFETT: I want to note what's up there, I feel that the vote we took on August 15th, that does move us towards those components that are in tier 2. But there are

still a lot of questions that I have on option A and option B that need to be dealt with in more detail.

MS. DAVIDSON: Support of tier 2 but many questions about A and B.

MR. KOEHLER: Catherine.

MS. BRESLER: Comment first. And I have to say that I wouldn't --

I don't know if I'd take any amount of money to be in Navigant's shoes right now. I respect all the work that you have done, and appreciate the time that you have spent, so I know this is a difficult task.

The question I wrote down as we started talking was: Does this hybrid plan have the possibility of being acceptable; and if so -- or if not, what would it take for it to become acceptable?

My view is that it's not acceptable. And that's just based on what I think are some unsupported and unsubstantiated presumptions that what is in that plan is really going to increase coverage and decrease cost of care.

DR. LUBIN-JOHNSON: Let her finish.

MS. DAVIDSON: Making assumptions and may result in --

MS. BRESLER: No, it's just the unsubstantiated presumptions that what's in there is actually going to increase coverage and increase cost of care.

MS. DAVIDSON: Okay.

MR. KOEHLER: Any --

Clean sheet.

DR. LUBIN-JOHNSON: I would like to agree with what one of the previous members is saying, that I would like the focus to be on tier 2 options.

And of course lots of --

You know, I know there's a lot to be worked out in it, in the plan itself. But hopefully with answering, you know, the concerns that have been mentioned thus far, that would sort out some of my issues.

I would like to say, as I stated before, in terms of the access issue, that there would be some provision in the plan that would look at increasing putting more persons of color

in the pipeline to be health care providers in this state, to make sure that there is adequate access. Because I don't think that -- that process doesn't start when someone is out of school, out of residency practicing working in a hospital.

You got to incentivize people. Make it affordable for them to do the training, go to school, do the training to provide care.

So I would hope that that consensus item is developed a bit more fully in reference to that.

MR. KOEHLER: Mike.

MR. MURPHY: First of all, Dave, let me thank you for allowing us this catharsis.

MR. KOEHLER: He is thanking me.

A little bit louder, Mike.

MR. MURPHY: I have many concerns, but I think a lot of them are (inaudible). And I'll preface it by saying, I think all of us are here for the same purpose. We all really wanted to bring something to the table that we thought increased health care.

I think when divergence of

opinion occurs, whether you think the public sector does a better job or the private sector does a better job of that, I think what is reflected in the proposal is somewhat a nearsighted view that the problem with health care and the costs associated therewith are with the industry that finances those costs.

And I think that it takes away more opportunity to really get at the benefits that can be achieved through doing things to enhance personal choice, and personal responsibility, and getting people reconnected to their own health care, and what the costs are associated with that. And I think we have missed a lot of that opportunity here, by focusing in on the financing industry in health care.

I think --

I don't think it's going to be any more productive. I think it's actually counter-productive. It would be no more productive than if we were trying to increase the ability for people to afford homes by focusing then on the mortgage. Therein lies the

crux of the problem. I think that's what this proposal does.

DR. LERNER: I have a question, just a clarifying question, Mark, Ken, back to Pam's comment: Are you suggesting that -- I don't want to put words in your mouth -- but, are you suggesting that either extreme, not all public versus all private is not the right way to go, but that some accommodation that improves personal responsibility, consumer item, that private market as well as where it's necessary, a public-oriented program, that is something that you would focus on?

MR. MURPHY: Yes. I think the current system allows for that. And I think the proposal was ostensibly thought to represent in some way the insurance industry, both public and privately.

DR. LERNER: Thank you.

MS. DAVIDSON: Could I read that back what to make sure I am reflecting your comment?

I have enhanced spending and bring people close to cost of their care. We have gotten away from this in model by focusing

on those that finance the system, allow for public and private options.

MR. MURPHY: I think Dr. Lerner offered the last point.

DR. LERNER: That's right. Could you agree?

MR. MURPHY: We can go into --

I agree with what was said at the start of the exercise.

I think basically, although in Medicaid programs that I think -- that are already operated under a consent decree that they basically alluded to the fact because of payment structure is not providing people with primary care that they need; and building on that I think is -- it will be helpful to the State of Illinois.

MR. ROBBINS: If this is inappropriate then --

MR. KOEHLER: I don't want to break the flow.

MR. ROBBINS: More clarification for Mike.

When you -- And I am not trying

to argue, I just want to understand.

When you say that allowing the private sector to do certain things, do you think there is a way that the private sector could achieve the expansion of care of a bold nature rather than a more modest nature?

Modest may be all we can do. I am not trying to argue the point, I am trying to understand whether that private approach has an end point that's comprehensive.

MR. MURPHY: I think we can do some things that would be considered bold maybe by us, maybe not by you. But I think over time incrementally would get us to a point that we are significantly getting a solution to the problem.

I don't think it would be over --

But I don't think any of the proposals we have seen here would have that result either.

MR. ROBBINS: Okay.

MR. KOEHLER: Joe.

MR. ROBERTS: Mike sort of stole my thunder.

I want to bring up one thing that Jan brought up -- and I thank you, Jan -- up to this point has always talked about looking at the issue of health care crisis here in Illinois as an insurance issue, and a cost (inaudible). Haven't talked about overall costs of health care; and what are the factors that affect that cost. So the wellness aspect that Jan was talking about, a significant part of this whole process that we haven't even talked about yet, we need to look at the costs of health care, not necessarily how those costs are being funded. And the proposal that was presented just shifts the burden and doesn't necessarily affect this.

Also I want to comment on Terry's issue that the impact economically that this product will specifically have on insurance carriers and on employers need to be reviewed significantly. Because we cannot propose a plan that is going to have a negative impact on our employers. It would be a crucial mistake on our part.

DR. LERNER: First of all, let me introduce myself. William Lerner, for the

record. If you didn't receive the e-mail, I apologize for not being here. I had a funeral attendance. Thank you, Dave, for continuing to do so.

Besides the one I gave Mike, and I'll take credit for it, putting it in Mike's path, worried about when we are looking at policy changes always is to try and to subject the unintended consequences of any of the actions that we are trying to look at.

We know -- we think we know the intended consequences of what we are trying to achieve, but it's the unintended consequences usually that cause us some problems. To the extent we can forecast them at all, I think it would be helpful to back us up, rethink the model and move us forward.

And I also want to congratulate Navigant/Mathematica Enrollment for helping us to get to this stage of the game, because there's nothing easy about what we are dealing with.

MR. KOEHLER: Just a quick comment. I guess I'll go back to how we started this

process with the innerspace discussion. And part of that is: How do I help you achieve your interest as well as you helping me achieve mine?

And I think that what I have heard especially from the people involved in the insurance and underwriters' point of view, I guess that's what I really would like to see, is how we can take and make this thing work for you as well. Because I don't want you folks shut out of the process. I would like to see us try to really maximize, as much as we can, whatever way we are going.

Talked about tier 2. I think that's worth exploring further. But how do we make sure we have as much interest as we can accomplish as possible? If that means taking a new look at the private insurance market and how it might be, you know, reworked to fit into this, then that's what I would like to see.

Ruth.

MS. ROTHSTEIN: Kind of worries me a little bit. I don't think we have to make anybody happy. I think we have to find the best solution to ensure the maximum number of people

in the State of Illinois, for the best possible program that we can put together. So I think that's more serious than anything.

I started out this morning being confused by the complexity of the proposal. I still am confused. I still have some problems with the complexity. Because I think one of the reasons we were never able to come up with the plan, always was too damn complex. People don't understand. Legislators don't want to deal with it. And it affects everybody's own personal needs.

I have a problem again how to figure out the best possible system that meets the needs of a hundred percent of people that we deal with.

Tier 1, tier 2. Tier 2 is better than tier 1, so I am for that. But I think that --

I wanted to just say, and I will give it up, Congressman Davis, when he used to be a commissioner, used to say at every commission meeting, whether it be problems with money and budgets and public policy and how to

maximize, he would say, everyone wants to get into heaven but nobody wants to die to get there.

MS. DAVIDSON: How about support of tier 2? How about some support of tier 2 concern about complexity?

MR. DUFFETT: And getting to heaven.

DR. YOUNG: Well, I would characterize a very thoughtful presentation, and give accolades to New York's tax. And comments from all parts of the room demonstrated what happens if you try and solve this problem without having a single-payer.

Everything falls into place. That instance (inaudible) applies to the problem. At least in one instance I felt you had to go to the (inaudible) but the low voting group to balance the budgets, and should have done that. Take single-payer off the bottom and see how you would work, it would be magnificent.

I have a lot of ideas. But they do represent some old hat, that is to say these things don't work. That is to say employer mandate. You heard the beginnings of the

worries about that just in this first round.

Individual mandate is a no starter. It doesn't work. People you are trying to insist -- and does still run this, prime money for insurance, even subsidized insurance, don't have insurance because they don't even have the money to have it. So it's kind of an internal contradiction that they can't get over.

Word complexities were used a lot. I echo that. It is unnecessarily complex. But that's what you are forced to do. You know like a menu 1 from column A and 2 from column B to get to the goal. You must get to the goal. You charged for the meeting. Jim charged us because excellent in the writing and reminds us at the end of our deliberations what our task is, and I hope we do it.

Another remark. The money is screwed. You are asking for billing to the state. That is scrapped.

You are asking larger amounts for people whose employers have demonstrated inability to put aside money for insurance. And

I think it's dead on arrival in the way it came out here.

I am going to, of course, give the Legislature a chance to see what's undoubtedly minority. Maybe a miracle will happen and become majority. See that single-payer with simplicity, elegance and problem solving qualities given to legislators for their consideration.

I defy anybody on the commission that wants to join me in that, I will be glad to have it, in another --

MS. DAVIS: Another task. I sat on the task force for Stroger (inaudible) task force.

The county system is rapidly becoming a state system. They are going from every county in Illinois. They are busting at the seams. And to me I feel I want to put a face on the needs for us to reach a consensus to introduce to the Legislature, because people are suffering.

The issue of quality for me, I did not see it in the proposed plan; therefore,

I cannot, as a public health professional, see where we are going to decrease disparities and promote longevity. So that's an issue that I would like to see happen.

I would like to second Dr. Lubin's issue of dealing with people of color in the pipeline, as well as in the distribution throughout the state.

We have so many Spanish-speaking residents in our state, as well as Rock Island, 62 other language areas. And those individuals live here.

So in our plan we have to produce people that are going to provide quality services and have indicators that would monitor this.

And I agree with Joe and Jan that -- and Mike that it can't be just about insurance. We have to put some other meat on the table.

DR. LUBIN-JOHNSON: Can I add some things to mine?

I am number ten. And there is room.

MR. KOEHLER: And it's quick.
DR. LUBIN-JOHNSON: It is quick.
I would like to echo Jan's concern about wellness and preventative measures.
I am number ten. Over on the end. Wellness and prevention measures.
DR. BARBATO: Do this quickly. There is clearly more than one solution to what it is we are going to do. And I would be quick to wind up behind Quentin's pitch for a single-payer system, if our only objective is to employ equal access to high-quality health care, that is a setting.
There is a, in my lifetime, sense of what it is that I think needs to be able to be achieved to be able to get off the pot right now and improve health care for everyone in the State. And my practical observation is that it's going to continue to require more private and public interest; is going to continue to require more money than is being committed to the --
The question is: Whose money is

it going to be that makes it possible to get off the spot that we are on currently?

I share the concerns expressed about what will necessarily be under the -- this last iteration of the hybrid proposal.

And expansion really depends on Medicaid. So the question of whether or not, under a different model, Medicaid is going to provide a great level of coverage services than they are currently, it's not adequate. That remains largely unanswerable.

And some of the suggestions today about what it would require to revamp Medicaid rates inclusive of the different kind of waiver, I think poses a huge series of questions and challenges for us.

Whether or not the participation of other insurance industry, insurance markets and employers works for either of those groups that we framed the question, I haven't come up with the answer. So we are left with a -- We are left with the need for far more detail than the -- of the sensitivity analysis, to get some sense of how much the Medicaid program might

expand; what the rates will be in order to be able to make it doable for the providers; what exactly is acceptable or workable for the insurance markets; what exactly is workable for employers. So I think we have the right categories.

But as someone always said, we have got two-dimensional analysis for something that's three dimensional.

MR. KOEHLER: We are going to pause right now to switch the reporters.

(PAUSE.)

DR. LERNER: All right. We're back. Under the Open Meetings Act, they're certainly allowed to fill. Ken, you're next.

MR. BOYD: Okay. When I look at this hybrid model, I represent working men and women out there. That's what I do. And when I look at tier one, it only covers 32 percent of the people. Tier two covers 89 percent, which number-wise looks really good.

My concern is with the individual mandates because we're going to look at people who can't make those decisions right now for themselves. They don't have health care. They don't know what they're going to do, how they're going to do it. But yet, we are going to put this ownership of society (phonetic) on all these people.

And I have some other concerns because, as Ken said, when you build it they will come. And what I do everyday is I work with employees and negotiate with employers, and I see a rush all the time of going down to the lowest common denominator and somehow there is going to be a will, there is going to be a way,

where employers will be able to get out of their quality health care program and put it back onto the State under the Medicaid program.

This not only affects the quality of coverage we have for the people in the State of Illinois, but it's going to affect the hospitals. It affects the insurance industry. That affects everybody.

And that's one of the unintended consequences that we all have to look at here is by doing that what are we going to do to everybody. It's not just labor. It's not just employers. It's everybody who's out there. And we are charged with quality care.

And yes, we should be building quality care networks and making things better for everybody. But by just rushing to say, hey, here's tier two, it's going to cover 89 percent of the people, that is going to open up a Pandora's box of problems for everybody sitting in this room. I truly believe it.

You know, if you build it, they will come. I see employers rolling it right back down to getting out of it. Putting it on

somebody else because in part of the program there if you didn't offer coverage, then your employees can get subsidies. If you did offer coverage, there is no subsidies. Now, that's going to create a disparity for employers. That hurts everybody. That is going to hurt wages, which affects everything down the line.

I mean, you can just start opening up everything we have here. Yes, covering 89 percent of the people, it's truly a benefit that we can have, but I think what we are going to do is destroy more than what we are going to help here with this program.

I think there is other problems out there that we have to take a look at so we can cover everybody in the state and all the men and working women in the state and help the employers in the industry in the things we can do.

I don't have the easy answer for them. I don't think anybody in this room does, but there has to be a consensus that we can all come together with. But I think this plan here is going to hurt more people and more employers

than what's it's going to help.

DR. LERNER: Craig.

DR. BACKS: I gave a lot of speeches last year as president of the medical society. I am not sure any of them was less important than what I have to say to this group but, hopefully, it will be shorter.

A number of things come down to cliches as I think through this material in detail. (Inaudible) -- applies statistics. We can deal with a lot of those. You know, unintended consequences, although I would say there are many things that we might not intend to be a consequence, but I think we are all kind of getting hung up on the unanticipated consequences. If you anticipate some unintended consequences, we might accept them as acceptable if they do fall forward.

The two other things that I think do apply though go back to an earlier discussion where I can't remember his name, but he came from one of the think tanks dealing with this and talking about negotiations of moving from no but to yes. In other words, yes, if in my mind

says employer or individual mandate. No, but wait a minute. Yes, if it's subsidized by some form of subsidy that's publicly financed.

Who among us thought it wasn't going to cost anything to do any of this. I mean, I didn't think so. Somewhere somebody's option is going to go forward in the scenario or at least going to feel that way. Why do that because you're saying that, well, cliche is that sacrifice is just giving up something. It's giving up something good to get something better. So in some sense somebody is going to sacrifice something that's good to them but apparently receive something better in terms of the universal coverage.

And then, finally, that the perfect -- I shouldn't say finally. That's the last of the cliches. That the perfect is in the good. I'm really worried about moving backward by worrying about getting it perfect and missing out on the opportunity to do something awfully good.

And I don't want to be sitting in the same room maybe ten years from now with the

same people saying, you know, my God, we damn near got it perfect. Or even not in this room but saying that we were part of a process that's accomplished actual coverage. You know, we still got our issues to deal with.

And, frankly, the other thing I want to say is I'm kind of glad that our constituency didn't submit a plan that we feel compelled to defend. I really -- I am concerned that once we put forward a plan that we feel compelled to defend it because we have a constituency at home to represent as well.

Going to -- one thought on the inequity of subsidized people currently don't buy into insurance and not those that do, even though their incomes are the same. Perhaps some kind of time limit or phase out on that because the point of doing that is to bring more people into this system without using resources to fund people who are already in the system. So just a detailed thought on that.

As I look at moving -- clearly moving from tier one to tier two is in my mind the only thing that merits or the only way to

honor what we have been doing here is if you settle for tier one I think we offer ourselves really short and accomplished very little for an awful lot of effort.

In terms of looking at moving from A to B, as I see it, I don't mean to -- my comments to imply a value judgment one or the other. I just look at it as a choice. Do you want a more private, commercial bend to this as opposed to a government bend, which would be more in the B category.

Do you want change that come by negotiations between private parties and between insured providers and employers or do you want to come to an employer process. Both are messy. Just which do you prefer.

And with the private commercial side, I think you see more costs but more choices. I am a little concerned that with the B process you might see more cards but -- more insurance cards but not necessarily more care. If you just create the pie to slice it into smaller and smaller pieces, there will be fewer providers providing.

So I'm going to save -- I'm going to stop at that. There are a lot of other things I can say, but I do hope that we move forward, that we don't move backward and that we are not getting caught up in the details and we keep the big picture in mind and that we do something good, even if it isn't perfect.

MR. KOEHLER: Tracey.

MS. PRINTEN: I'm in support of not wanting to be here ten years from now, which is why I support the model as a framework and to really discuss the details. And I may be the only person at the table but I found that tier one, tier two, option A, option B really helpful in looking through a lot of the details and I appreciate it. I think I'm the only one here.

DR. BACKS: I'm starting to get there.

MS. PRINTEN: The Medicaid -- (inaudible) -- me as well especially when you read about projected access problems that Medicare rates and we are talking about one covering people at Medicaid rates. It just doesn't make any sense to me.

There is also one more thing.

I'm concerned about specifying in your -- I forget what it was under. But specifying things like leap frog (phonetic) or bridges to excellence, I don't think it's necessary to be that specific about -- I mean, generally you can talk about evidence based physician reviews sorts of quality measures. But I think it's dangerous when you get into specifying which company you're going to use, which consortium you're going to use.

MR. KOEHLER: All right, Greg.

MR. SMITH: Throughout the process of coming to these meetings, I'd always hoped there would be an opportunity for each of us to kind of give a statement about what we believe and what we hope to accomplish.

And I have been thinking about what that -- what that speech would be, and I'm not going to give it today because it would be way too long, and I don't think that I could say things any more eloquently than have already been said.

So to stay on task to say what about this model, I simply say that I agree with

Pam and Mike and Joe that we need to have a good discussion on potential outcomes or unintended outcomes or whatever we want to call them. We need to address the issues of the overall costs, not just the redistribution of who pays for it. Those are my two main items as far as that.

So, basically, to summarize that I wouldn't go with much of anything as far as this particular proposal.

MR. KOEHLER: All right. Art.

MR. JONES: If I had my preference, I would say we should move toward a single payer before you -- with your last concept. So given that that's how we are going to go, I think that I'm very supportive of the current program with tier two as long as there is a plan B option.

I would like to think that the private sector would solve this problem but the bottom line is the last 50 years they haven't solved this problem.

You know, we looked to the private sector to solve the problem with the elderly and finally it wasn't until we had Medicare that we solved the problem with the

elderly. We looked to the private sector to take care of the poor. It wasn't until we had Medicaid that we had a program for the poor.

And if we think the private sector is going take care of the problem with the uninsured, I think is unrealistic. I think they have had the last 50 years. There has been no progress. In fact, they have moved to the opposite direction.

I agree with the comments about wellness. But I work at a health center where half our patients have no insurance, and I can tell you that you can talk about wellness all you want. When you have high blood pressure and you can't get your medicines and you can't see a doctor, you can talk all the other kinds of things, fitness centers, whatever, but you have got to have access to basic care. Access to basic care doesn't promote total wellness. I agree with that. But you've got to have access to basic care which our uninsured don't have.

The issue of the individual mandate that people have been criticizing I think it depends on how affordable it is, and I

think that what I've heard people saying at the testimonies is people wanted affordable care and if the -- you know, for the way this is laid out as far as individual mandate is that the premiums are non-existent if they're below a hundred percent and they are very affordable otherwise. And I think you get people and I think that's what people want.

As far as the employer mandate goes, I think the way it's laid out here it's an aggressive. It's eight percent. If you choose not to participate, it's eight percent of the premium, which I think is based upon people's income. I think that's a fair way to do it.

I think one of the criticisms of our program now is that, in fact, it's not progressive. If you look at other countries that have -- that are industrializing the percentage of the poor, the rich pay higher percentage of their revenue to support the health care system, and that's what needs to be in this country also. I think the way you've laid it out is progressive. I think it's fair.

For me as far as providers, it's

kind of nice going at the end because you hear everybody's comments. But it's a little hard for me, and I am a provider, but it's hard for me to look and say we are going to put another four-and-a-half billion dollars, another four billion dollars into the pot and say that we are concerned that there is not going to be enough money for us as my providers to take care of this. There is no reason to think that, in fact, that there is not.

I think everybody has to run the systems and everybody is kind of saying, oh, gosh, they're going to take my uninsured population. Now, I'm going to get Public Aid rates. But we are talking about taking the amount of the money that's here and adding four billion dollars, 1.4 from the employer assessment and another -- what's my numbers, 2.6 billion from the state.

How can we say that there is not adequate resources then to take care of the population. It's another four billion dollars we have going into the pot. In fact, you look at the fact that there may be even more than

that because you are now mandating medical loss ratios, use the term, of 15 percent.

That means that presumably there will be even more of those insurance dollars for those insurance companies that are making a heavy MOR below 85 percent. Even more of that goes into the system.

So I think for us to turn down an opportunity to get those extra dollars that are recognized to go into taking care of the poor, it doesn't -- it's not a valid argument for me. I just don't see it and I'd love to see you run the numbers and tell me different. But to me it's an extra four billion dollars plus going into the system.

I would like to see -- the one adjustment I would like to see to the system is that under plan B that employers have the option to buy into that. Because I think that's the competitive thing.

The problem with single payer is that it doesn't allow the insurance companies to at least compete. And I understand that we give up some of the efficiencies and we move towards

this way but at least give them an opportunity to compete. But make sure they do have to compete.

So that if as an employer I decide I want to purchase into part B, I should be able to do that. And then if down the road it turns out that the insurance companies can't compete with that, well, maybe, in fact, maybe it's true.

Maybe in fact it is that the administrative cost is only three percent and maybe that's a decision that we need to make and say, hey, we can no longer afford to stay and to put 15, 20 percent to put into administrative profits when it comes to health care.

The problem with the private sector is the private sector looks to follow the dollar, okay. And that's just the way the private sector is. You go where the money is. Well, the money is not with the uninsured.

So I think that this is an excellent proposal. I think it's one that gives us an opportunity to move towards -- I see the end point of this, quite frankly, is that either

insurance companies will change quite a bit. Well, they'll decide it's not profitable to operate in this state. Then we will have one plan which then we get to our single payer system. So that's what I'll say.

MR. KOEHLER: Senator Martinez.

SENATOR MARTINEZ: Well, as a legislator that is going to be involved in discussions with my other fellow colleagues in the Senate, I think, you know, there is -- I think you said it right when you said that there is -- there has to be a starting point and this is a starting point.

I think that we are having discussions. We have been having discussions throughout the last year about this. Everybody has been able to participate. There is not going to be an agreement by everyone here in the room, I don't think.

But I think that when the ultimate end plan is to address the issue, there is a lot of great things that are being said here and I think that, you know, we just -- I don't think we are ready to take a vote yet on

this. I think there is still work to be done. There is a lot of -- I think you said -- what was it, the complexity of all this information.

You know, it's kind of hard to -- for people like myself that is not a provider, that is not an insurance person to really take in and know that every entity out there is getting a fair play in this whole entire scenario that we have here. You know, at the end of the day, you know, we are going to do what this committee takes back.

And I think the discussion then would become, you know, among the legislators what -- you know, what the work that everyone here has done which has been great but I think, you know, at the end of the day we really just want to be able to make sure that we provide the services, especially for those that are underprivileged that we have in our community.

And, you know, going to a couple of the hearings, you know, the people's voice is they want insurance. They need insurance and I think that we are headed there. We are headed there. We are just not quite there.

And I think all the information that we have been able to gather and some of the plans and proposals that have been presented are all well-intended but we still have -- you know, we still have to have more discussions and that's what I want to see happen.

I just don't feel that we are quite ready and I think taking aback because we are rushed for time is not the right thing either. This is something that needs to be worked on, and it's never going to be perfect, but at least we are going to be able to agree on some things that are important to the people that we are going to serve.

MR. KOEHLER: Senator Trotter. We are just kind of going around and commenting.

SENATOR TROTTER: Thank you. One, let me begin with thanking Navigant. Because I think it was very helpful which they laid it out today giving the two different plans, the options. And for someone who hasn't been to all the meetings, it's certainly -- and I don't want to be getting through all that. So I want to thank them for making it -- at least simplifying

it at this point.

But as pointed out by Senator Martinez, the bottom line is when President Jones volunteered me to be on the task force --

SENATOR MARTINEZ: Same with me, okay.

SENATOR TROTTER: -- I don't believe that he believed that we will be coming back with a finite plan. That's not how we do business in the General Assembly, but he did expect for us to come back with a plan, a working plan that we could start moving things forward.

Certainly don't want to be ten years. You know, we have -- as legislators we have shelf life. You know, we don't have term limits but we have shelf life here.

So the thing is I believe that we need to go back with something. I do like plan B. I think one of the things that we have been looking at not just last year, not the year before that, but for the past seems like forever it is coming up with a plan whereas we can deliver a good, solid health care system to those uninsured and underinsured individuals who

are amongst us.

The accountants, the efficiency experts are always going to find -- try to find a way to circumvent that because they are dealing -- they're looking at the bottom line.

But I think we as legislators have a responsibility also to take care or at least try to deliver services to the 12.5 million people who live in the state and this is certainly a giant step towards of where we begin and the fights that have been going on through the years, so I think this is very positive what we are doing.

In the General Assembly, as you all know, they are all attractive balances. So even when we go back down to Springfield, the conversation that is going on here is going to be going on in our caucuses as well. And so we are -- again, have work to do. But I would like to think and I do know that the President and the others, the principals, would like to see something come out of this.

So we certainly can't dump what's been going on and say let's do this for another

year because we have come too far to go backwards, as the gentleman said across the room or across the aisle.

MR. KOEHLER: Good. Thank you. One moment for a commercial interruption.

Can we take a five minute break and come back.

(WHEREUPON, a recess was held.)

DR. LERNER: Ladies and gentlemen, if I could get your attention. If I could have everybody's attention, I would like to call the meeting back to order.

I think that everybody has done a really good job, not only in thinking about and vetting the modified hybrid tiers one or two, options A and B, but laying out 20 some odd concerns, issues, concepts, thoughts that need to be considered as we go forward.

The modified hybrid is, in essence, a baseline, and we have taken more than 12 months to get to this baseline. We have heard from 21 different sites where we had public hearings, and we have heard a lot of

concerns from a lot of different people. It's ridiculous to go backwards, as someone said. We have moved the flag forward, and we need to continue to move forward.

There isn't a clear path, however, to get from point A to point B. As we are sitting here with 20 some odd concerns and a lot of material, and for those of you who did see my e-mail, even I after several reads find this to be very complex, and there's a lot of details to be considered.

We don't want people to draw lines in the sand. We have worked too hard to develop a high, medium and low consensus items. We have worked too hard to list 90 some odd shared interests several meetings ago where people have talked about what we are trying to accomplish.

And Jim Duffett has reminded us very clearly as we do at every meeting what our overall goal is, which is the charge that is before us from the Act.

Towards that end, I would like to suggest that this is the right time, potentially

with your concurrence, for the task force to consider adjourning and to have you allow your steering committee to meet to talk about two things. One, where do we go from here and how do we get there. Because you've made some really wonderful suggestions and we need to vent that. And two, as I mentioned before, we need to talk about how and where and why we need to go forward with a minority report if the minority report is part of the overall report and if there's some administrative details that need to go into that.

Now just to remind you, if you should agree that this would be the right time to adjourn, the steering committee is an open meeting, so anybody that wants to stay can certainly do that. We cannot not adjourn and continue down this path, if you would like. But it seems sensible to allow a small group to take under advisement some of your suggestions and to move forward with that.

MR. ROBBINS: I would move to adjourn.

MR. SMITH: Second.

MR. KOEHLER: Can I have a discussion

on that?

MR. ROBBINS: I think that's what happens after you make a motion and have a second.

MR. KOEHLER: No, I just wanted to ask one point while we are still in the meeting here because we had some suggestions about setting up some subgroups or whatever. In terms of the Open Meetings Act, can we do that and if so how.

MR. CARVALHO: Yes, I have collected a couple of questions that you have asked during the morning and afternoon.

You can have any number of you meet consistent with the Open Meetings Act. In other words, in an open meeting. So if you wanted a subcommittee focussing on topic A or B to meet with Navigant that's fine. Just so that we have to go through a posting, agenda, notice of minutes would have to be kept and the like.

Also, if a number of you less than a majority of the quorum, which a quorum is 15, so majority of the quorum is eight, so if any of you are not charged or committee or subcommittee or seven of you are not charged in

committee or subcommittee meet, as you may have been doing over the course of the year, that's fine too.

But I think you need to be solicitous of Navigant's time, too. You need to do something in an organized way. You have utilized having individuals just contacting Navigant with questions. So if you want to develop something consistent with the Open Meetings Act and look at specific questions, that can be done.

The other question was something about the cost to the state if nothing is done to change. I think what you're referring to is Section 10(F) of the Act. Asks for your report to include the projected cost to the State of the Illinois over the next 20 years if no changes are made in the present system of delivering and paying for long-term care services. I think you may be comparing that with that provision. There is nothing in Navigant's contract on this point. We are handling this in another way to get you that information but it wasn't through Navigant.

And then just miscellaneous information, yes, that family of four federal poverty, the level the feds come out with that every spring, and in 2006 the family of four was $20,000.

MS. MITROFF: That's 400 percent.

MR. CARVALHO: I'm sorry. 400 percent is $20,000.

And then I checked with the person who puts transcripts up on the web and the ones that aren't up there -- there are some up there now. And the ones that aren't there should be up there tomorrow. Just follow the navigation. Our front page has the task force to the link there and go to the -- where it says task force and you will see the links to your summaries, as well as your transcripts.

DR. LERNER: I have talked to Dave and Dave over the last few days. I personally am less concerned about timing and much more concerned about a good product out of this working group. And so if we have to extend ourselves yet another month to the extent that we have physical support for this or some other

way of doing it, then we should do that.

But I don't think we are that far away with coming up with an outstanding product. There's a lot of details that have to be dealt with. So I want to take the time frame issues out of the equation.

There's a motion on the table and it's been seconded. Any questions or comments?

DR. LUBIN-JOHNSON: I guess before we adjourn in terms of turning it over to the steering committee, a couple of questions and a concern about process that you all would entail.

I guess a thought of mine is, you know, what is a possibility and I would like to ask this question to the persons from Navigant and Mathematica of taking it into consideration all the comments that you have before you and tweaking the plan based on those comments.

Is that, you know, a realistic task for you? A lot of the comments are similar but is that realistic for you?

UNIDENTIFIED SPEAKER: I think that because some of them are so in direct conflict of each other, you know, that we -- that is kind

of how we get to these various options. So I think we need some better guidance as to what you want to seek. When there's two opposing sides, you really want to see all of that.

And I think the second issue is that some of these points identified the need for very significant additional detailed analysis, and then I have also heard comments and suggestions maybe that level of detail is too much. So certainly we need some additional clarification, I think, before we can move any further.

DR. LUBIN-JOHNSON: And my second comment would be that Dr. learner, yes, I'm in agreement with you that another month, you know, I don't think it's going to cost us anything but I would -- you know, not to mean to have any bias, but my State Senator is sitting on my left and I would go along with his sentiments that I would hope we could come out of this with something to produce in the not too distant future meaning --

DR. LERNER: I am right with you.

Jim said it appropriately. I

think we have moved the flag forward. I believe we are still moving the flag forward and we just have a little ways to go. But it's the hard yards.

Any other questions or comments? The motion and the second is on the table.

Hearing none, all those in favor please say aye.

RESPONSE: Aye.

DR. LERNER: Opposed, no. Abstentions.

(No response.)

DR. LERNER: We need about ten minutes to reorganize the room and then the steering committee will get back together. Thank you very much.

(WHICH WERE ALL THE PROCEEDINGS HAD IN THE ABOVE-ENTITLED MATTER.)

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

We, TONJA JENNINGS BOWMAN and DONNA T. WADLINGTON, Certified Shorthand Reporters, doing business in the County of Cook and State of Illinois, do hereby certify that we reported in machine shorthand the proceedings in the above entitled cause.

We further certify that the foregoing is a true and correct transcript of said proceedings as appears from the stenographic notes so taken and transcribed by us this 19th day of November, 2006.

_____

TONJA JENNINGS BOWMAN
C.S.R. No. 084-000299

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DONNA T. WADLINGTON
C.S.R. No. 084-002443