ADEQUATE HEALTH CARE TASK FORCE

WEDNESDAY, APRIL 26, 2006

MICHAEL A. BILANDIC BUILDING
160 NORTH LASALLE STREET
ROOM N502 -- 5TH FLOOR
CHICAGO, ILLINOIS

TRANSCRIPT OF PROCEEDINGS had in the above-entitled matter at 10:30 a.m. as reported by Victoria S. Sawyer, RPR, CSR.

PRESENT:

MR. BRENT ADAMS
DR. CRAIG BACKS, M.D.
MS. STEPHANI BECKER
MR. KENNETH BOYD
MS. CATHERINE BRESLER
MS. ELENA BUTKUS
MR. BRUCE CAMPBELL
MR. TIMOTHY M. CARRIGAN
MR. DAVID CARVALHO
MS. MARGARET A. DAVIS
MR. J. TERRY DOOLING
MR. JAMES A. DUFFETT
MS. RENNA GERBER
MS. JOY GETZENBERG
MS. JUDITH HAASIS
MR. JOSEPH HYLAK-REINHOLTZ
DR. ARTHUR G. JONES, M.D.
MR. MICHAEL JONES
MR. DAVID KOEHLER
MR. WAYNE LERNER
MS. MIRIAM LINK-MULLISON
MS. BETH LISBERG NAJBERG

DR. TIMOTHY LONG, M.D.
DR. NIVA LUBIN-JOHNSON, M.D.
MR. RANDALL MARK
MS. LAURA MICHALSKI
MS. PAMELA D. MITROFF
MR. JAMES M. MOORE
MS. TRACEY PRINTEN
MS. RUTH M. ROTHSTEIN
MR. RALPH SCHUBERT
MS. SHERRY SHERMAN
MR. KENNETH SMITHMIER
MS. MARGARET STAPLETON
DR. BABS WALDMAN, M.D.
DR. QUENTIN YOUNG, M.D.

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MR. WAYNE LERNER: My name is Wayne Lerner, and I have the honor of serving as the chairman of the Adequate Health Care Task Force. My day job is president of the Rehabilitation Institute of Chicago. To get us together and the first thing that we typically do is go around the room and introduce ourself. Please talk slowly and articulately so that our court reporter can get that information.

And also as a reminder, please turn off your phones, PDA's, and other electronic devices. Electronic defibrillators are okay as long as they're on vibrate so we can keep our attention to the presenters.

Elena?

MS. ELENA BUTKUS: Elena Butkus, Illinois Hospital Association.

MR. MICHAEL JONES: Mike Jones, Illinois Department of Public Health.

MS. SHERRY SHERMAN: Sherry

Sherman, Illinois Department of Public Health.

MR. JAMES M. MOORE: Jim Moore, OSF Health Care.

MS. TRACEY PRINTEN: Tracey Printen, Illinois State Medical Society.

DR. CRAIG BACKS, MD: Craig Backs, Illinois State Medical Society.

MR. JOSEPH HYLAK-REINHOLTZ: Joe Reinholtz, Department of Health and Family Services.

DR. TIMOTHY LONG, MD: Tim Long, Near North Side Health Services Corporation.

MR. RANDALL MARK: Randall Mark, Cook County Bureau of Health Services.

MS. JOY GETZENBERG: Joy Getzenberg, Chicago Department of Public Health (inaudible).

DR. QUENTIN YOUNG, MD: Quentin Young, physician for the National Program.

MR. DAVID KOEHLER: Dave Koehler,

(inaudible) Council.

MR. WAYNE LERNER: Wayne Lerner.

MR. DAVID CARVALHO: David Carvalho, Illinois Department of Public Health.

MS. JUDITH HAASIS: Judith Haasis, Community Health.

MS. LAURA MICHALSKI: Laura Michalski, Community Health.

DR. BABS WALDMAN, MD: Babs Waldman, Community Health.

MS. MARGARET DAVIS: Margaret Davis, Health Care Discretion of Illinois.

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

MR. KENNETH SMITHMIER: Ken Smithmier, Memorial Hospital.

MS. PAMELA D. MITROFF: Pam Mitroff, Mitroff Consulting.

MS. RUTH M. ROTHSTEIN: Ruth Rothstein, Chief, Cook County Bureau of Health Services, retired.

MR. J. TERRY DOOLING: Terry Dooling, CJ (inaudible) and Company.

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

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

DR. ARTHUR G. JONES, MD: Art Jones, Longer Christian Health Center.

MR. RALPH SCHUBERT: Ralph Schubert, Illinois Department of Human Services.

(Introductions were made of people who were seated outside the hearing capabilities of the court reporter.)

MR. WAYNE LERNER: I think that's everybody. Thank you very much. Also please remember to talk loud as we are not microphoned here today.

We have no approval of the meeting summary because we don't have

a meeting summary. Also I don't think we have a quorum so we couldn't vote anyway. But -- we do have a quorum now? It's irrelevant. This is Chicago. We could have taken a vote.

Now we'll do some public hearing briefings. I don't have my list with me. But Margaret, you're really the best person.

MS. MARGARET DAVIS: In Deerfield (inaudible). Clawndale Health (phonetic) is the major provider there. They're doing $12 million in charity care.

One person talked about having a heart episode. Didn't turn out to be a heart attack. But he talked about the fact that he had to make a decision whether or not to live or die because if he died his family would get $100,000 in life insurance. If he lived, he would be bankrupt because of the costs of insurance.

The Lake County Medical

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Society, Craig did not know about the metteslovski (phonetic) legislation. They wanted to hear more about that. They felt doctors were fleeing the area. However, with the new malpractice insurance legislation, it seems to be stabilizing. They want to track that to get a handle on it.

Peggy McDonald, she's an ethicist, a nurse and a nun. And it was very delightful to hear how she has gained trust of the supposedly wealthy people in the north area. And she found so much suffering in those mansions out there. Because of the downsizing, people have lost their insurance. They are going bankrupt. But yet they try to keep the airs of being upper middle class. And many of them are going on to divorce and having great foreclosures out in the north area. Corporate mergers have led to the elimination of health benefits to release people as well as

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pensioners.

Dr. Gregory Jacobs talked about a new bill that may pass, introduced by Senator Donne Trotter, Senate Bill 2799, which will broaden the scope of services of dental hygienists. These dental hygienists would then be able to into the schools and in the nursing homes. In the schools they can do dental sealants, and in the nursing home they can provide services and expand the dental opportunities in the State of Illinois.

MR. WAYNE LERNER: Anybody else from Deerfield want to make a comment? I was there, but Margaret already did the best job. Any questions?

What was the next hearing?

MS. MARGARET DAVIS: The next hearing was in McHenry the next day. Centegra Medical Center (phonetic) is the major provider out there, $36

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million in charity care. Mental health services is woefully inadequate, and it's a two-month waiting period. The change in the formula -- again, David, the people are having psychotic episodes because you just don't abruptly take people off their psychotic drugs simply because the University of Illinois has said that there's other drugs. You have to taper them.

And they raise the issue that whereas there may have been a cost savings on the pharmacy, you did not get it because the people have wound up in the hospital because of psychotic episodes.

They do not have the staff to do the medical form changes. I raised that. They don't have the staff to do it.

This is the first one that I got a chance to chair. I've been to 20. I haven't had a chance to chair.

I got a chance to chair that one, and I did it my way. I had a debate. I gave people extra time. I talked to them. I really had fun there.

MR. WAYNE LERNER: You want a new job? I've got one for you.

MS. MARGARET DAVIS: The Medicaid. This whole notion of when you are sick and down and you don't have any dependents, it's very hard to get on Medicaid. Even though you think you're disabled, they don't think you're disabled. And as a result there's a lot of suffering related to that. People need the lawyers, the disable lawyer people. They need them out there in McHenry County because they're getting turned down because the county is perceived as an upper class county. But there is great pockets of poverty there.

There is a farm community there. They are dying on the vine. They don't make a lot of money on

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farming. They're older people. And they have to pay individual insurance totally about $13,000 for themselves and their wives. And that doesn't give them enough money to live off of.

The free clinics are complaining that when they charge a sliding fee they then cannot go under the Good Samaritan Act. So they would like for us to look at changing or expanding the Good Samaritan Act because they're not getting a lot of money. But they get a little money, $5 or $10 for a visit. And that just wipes out the Good Samaritan clause and makes them prone for medical malpractice.

Then lastly, David knows about this. (inaudible) from the governor's office knows and (inaudible) from IUPH knows there was a heart wrenching testimony. This is where I think, Wayne, we've missed the

boat. I feel that if we care we should have had representatives from code agencies. Tim Gordon, he's the only one coming from insurance mostly. But there's not an interaction to solve immediate problems.

This last case -- I passed it out to most people -- was a mother who had a multiple dystrophy daughter. And this daughter has to have rehab every day. And public aid has not paid the rehab people for almost going into six months, and they're threatening to pull out. So this is a life or death situation. I told the mother in two weeks if you haven't heard from these agencies, give me A call. I'll get the legislature involved. I already talked to Tim. We're nurses. When we see immediate suffering, we try to get on it. Because these people will die for lack of services.

Thank you.

MR. WAYNE LERNER: Thank you, Margaret. Anybody else at that hearing?

MS. PAMELA D. MITROFF: I think Margaret's synopsis is excellent and on point. I think the one thing that I'm just amazed by when I attend these is how people are so appreciative that we come out there. And I guess it kind of worries me that there are a lot of expectations for what we're doing and that we'll be able to meet these expectations.

MR. WAYNE LERNER: Said another way, the problems are so pervasive that there's obviously not a simple answer to this. Yet everybody is hoping that we'll come up with one fell swoop.

Any other comments on this hearing? Is there another one? Collinsville?

MR. J. TERRY DOOLING: Jan Baker

was chair at the Collinsville meeting. She sent me an email and asked me to share some of her remarks.

There were about 300 people in attendance. It's kind of hard to estimate. It was a fairly fluid crowd. We had in excess of 40 presenters at that meeting. So Jan's points were health care dollars are being spent across the river, meaning St. Louis. Many health care people are now working across the river.

One of the doctors there testified and stated that one physician results in the employment of 58 additional people in the community and much of that has been lost in metro east. I think the counties of Madison and St. Claire, there's been an exodus of anywhere from 130 to 160 physicians in each county due to malpractice practice over the last three years. So the physicians are not there for the patients. The

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hospitals are hurting because of the lack of physicians. And ultimately the people are really having trouble finding access.

One neurosurgeon testified -- and there are no neurosurgeons south of Springfield basically except for a couple -- that he had worked with a group of two doctors and all of them covered basically two or three counties. He's currently -- he's currently working alone and covering 19 southern Illinois counties.

Very large outcry for universal single payer health care. United Congregations of Metro East were there in force. And nearly all their speakers were in favor of universal health care as were the United Steel Workers there in force. I believe the steel workers presented a petition with some 4800 signatures to the group endorsing single payer or universal health care.

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There were a couple public health care people there from county public health associations. And in doing their annual self assessments, I think they both said the last three years access to health care was the biggest problem they determined in their counties.

Doctors don't feel they are being paid for preventative care and feel that's a key part of any plan. And others testified that mental health should certainly be included in anything that we come up with.

I think that one of the most interesting pieces of testimony was a gentleman from St. Louis United Way. And he was a resource referral person. And his responsibilities was Metro East, I guess primarily Madison and St. Claire counties. He said he was running out of sources to refer to on the east side, and most of his referrals were having to go to

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St. Louis.

MR. JAMES A. DUFFETT: Just a couple other things to add. Out of the 16 hearings that I have gone to, I would have to say at least that was one of most moving ones of stories of death regarding access to health care. And we've heard those stories before. But there were several of them. And it was I just thought pretty intense.

Along with mental health, dental care of course continues to be out there.

And then I think there were at least three or four hospitals that testified that talked about just the increases of charity care and the diversity of people that they have seen getting that care today versus a year or two years or three years ago.

MR. DAVID KOEHLER: Steven Berger (phonetic) was the neurologist who spoke towards the end there. And he

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talked about -- I wrote this down -- that his staff has gone from two to 12 because of the paperwork. I think that's an important point to remember.

Also one of the stories. In fact, it was the very first woman that testified. Her name is Marcells Freeberg (phonetic). Talked about her parents had a restaurant in a small town there and a very good business. In fact, they started a second restaurant. And they ended up having both parents had heart disease. And any way, the short of the story was that it completely bankrupted them, and they lost all their business. They ended up having, I think, to go on Medicaid to be able to get care. So just the personal tragedy stories continue.

MR. WAYNE LERNER: Any comments or questions?

DR. QUENTIN YOUNG, MD: Thank

you. I want to congratulate you (inaudible). He observed problems were so pervasive that there's no simple answer. I think there is a simple answer.

MR. J. TERRY DOOLING: Senator Obama (inaudible).

MR. WAYNE LERNER: Thank you very much. Thanks, Quentin. I think I'll let that one go.

Any other comments before we go on? We should be getting pretty close, and I can't put my hands on a schedule. But we should be getting pretty close to finishing.

UNIDENTIFIED SPEAKER: One more. May 11.

MR. DAVID KOEHLER: Can we have a show of hands of how many people are going to attend that on May 11 from 4 to 7.

MR. WAYNE LERNER: We'll send another note around to task force members to find out who can make it.

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MR. DAVID KOEHLER: Thank you very much.

MR. WAYNE LERNER: Now let's move along. One other housekeeping. I just happened to notice that our reporting period is over. So if you haven't turned in your attendance sheet, please do so. Here's mine. Do you have yours?

The public hospital -- is Dr. Winship here? Thank you very much. Would you take it from here?

MR. DAVID CARVALHO: The theme for today is the public safety net. And safety net is a very widely used concept in medicine. I've seen physician owners of specialty heart hospitals refer to themselves as a safety net in the community. So I know that like everybody in the human profession refers to themselves as a safety net, and it's not a tug of war over the term.

But I think however anybody

uses the term you would have to recognize that the public safety net plays a special role in the safety net. Emtolla (phonetic), the emergency law, has sometimes been described as being akin to the line from Robert Frost's poem about that home is the place where if you have to go there they have to let you in. And I suppose that's true for all hospitals in emtolla. But the thing that's unique about the public safety net is this is their mission to let, to provide as many folks with care as their resources will allow.

And I think one of the themes that you will see in this morning's presentations is how frayed the public safety net is. We have -- and I suspect most of them will recoil at using the term, so I'll use it for them. We basically have a system that rations care in the public safety net to the extent of the resources

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available. So while the public safety net is there and extends a welcome to all, without resources there is, in fact, a rationing going on in the form of lines as well as virtual lines, three months, eight months, 12 months to get an appointment and the like.

Every proposal for addressing access to care for all residents of Illinois will undoubtedly have to take into account the public safety net in existence and historic role and how does it fit into a plan.

The Massachussetts plan that you read about and will be the topic of future materials as well as potential analysis took into account the special role that Boston and Cambridge and Summerville public safety net hospitals play in the fabric of care in Massachusetts. Even when there are discussions about single payer plans, there is a recognition of the public safety net,

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has a special role to play.

So we wanted to provide an opportunity for you to hear from all the different elements in social safety net. Some of you are part of a social safety net or have been and some of you have interacted with it. But I suspect until today I've not linked together all the different ways in which there is a public safety net. Sometimes working together; sometimes working just contemporaneously to provide a home for those who have no other home, no medical.

The first presentation is from the Cook County Bureau of Health Services. And many of you know Ms. Rothstein was the chief of the Bureau of Health Services, and I used to work at the Bureau of Health Services as well. We both survived. And although there's a line from the movie, On the Water Front: "The

living will envy the dead."

I don't know if those who remain, I think maybe those with left. But we have with us Mr. Randall Mark who is director of policy at the Cook County Bureau of Health Services. And Randy will present on the Cook County Bureau of Health Services. But also the broader role of public hospitals and public clinics.

It may come as a surprise to you, I believe there are over 40 public hospitals in the State of Illinois. Many of you probably do not know of other than Cook County Stroger Hospital and Oak Forest Hospital and (inaudible) Hospital in Cook, there are over 40 public hospitals in the state. And Randy will present on the topic of public hospitals.

MR. WAYNE LERNER: Randy, just before you get started. I need to apologize for what could be

interpreted as a snide comment to Quentin's comment. What I mentioned -- I didn't mean it that way. When I mentioned there's no silver bullet, I'm overwhelmed with not just the payment issues but the delivery system issues, the distribution of manpower issues, the transportation issues, the language issues, all the issues that go around needing to provide access to care. So Quentin please don't misinterpret my comment.

DR. QUENTIN YOUNG, MD: That helped a lot.

MR. WAYNE LERNER: Randy, will you take it from here?

MS. COURT REPORTER: Can we stop for a moment? I'm having a very hard time hearing. This is making a lot of noise over here.

MR. RANDALL MARK: Thank you. Good morning. Ruth, David, we miss you both. Come back any time.

There's lots to be done.
Mr. Chairman, members of the task force, my public health colleagues from the Illinois Department of Public Health, other attendees, thank you for inviting the Cook County Bureau of Health Services to present to you today.

Thank you for the diligence and hard work put forward by all of you and your staff over the last many months, policy goals set forth in the Health Care Justice Act represent the most worthy impulses of our citizenry and political representatives. We all are grateful to you for your service in seeking the methods and means to provide quality, affordable health care access for all Illinoisans.

I am here today representing Dr. Daniel Winship, Chief of the Cook County Bureau of Health Services. Dr. Winship unfortunately is out of town today. I know he's disappointed

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that he is not here to address you himself.

Let me quickly sketch out what we do at the Bureau. Many of you will already be familiar with much of what follows. But permit me to outline briefly the mission, the role, current organization, and activities of the Cook County Bureau of Health Services.

The Bureau is the premier safety net provider in the region and in the state. Our mission, to provide access to health care services for all residents regardless of their ability the pay, makes our role unique in the community. We carry on today an historic role -- as David referenced -- 150 years old during which Cook County has provided medical care to those who need it.

By many fold, the Bureau is the largest provider of services to the combined uninsured Medicaid

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populations in the State of Illinois. To cite only a few measures of the scope of our system's activities, we furnished patients with more than one million ambulatory visits last year, well more than 300,000 emergency room and urgent care visits. We dispensed 3.8 million prescriptions -- let me say that again. 3.8 million prescriptions. That is 70,000 some per week -- and provided more than five million procedures and tests.

In brief the Bureau is the third largest public system in the nation operated by a local government. The Bureau consists of three hospitals -- the Stroger Hospital, that's the tertiary of the new, still new hospital which Ruth, David, many of us devoted many years to get going and up and running. And benefits our staff and our patients enormously.

There are 26 clinics in the

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communities of our residents, some of them at schools. We provide public health services in suburban Cook County through the Cook County Department of Public Health, which does mainly preventative and education services as well as true public health function in communities which don't have their own public health department. We operate a nationally renowned -- we operated a nationally renowned specialty center for the care of persons with HIV and AIDS and related infectious diseases. Ruth M. Rothstein (inaudible). Additionally, we provide health care services for the detainees at the Cook County Jail in one of the country's largest health facilities -- correctional health facilities. In all approximately 400,000 persons were provided health services by the Bureau last year.

In addition, Bureau of Health actively partners cooperatively with

private and nonprofit health sector providers throughout the community. From Northwest Community Hospital in Palatine to Ingalls Hospital in South Chicago, the Bureau partners with 16 community hospitals across Cook County to more effectively render health care services for our clients and to productively leverage our own limited resources with those or our partners.

For more than 50 community clinics beyond our own clinic systems -- City of Chicago clinics, faith-based clinics, federally qualified health centers -- the Bureau partners provide patients with specialty care access. While community clinic capacity to provide primary care access thankfully has grown in the last decade or more, the constant demand for specialty care access for diagnostic like radiology exams and cardiac stress tests, for appointments with specialists and

subspecialist like ophthalmologists, dermatologists, and cardiologists, this demand overwhelms the community providers.

The Bureau stands virtually alone as the safety net linchpin in the provision of these specialty services to the uninsured. In recent years we have made access to specialty services available to community providers by means of an Internet-based referral system by which any affiliated clinic, physician, can request an orthopedic appointment on their PC in their office.

In terms of overall resources and financing, the Bureau budget exceeds $900 million annually. For the current budget year and for the last budget year the real resources available to the Bureau for service delivery through the County's annual appropriation has been flat in real dollars.

Our revenues, principally Medicaid revenues, have in recent years provided approximately 70 percent of our operating expenses. The counties subsidies providing the remainder. However, this year the Bureau has faced a $70 million decline in Medicaid money due to the continued phase-in of federal regulations regulative to upper payment limits. Next year, the final year of this phase-in, an additional $30 million of Medicaid revenues will be lost from that source.

At the same time through special intergovernmental financing arrangements between Cook County and the State of Illinois, literally hundreds of millions of additional dollars have been contributed to the state's Medicaid program for all providers that would not have otherwise been available. This year alone the state Medicaid program will

net more than $240 million for provision of health care services from the Cook County IGT program.

Moreover, because the Bureau of Health Services in the State of Illinois have over time forsaken DSH -- disproportionate share hospital -- payments to the Bureau, the largest provider of uncompensated care in Illinois, this supplemental financing derived from the ITG arrangements contributes heavily to funding the Bureau's costs of uncompensated care. And because Cook County, the state's largest safety net provider, does not draw on the state's limited DSH allocation, these funds specifically targeted providers for the care of the uninsured are more plentiful for all other DSH hospitals in the state.

I need not review the discouraging statistics concerning the growth of the numbers of uninsured for

this group. You already know that approximately two-thirds of the state's uninsured. About 1.2 million persons live in the metropolitan Chicago area. While I recognize the metropolitan area extends well beyond Cook County, I observe in passing that we have found increasing numbers of persons from beyond Cook County presenting for Cook County Bureau of Health emergency and outpatient services. One county health department in our area has been found to issue its patients directions to Stroger Hospital for clients who require follow-up apparently not available in that county.

Even a cursory examination of the trends in underinsurance over recent years quickly will reveal just how difficult an environment confronts those today who take on the mission of providing health care services to all these seeking care regardless of their

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ability to pay.

Like other safety net systems around the nation -- parenthetically, I think I have the number right, we work actively with the National Association of Public Hospitals. And they publish a figure that their members, the public hospitals, numbering 60 or 70 in the nation. And this membership provides 25 percent of the uncompensated care in the nation.

Like other safety net systems around the nation, many of them like the Bureau, operated by units of local government, we face increasing demands for primary care, specialty diagnostic and treatment services, increasing demand for emergency services, rapidly growing need for interpreter services, declining federal and state funding, work force shortages in nursing, pharmacy and technical areas, and difficulties in managing the growth of pharmacy costs.

In an age of ever escalating demand for services, continuing medical inflation, diminishing revenues from our primary revenue source, Medicaid, and virtually flat year to year appropriations from our board, the Cook County Board of Commissioners, the everyday challenges to operating a health system whose historical ethic is to serve all those who come in need indeed are daunting.

The failures of this nation's health care policies are manifested in Bureau of Health sites every day, in the persons queuing up seeking entry to our system through our clinics and emergency rooms. Day by day, hour by hour, difficult decisions are made as to the most urgent use of our limited resources. While we provide enormous volumes of care -- in my view, high quality, respectful care in almost all cases -- to the uninsured and others, clearly we cannot provide all that is

required even in our county.

So perhaps more than most the Cook County Bureau of Health Services wishes this group, your enterprise, success. Nothing would please us more than for the fruits of your efforts to lead to more timely access for care for all that would lessen the demand for services from Cook County.

Should you think we could contribute, we happily would work with your staff and your consultants on any analysis or review of recommendations. However, until that time when we reach a point of expanded access for the uninsured that we all desire, the Bureau asks each of you to support us. And we know many of you have. As I have reported, our Medicaid revenues, the financial linchpin of our system have been reduced and continue to be threatened.

Currently the administration

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in Washington has rule making in process that could, without legislative approval, eliminate all Medicaid supplemental financing for public hospitals such as ours. While we now feel the likelihood of success of these proposals may be lessened to some bipartisan congressional resistance, nonetheless the forecast expenditure reductions achieved by CMS from implementing these rules already have been scored in the federal budgeting process this year. Implementation of these rules would be catastrophic for the regional safety net, and likely as well, for the state Medicaid program.

Thanks for the opportunity to address you this morning on what is arguably the central social policy of our time. On behalf of Dr. Winship, and I might add on behalf of President's Stroger, a man who has devoted much of his life fighting for

the availability of health care for the poor, we thank you for your work and stand ready to work with you.

MR. WAYNE LERNER: Thank you, Mr. Mark. I just want to make a comment. Last week many of you joined me at a wonderful meeting at Blue Cross to look at the private sector options and plans and proposals before as input to our process. Today is a wonderful complement to that effort. And the task that we have before us is made even more daunting in terms of all the components of trying to solve this crisis and listening to not only the testimony at the public hearings but the people who are working in the guts, in this case the public sector. So I want to thank you for being here and express our appreciation for Dr. Winship and staff at the Cook County Bureau. We really do appreciate that.

Dave, did you have a comment?

MR. DAVID CARVALHO: Two things. First, we did ask each speaker to allow a couple minutes at the end of their presentation for questions so that you wouldn't have to wait until the very end if you had any questions on any one. So we have that time.

The other thing I wanted to mention in this context. I forgot I was going to in my introduction to Randy tell a story from the opening of the new County Hospital. And one of the events that Ruth had planned for the opening of the new hospital was an open house to the community. Alumni doctors had an open house and others had an open house. But there was an open house just for people of the community. And we heard a story from one of the guides who took folks from the community on the tour of the new County Hospital.

An elderly African-American man who at one point during the tour

said, well, this is all very nice, but where will I receive services?

And was told right here.

He said, no. These are all private rooms. Where will people like me who are uninsured receive services?

And again, he was told this is where. The disbelief was a combination -- for people who work on the project it was very poignant to recognize that this was going to be provided to a community that really didn't expect it. But on the other hand the expectation on his part that because he was poor and uninsured that he was and always would receive a second tier of care was really the most compelling story for me from that whole project.

So I guess it's just a reminder as we go forward the stratification that does exist and how much of that stratification are we

going to alleviate from the work product of what we do.

MR. WAYNE LERNER: Let me start off the questions. Next week several of us will be going to -- hopefully lots of us will be going to Washington for the annual American Hospital Association meeting lobbying Congress for some of the changes. Are you aware of whether that last issue that you reference is on the agenda for us to pick up the hospital association and will there be representatives from Cook County joining us in DC next week?

MR. RANDALL MARK: Latter point I'm not aware that there will be Cook County representatives next week. The first point I believe AHA is on board on this. The National Association of Public Hospitals has built an alliance with the children's hospitals and all the associations. The Illinois Hospital Association has been very

supportive on this. The Metropolitan Health Care Council has been very supportive on this.

And there is a -- there is a letter circulating that I think has April 28th as the final day for House members to sign on, a letter that in very strong terms opposes this rule making. And in Illinois I'm extremely happy to report that Ray LaHood has signed on to this.

MR. WAYNE LERNER: Right. Well, you can be assured that I, among others, will be taking up that along with the rest of our policy issues when we go to Washington.

MR. RANDALL MARK: Thank you. If I could, I'll send you some specific points.

MR. WAYNE LERNER: Please do.

DR. CRAIG BACKS, MD: Could you clarify exactly what it is that in the rule making process is creating this problem?

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MR. RANDALL MARK: The rule simply is, would limit public hospitals. It's targeted at only public hospitals to total Medicaid revenue no more than their costs of treating Medicaid patients.

MR. DAVID CARVALHO: Under the current system there are opportunities to subsidize public hospitals. That was what Randy described in the ITT and other upper payment limit programs. And that opportunity would be taken away, which would both diminish the revenues to Cook County Bureau of Health Services, but as importantly -- and this is why the hospital community as a whole is very active -- take away the benefits that are currently distributed to other hospitals and Medicare and Medicaid providers generally by virtue of the additional revenues brought in.

It was embedded in Randy's remarks, but perhaps bears repeating.

Because of the way the program is structured, not only does Cook County Hospital receive revenues in excess of costs to subsidize the uninsured, but the state receives revenues of $250 million a year, which would go away if this mechanism that's used to reimburse Cook County Bureau as well. It's been embedded in the system since it was created 14 years ago. All hospitals and Medicaid providers in this state benefit from that additional revenue the state retains from the program.

MR. WAYNE LERNER: It's really what I've described especially to my employee is it's just an example of the Robin Hood economy of health care where we just find ways to take from one source and subsidize the other. It's terribly unfair. But this is one where the hospital communities have come together for as long as I can remember to try and maximize the

revenue back to the state to benefit Cook County as well as other providers. And it becomes part of this complex fabric that we have to somehow figure out what we're going to do.

MS. MARGARET DAVIS: Thank you. It was a good presentation. Many years ago a delegation from Illinois we met with Donna Shalala about the ITT. And nothing ever happened to solve the problem, and now we're at a point where it may be eliminated. I would like to caution you that if we are able to solve uninsured problem, that you and your policy people begin to look at how the utilization of Cook County will be different given that other hospitals would now be able to take the uninsured. Because of some of the discussions that happened in New Orleans, the closing of security hospital and maybe eliminating funding for that. So we have to be proactive,

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and we would probably need to have you do a policy paper on that.

In McHenry County some of the representatives, the community says that many people -- and I'm not sure if that FQHC is in McHenry County -- but they say that people are told to go from McHenry to Cook County. And they felt it was unfair for McHenry to be sending their indigent to Cook County and not reimburse them. Do you have a mechanism to get reimbursement from other counties that are sending indigent people?

MR. RANDALL MARK: That's an excellent question. And in fact, we do not. It is an issue that over the last two years or so we have paid close attention to. And we have looked at the data closely. We have found the number of visits from persons from outside of Cook County. We've presume that this is the lowest, this is low ball estimate because many

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people who come from outside disguise the fact that they're from outside and may use a cousin or an aunt's address in town. We also have estimated the cost of delivering this care. And the costs are significant.

Now, we have not -- we were actually working in a process this past year working up to approaching the other counties. And President Stroger actually referenced this issue during the budget hearings a few months ago. So we have not approached the counties directly. However, the way we have tried to make use of what we have learned -- and I think it's been effective -- is we've gone into Washington into the congressional offices. We have shown Speaker Hastert's office that six or 7,000 ambulatory visits came from his district to Cook County. And around the horn. Actually Dupage is the biggest sender.

And we think this has helped us at least on the political side getting people to be more sensitive to our political needs in the collar counties, even on the red state side of the street. As and I said we were extremely -- not many people come from Peoria. We were extremely pleased to hear that Ray LaHood is supporting the letter.

So Margaret, it's a long answer. But I think this is coming soon. We have to devise a sensible approach for doing that.

MR. WAYNE LERNER: We have to move along in order to hit this time frame.

MR. RANDALL MARK: Thank you, Mark my pleasure.

MR. WAYNE LERNER: Hopefully the presenters can stick around so we can --

MR. DAVID CARVALHO: Also, to the extent that we slip a little bit on

time line, it just eats into the tail end of the meeting which is usually not as wholesome anyway.

So the next presentation regarding federally qualified health centers. Again, some of you are from federally qualified health centers and know exactly what they are. But the universe of primary care centers is not simply publicly owned or -- within the universe of community health center there is a sub-set of federally qualified health centers who are specifically charged and funded by the federal government to provide services through Medicaid and to the uninsured and frankly anybody who shows up.

So we have with us a representative from a community federal qualified health center, Dr. Timothy Long from Near North Side or Near North Health Center.

Dr. Long?

DR. TIMOTHY LONG: Good morning.

Thank you for kind of giving community health centers the opportunity to kind of explain ourselves. I hope that is our role of how we fit into the safety net in Illinois. And I would have to say before I even start any comments, we would not be able to provide the care we provide without Cook County Hospital and John Stroger Hospital and the Bureau. So it's very -- I just want to make that comment out there.

Community Health Centers are privately run organizations that fit into the safety net like many of us around the room. And I think some of the goals of my presentation today is really to just give a brief introduction to what community health centers do and how we can provide some care, but not all of the care, and how I think all of the people around the room are working together to come to this common goal of providing health care, whether that's insurance or not

insurance, but ultimately health care to improve the health and well being of people both in the Illinois and the United States.

So I'll briefly talk about community health centers. I'll talk about what our mission is which is probably very similar. I'm going to bring the mission from the organization that I'm representing here, Near North Health Service Corporations and specifically talk about some things in Near North Health Service Corporation. But the concepts from Near North are very similar to community health centers and federally qualified community health centers across both the State of Illinois and also the United States. Then what our vision is, our locations, what our programs are, what makes us unique as opposed to maybe some other organizations or maybe what we think why we're unique, and then some

facts.

Community health centers are local, nonprofit privately-owned community-owned health care providers serving low income and medically underserved communities. We are also known as Federally-Qualified Community Health Centers because we are primarily funded from the federal government. And some of our largest funding comes from the federal government under the 330 grants. We are located in areas where this is need, medical need. And our goal is to improve the access of care for millions of individuals regardless of their insurance status or their ability to pay.

Community health centers reduce health disparities, serving as medical homes and family physicians to over 15 million people nationally, a number that all of us is growing. Health center patients are among the

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nation's most vulnerable populations. People who even are insured who nonetheless remain isolated from traditional forms of medical care because of where they live, let's say, or who they are, what language they speak or their levels of complex health care needs.

46 million Americans, as all of us I think know, in this country are uninsured. 1.7 million in Illinois and approximately 800,000 in Chicago.

The mission for community health centers are very similar. We are run by a volunteer board of directors that is made up of users or health center users that come to our health centers for primary care health. And we exist to improve the health and well being of the people in communities we serve. We use primary care concepts, prevention of illness, and the promotion of healthy

lifestyles. And you'll see that in the programs that we operate. We focus on the medically underserved. And we will be sensitive to both the cultural and linguistic needs of the people that we serve.

In acknowledging that environmental, social, and especially cultural factors influence one's health, our program will empower individuals to be healthy through education, preventative health, and skill building. We will advocate for safe and healthy communities. This goes beyond kind of the traditional of just primary health care, but a sense of well being meaning safe communities, safe roads, safe air.

We will play a role in educating and training medical and health care professionals to assure the accomplishment of our objectives.

And obviously as I mentioned, the composition of our board is

representative of the communities that we serve. Again, over 51 percent from the volunteer board are users of our health centers.

Our vision of where we would like to be is recognized, as Cook County does also, as a premier community health center providing quality comprehensive health care to the medically underserved. We will strive to provide 100 percent access with 0 health disparity.

These are just four of Near North Health Service Corporations primary care locations. We have four other sites, a youth drop-in center at Cabrini Green. We have a senior citizen's building in CHA housing complex. And we have two nutrition and education programs on the west side.

But in our packets here, we have all of the federally-qualified community health centers across the

state. There are 254 locations across the state. All run by the same type of organizations providing the same type of services. And each community health center as a private nonprofit organization partners with places like Cook County Hospital. Like for Near North, we partner with Northwestern Memorial Hospital, Children's Memorial Hospital. And we work with other hospital systems to provide the care that we provide also. We're generally providing the primary preventative ambulatory care.

Our core services in community health services are pediatrics, women's health, both well women and OB/GYN, internal medicine. Those are our primary services. We also have podiatry, ophthalmology, mental health, oral health, radiology, on-site lab, medication dispensary. All of these are on site.

And then as we believe health

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care is more than just health, it is the sense of well being, we have complementary or comprehensive services including social work with licensed clinical social workers, domestic violence counseling, on-site subsidies treatment, family support services and case management -- which I think we're going to be hearing about some more -- maternal child health programs. As we get funding from many people around the room, I wanted to make sure that we thank them. Our HIV AIDs program, many of the community health centers have Title II and Title III Ryan White funding.

Youth programs, we have a youth initiative program that has a team clinic and also youth after school drop-in center in Cabrini Green. We believe that health care and healthy lifestyles starts during adolescents. We need to teach our

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adolescents how to live a healthier lifestyle.

Post-partum depression, perinatal depression, mother and children's programs. We are hugely involved and invested in nutrition and wellness. We have cooking classes, we invite chefs. We have WIC. We have a very large WIC program. Many community health centers across the state have WIC programs.

What we believe as a community health centers that makes us unique is that we try and find innovative ways to work with both public and private health care institutions to integrate our services. One example is the Alliance of Chicago Community Health Center with four primary health care organizations in Chicago. Howard Brown, Erie Family Health Center, and Heartland Health Alliance along with Near North has formed a company to

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implement an electronic health record system not only to provide electronic health records, but also as a data repository so that we can do quality improvement projects on the data of all of our patients across all of these community health centers. And hopefully, as we all know health information technology is here, it's going to expand, we must make sure that we're moving from the paper to the electronic record. This is one way that makes community health centers unique.

We also, like many others around the room, have patient transportation. Patient advocacy. We are very involved in men's health. And we have a city-wide men's health program, which I'd like to make a plug for, is in June. Hopefully people will be hearing some more about that.

Our depression programs, we have hospital visitation programs

where our case managers and maternal child health individuals will go to the hospital along with the physician, discuss breast-feeding, discuss perinatal depression, make sure they have an appointment scheduled with their doctor for their newborn follow-up and also their six-week post-partum follow-up.

We have on site patient resource and education rooms which we use our computer-assisted learning where our patient advocates will help train our patients to do online searches to learn more about health information that their doctor has just talked to them about across the hall.

We have Wellness Works Program as I mentioned, which is an individual and group nutrition and exercise programs. Obviously we have smoking cessation programs, which has been known to work. Maternal and child health distribution programs,

breast-feeding rooms, grocery stores, substance abuse. Acupuncture is something that we are doing three days a week. We have found in our subsidy treatment program, but we have also no opened it up as evidence-based research has shown that it works on chronic pain for knee, osteoarthritis.

And most community health centers across the country, and specifically many in Chicago and Illinois, are involved in a person funded or sponsored National Health Disparities Collaborative, which started with diabetes in 1999 and moved on to cardiovascular, depression, and asthma. And also integrative health care.

These are some brief facts just about Near North, but they might be representative of other community health centers across the state. We see 83 -- in fiscal year '05 we saw

83,000 medical visits, probably another 15 to 20,000 nonmedical visits.

Our funding comes from a number of different sources. And we need to make sure that those funding streams, like every other place, continue. And I agree with the comment, we can cut money some place and give it somewhere else, but it's all going to provide health care for whoever is providing it. We need to be conscious of where money is being cut and where money is going. 38 percent of our funding comes from federal, 19 from state, 4 from city. Thank you. 12 from corporations, United Way and other foundations, and 26 percent from patient fees.

We do ask patients to contribute on a sliding fee scale. We will still see them if they do not have the ability to pay. But we believe that patients should pay

something for their health care. They respect it more if they pay $1, $15, $20. And 36 percent of our patients have Medicaid, 9 percent Medicare, and 55 percent are unsponsored or under the grant that they have no third party payer.

This is coming from community health centers from the Illinois Primary Health Care Association, which has asked me to be here today, with all of these health centers across the state. We see as a group of 254 community health centers across the state 900,000 patients in fiscal year '05. 3.3 million medical encounters. 319,000 uninsured patients were served. 372,000 Medicaid, 51,000 Medicare. And then most of these patients are below the poverty level, and ethnic breakdown is there.

The funding, again, for community health centers in general is pretty representative of what we see

at our community health center, Near North. 44 percent coming from grants, 39 from Medicaid, 8 from private insurance, 4 from Medicare. Federal funding as we may know, federal funding has failed to keep pace with the cost of the uninsured, costing about $462 a year where federal funding is paying about 270.

The 330 grant from HRSA is the only designated source of revenue specifically for the care to the uninsured for us as community health centers. And Illinois community health centers have doubled the amount of charity defined as sliding fee care and bad debt. Provided to patients at a time when the amount of free care is going down in some other, made private groups. In Illinois, community health centers as a group have provided 97 million in charity care.

These are some statistics which probably are very similar to

county, the city, and other places. We have seen 104 percent growth in our total patients since 2000. 117 percent growth in patients under the 200 percent poverty level. 107 percent growth in uninsured patients. And a 98 percent growth in Medicaid patients. And specifically as our aging population, we are seeing more chronic decease. We are needing to manage chronic disease better. We have seen 152 percent growth in patients with diabetes. 181 percent growth in patients will hypertension. 119 percent increase in patients with asthma and 171 percent increase in patients with HIV.

So community health centers and the safety net work together to provide primary medical care to the underserved. We are, again, private, nonprofit primary care providers serving the poor, uninsured, low income, elderly, and the medically

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underserved. We partner and must partner with both our hospital partners, both private and public. This is a private-public partnership that we're doing here.

We're striving for cost effectiveness. We watch every penny, like probably many other organizations. And we feel we do a pretty good job of that.

We also attempt to improve access to primary and preventive health care through the 254 primary health care sites located across Illinois.

Accountability is something that we're very strong on. We meet strict uniform national standards. Many of the community health centers are joint commission accredited both on ambulatory care and behavior health care, like Near North.

We are into the development of the economy in the communities that

we serve, our local economy. And we have injected as community health centers across Illinois 332 million in operating expenses into Illinois communities and directly employ 4,250 individuals.

One thing that is very important to community health centers is the reduction of health disparities. The bottom line I think for community health centers in the safety net is that we are a vital and integral part of the health care delivery system of the safety net in the United States with capacity to grow and meet the challenges of the uninsured.

MR. WAYNE LERNER: I want to thank Dr. Long. I left off with Dr. Johnson and Dr. (inaudible) if you want to start out with a question.

DR. NIVA LUBIN-JOHNSON, MD: No. If I could still question Randy.

MR. WAYNE LERNER: Let me wait

just a little bit on that.

DR. NIVA LUBIN-JOHNSON, MD: This is a statistic. If he has it, maybe he can give it to us. Is the percentage of those that Cook County serves that are not from Cook County. I think that would be very helpful information for us.

MR. WAYNE LERNER: Did you hear that, Randy?

MR. RANDALL MARK: I did. Last year there were approximately 45 or 50,000 ambulatory visits from outside Cook County. That's out of a total of -- I could get you something.

DR. NIVA LUBIN-JOHNSON, MD: About 5 percent reporting.

MR. WAYNE LERNER: Thank you. David?

MR. DAVID CARVALHO: I serve on the board at the Heartland Clinic, which is a FQHC. Talk a little bit about the uniqueness of Medicaid patients and how they are figured into

the mix. That kind of surprised me when -- we just made the transfer from free clinic to FQHC about three years ago.

DR. TIMOTHY LONG, MD: Community health centers have been afforded flat fee reimbursement rate to community health centers for our Medicaid patients. And that allows us to supplement some of the other free care that we provide that is uncompensated. So our pair mix is very balanced in the sense that the percent of patients with Medicare and Medicaid and basically no third-party payer is very important.

I do not believe that we would be able to serve all Medicaid because our mission is to see people who do not have insurance. And our Medicaid patients are our wealthiest patients.

MR. DAVID KOEHLER: I just want to make the point that we watch this

every month from the board's perspective because that percentage mixture, because we have similar kinds of percentages. If we don't get Medicaid, we don't have enough revenue to spread out to the uninsured population. And it's one of the reasons why FQHC's can make (inaudible) and others. Our hospitals have had clinics where it's an extra burden because you don't have that accelerated rate whereas FQHC's have that built in. Part of the process I thought the group should be aware of that. That this is a very different kind of strategy that FQHC's can do this because of how the rules are changed for them whereas other groups can not. It's just part of the mix. You have to have that mix. So they already are counting on the fact that you're going to attract some of the Medicaid patients to help spread that cost to the uninsured.

MR. WAYNE LERNER: Ken Smithmier?

MR. KENNETH SMITHMIER: No.

MR. WAYNE LERNER: Margaret?

MS. MARGARET DAVIS: Two things. How do you address the malpractice for your physicians? And then also why are men who are uninsured not marketed to by the FQHC's when there is so much need?

DR. TIMOTHY LONG, MD: First, under malpractice as federally qualified health centers, all employees and physicians and providers are covered under the Federal Torts Claims Act. The federal government picks up the malpractice. That is a huge benefit to community health centers. And we acknowledge that benefit.

Secondly, men's health. We at least at Near North feel that although we appreciate all the money coming for maternal child health programs, men are left out. And men

are in this age group that are not provided primary preventative health care. That is one reason why we promote Men's Health Week, an annual week every year in June leading up to Fathers Day where we target men around the Chicagoland area to come and get free screening for diabetes, hypertension, substance abuse screening, and link them into treatment at any community health center or other partners anywhere. The purpose of that one week is to highlight the need for men because there is very little, if any, funding to target men who have health care needs.

MR. WAYNE LERNER: I want to thank Dr. Long for the presentation. And just as we move to the next one, I want talk off line. I didn't see rehab up on your list. Diabetes care and some others, that's the linkage to disabled population or those who will

become disabled. So we thank you very much.

MR. DAVID CARVALHO: Our next category as I mentioned, not all clinics are FQHC's. As Dr. Long and Lerner mentioned there are some special forms of reimbursement provided for FQHC's to help fund their mission, both in terms of cost-based reimbursement for Medicaid and 330 grants. But if you hear how challenging it is even with that to provide for the mission of FQHC, you can imagine how challenging it is to fund clinics who receive no such special reimbursement. And so we have with us executive director from a free clinic, Community Health, on the near west side.

MS. JUDITH HAASIS: I'm passing around additional copies of my presentation. What is different about what you'll receive here is that there is a map attached to the back of it

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that gives you a sense of where the free clinics are in the State of Illinois.

Good morning. My name is Judith Haasis, and I'm the executive director of Community Health, the largest free clinic in Illinois and one of the largest free clinics in the country. I appreciate the opportunity to be here today. And I also want to introduce Dr. Babs Waldman on my right, who is our volunteer medical director and a member of our board of directors, and Laura Michalski, the director of clinical relations at Community Health who also serves as the president of the Illinois State Free Clinic Association, which represents 32 free clinics throughout state providing services to approximately 35,000 uninsured individuals.

I have been asked to provide an overview of the role of free

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clinics in Illinois' health care system. I truly appreciate this opportunity because it provides an important forum to acknowledge both the long tradition of community based services represented by free clinics nationwide and the significant impact that free clinics continue to have on meeting the needs of our most vulnerable residents.

Over the last 20 years, Illinois' free clinics have been working in collaboration with other safety net providers to offer critical services and medications for the uninsured and underserved. According to our most recent data, there are 32 health care providers that identify themselves as free clinics in Illinois. Ten are located here in Chicago and the remainder are located throughout the metropolitan area and downstate. These numbers do not, of course, include the federally

qualified health centers that Tim Long just referenced, the city and county public health clinics, public hospitals and their associated clinics.

What makes a health care provider a free clinic? A generally accepted definition developed by Illinois Free Clinic Association identifies a free clinic as meeting the follows six criteria:

First, the organization's primary mission is to provide health care services for free or at a very nominal administrative -- with a nominal administrative fee to individuals with limited resources. In the case of Community Health, all of our services are free. No fee is ever charged for any provider visit, whether it be rendered by a physician or a nurse. No costs is involved for all of our lab work or any of our medications.

Second, the clinic is staffed primarily or exclusively by professional and nonprofessional volunteers like Dr. Waldman. At Community Health, we have more than 500 volunteers including more than 110 physicians who donate their time and talents so that our health center doors stay open six days a week including four evenings.

Third criteria, at least 51 percent of patients we serve have no forms of insurance whatsoever. At Community Health, 100 percent of our patients are uninsured.

Fourth, the organization in order to be a free clinic is either an independent 501(c)(3) or is a program of a larger 501(c)(3) non-profit corporation.

Fifth, consistent with the mission of free clinics there is overriding commitment to minimizing barriers to care and to providing

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quality service.

Sixth, there is a diverse base of financial support from individuals, corporations, churches, foundations and government, though no more than 50 percent of our annual revenues can be derived from federal grants in order to be classified as a free clinic. At Community Health, over 90 percent of our revenues comes from private sources with a grant from the CDC being our only current source of government support, which is targeting our expanded ability to render chronic care management to the growing complexity of needs meeting the uninsured, meaning effectively uninsured patients won't be too arduous.

More generally stated, we can say the free clinics are private non-profit community based organizations that provide medical, dental, pharmaceutical, and/or mental

health services at little or no cost to low income, uninsured, underserved individuals. We accomplish this through the dedication of volunteer health care professionals and community volunteers along with partnerships with other health care providers. In-kind donations of goods and services are key, and funding is generally raised at a local level with little, if any, government support.

While 32 providers in Illinois have identified themselves as free clinics, it is frankly difficult to speak with certainty about the overall numbers of free clinics across our state. This is due in great part to the grass roots origin of most of our clinics and the fact that we simply don't have the resources across the board to respond to surveys that would help us better understand the breadth and scope of the services we offer.

With that said the National Association of Free Clinics, of which Community Health is a member, estimates that there are more than 2,000 free clinics nationwide. A 2004 report by the National Health Policy Forum estimates the free clinics serve more than 3.5 million uninsured individuals annually. Clearly, free clinics are a critical part of the safety net with a mission and a patient population that unites us, keeping us focused and vigilant.

But for all of our similarities, so too there are many differences. For those of you who have had the opportunity to visit a free clinic, you'll appreciate what we mean when my colleagues and I say when you have visited one free clinic, you visited one free clinic. For you see, we are a diverse group of health care providers with different models of service delivering different services,

an important distinction that differentiate us from one another as well as from other safety net providers, like FQHC's, which for example, have a sliding fee scale.

For example, while all free clinics benefit from the service of volunteer physicians and other health care providers, some of us also have paid nurse and mid-level clinicians on staff. While most free clinics are community-based, some our hospital-based and rely on those hospitals to provide volunteers and other related services. While the majority of free clinics participate in some type of referral from area hospitals, others rely on less formal relationships with local departments of public health.

For Community Health, and as Tim mentioned, we rely heavily on the Cook County Bureau of Health Services including Stroger Hospital of course. But we also have extraordinary

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partnerships with hospitals like Northwestern, Rush, Lutheran General, and Saint Joseph.

While primary care is available at most clinics, at most free clinics, on-site specialty care is also provided by many of us distinguishing us in an important way from federally qualified health centers and other safety net providers. For example, Community Health, again thanks to the volunteer services of our physicians, offer the widest range of specialty care among all of Illinois free clinics. With 15 specialty services available this year on site ranging from cardiology and gastroenterology to ophthalmology and psychiatry.

While uninsured and underinsured individuals represent the target population of free clinics, income eligibility varies ranging from 125 percent to 250 percent of the

federal poverty line, which is the level we have at Community Health. In some situations only patients from designated geographic locations are eligible fore care, while others like Community Health have no such restrictions.

In 2005, an estimated 35,000 unduplicated patients in more than 100,000 patient visits were served by free clinics in Illinois. This reflects consistent annual growth in the number of patients served, even while 45 percent of our free clinics including Community Health had to suspend intakes of new patients at some point last year because, simply put, our waiting rooms were overflowing. As of today, only 60 percent of these clinics have been able to reopen their doors to new patients.

This reality highlights two compelling truths. First, individuals

and families continue to seek out free clinics because they trust the quality care we provide and the cultural sensitivity reflected at our health centers. They appreciate the elimination of barriers, whether it even be a sliding fee scale or something like location that are presented in other settings that too often prevent patients from following through.

And second, while free clinics continue to try to expand our services, programs, and overall capacities, we can only push the envelope so far. Because even if we had a free clinic or another safety net provider located in every underserved neighborhood here in Chicago or in every county throughout the state, we still could not assure every resident what we believe to be their fundamental right: Ready access to quality, affordable and

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comprehensive health care.

In closing, Illinois free clinics represent an important, but limited, response to the needs of 1.8 million uninsured residents for whom a fragmented non-system of health provides no real answers. As free clinics continue our work, we recognize that short-term partial solutions will not serve the long-term interests of our uninsured and underserved residents who deserve more than any safety net can provide. We need nothing less than a comprehensive and sustainable universal health care program to build upon the public-private partnerships that have helped sustain free clinics and other safety net providers over the years.

The Illinois free clinics stand ready to assist the Adequate Health Care Task Force as you move forward to the development of recommendations to the state

legislature. We applaud your efforts. And thank you for the opportunity to meet with you today.

MR. WAYNE LERNER: Thank you so much.

Quentin?

DR. QUENTIN YOUNG, MD: For all of the presenters, the issue of overwhelming by demand (inaudible).

MS. COURT REPORTER: I'm sorry. I can't -- one moment.

Can we turn this off?

UNIDENTIFIED SPEAKER: No.

MS. COURT REPORTER: I'm really having a very hard time hearing.

DR. QUENTIN YOUNG, MD: I was going to ask them to the comment on for our enlightenment because we have to made recommendations, the extent to which resources are being overwhelmed. I was particularly (inaudible) hear the county and all its problems still has the support of (inaudible) and your discussion about

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how you have had to close doors. How much of that is a realty? Put another way, where are we at? Have we saturated our ability to help? Have we fallen behind in our resources?

MR. WAYNE LERNER: Who are you asking that question to?

DR. QUENTIN YOUNG, MD: The two presenters.

MS. JUDITH HAASIS: I'm going to ask Dr. Waldman and Laura to also chime in. There's no question, Quentin. We are overwhelmed. We're seeing an increasing number of uninsured residents walking through our doors with increasing complex medical needs. By that I mean that there are more individuals we're serving with at least one chronic illness. And we're estimating that at least 40 percent of our patient population have at least one chronic illness.

The more time and the more

resources are demanded by physicians like Dr. Waldman in meeting the needs of every individual walking in our door. Because our pie is not continuing to always expand in terms of resources, the number of appointments, the number of visits, the number of hours we're open is limited. And therefore, our ability to continue to welcome on average the 125 new patients who come in our doors every month is becoming increasingly difficult.

We are so reliant upon Cook County Bureau and specifically the resources of the hospital and related clinics for our referrals. And just yesterday I think we received official notification that for a patient receiving an x-ray today, we may not even see a report of that x-ray for more than one year. And without an x-ray, we are unable to refer many of our patients for other extraordinarily

important diagnostic services that are available. This is just one of many challenges being faced by an overwhelmed safety net system that is led in so many important ways by the Cook County Bureau.

DR. BABS WALDMAN, MD: There is the issue of quality and the issue of quantity. I mean, we can see so many people, but the issue is -- when quality starts shrinking down, when you give primary care, it's not just the (inaudible) and services. This is where I think we're seeing the biggest difficulty. I think it's difficult.

Plus, what we have put together is a patch work. It is definitely a safety net. It's just a patch work of a little from here and a little from there. We're scrambling to be creative. This quite frankly is not the way it should be done. And I think that's where the issue of numbers isn't so much the numbers,

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it's what we're doing.

DR. CRAIG BACKS, MD: Just a couple comments about what both of you did not mention was the Free Clinic Act and how it creates a higher standard of demonstrated injury improved for physicians who are seeing patients in free clinics and being sued for negligence. And that now extends now only to patient -- physicians seeing patients in the free clinic but also to physicians seeing patients referred from a free clinic. One of the problems that Dave's comment about the transition from Heartland to an FQHC (inaudible) of what happened in Springfield, when we transitioned from Health First Community Clinic to now (inaudible) Community Clinic, which is a FQHC, we now more difficulty getting specialty care for individuals referred from the FQHC because there is no immunity if you will. It's not truly immunity,

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but a higher standard of demand of proof of negligence of willful and wanton negligence. And so while primary care is actually improved, our access to primary care and access to specialty care has not improved and it's actually suffered somewhat because specialty physicians feel that it's not really -- it's just not a sense of fairness about the issue. And it's unleveled the playing field if you will.

Second point I want to make, and I don't think comment on this as you transitioned. We actually met with resistance from many of the physicians who were on our board and who were involved in delivering care, and myself included had some reservations, as we use our free clinic as a sort of crystallizing center to attract for FQHC. It had to do basically with it took it out of the realm of giving back to the

community and charity and giving to those in need and turning it into a government program. And from that, something really was lost in the community.

And I just bring that up, not so much to make a statement for or against one delivery of care, but there was something special about the involvement of the community in a free clinic and getting it together. We had builders who donated time to do renovations. We had pharmacists and nurses and hospitals donated services for lab and x-ray. Everybody really pulled together on this thing. And it's gone now. And we have something else in its place, and it's better in some way, but we did lose some things.

MR. DAVID KOEHLER: We were well aware of that fact, so I think we managed it pretty well. Our hospital community led by Saint Francis has been excellent in supporting this both

financially and with patients. But that was an issue because you do from a different kind of status within the community to a government funded program.

But the issue that we were faced with to understand is we had no more capacity. As a free clinic we were already maxed out. We had a waiting list of people. That demand was there, but we had no ability to grow with that. For us -- and we saw our resources diminishing in being able to help support that. We either had to go out of business or convert. We had no choice.

DR. CRAIG BACKS, MD: And Health First was facing some of the same issues.

MR. WAYNE LERNER: I mention the more we talk about it, obviously you guys are doing great work. Thank you.

MR. DAVID CARVALHO: One of things

that I think that you can see from this morning is perhaps instead of the metaphor of the safety net that sometimes we refer to a safety bridge, that from sickness to wellness. And that bridge -- one of the metaphors we use was that bridge over that river unfortunately not only has potholes and sometime very narrow lanes, but sometimes there's just whole sections of the bridge that don't exist. And the one that's been highlighted this morning is specialty care. There are primary care FQHC's, primary care free clinics, tertiary care at public hospitals as well as specialty care in the public hospital. But nothing out there on specialty care. It's a big gap. Nobody really subsidizes specialty care except a few charitable contributions of their time.

The transition now from local health departments regardless of whether everyone were insured, there's

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still a role, still be a role for local public health departments both in the traditional public health but the population based services. But everyone isn't insured. So if local public health departments have also stepped into those gaps to play the new traditional roles that they play.

And we have with us representing both the large urban and a smaller downstate health department Joy Getzenberg as many of you know from the Chicago Department of Public Health. And on the phone Miriam Link-Mullison, the director of the Jackson County Health Department.

Miriam, are you on the phone? She was on the phone. You all tell her I said very nice things about her.

MS. MIRIAM LINK-MULLISON: I'm on the phone now. I had muted myself.

MR. DAVID CARVALHO: Thank you, Miriam and Joy.

MS. JOY GETZENBERG: I think I'm

listed first on the agenda.

Thank you, David. Thank you, Mr. Chairman and other members of the task force for inviting me to speak today.

Our role in this safety net includes service provisions and other functions as well consistent with being a large urban health department. Currently we offer neighborhood (inaudible) health centers and two maternal and child health centers. Our primary care sufficiently (inaudible) designated FQHC lookalikes. Unlike Near North and others, we are lookalike, meaning we get the Medicaid cost base reimbursement, but we don't get a grant. And we are somewhat unusual at the local health department in Illinois to be an FQHC. There are a couple of others. In this part of the state, Will and -- Will and Lake. And McCoopin (phonetic) it's not there

yet, but it's moving -- it's moving in that direction.

We also provide more traditional public health services such as (inaudible) management, public health nurses, WIC, and other services as well. We also offer specialty medical care in the areas of STD, HIV and tuberculosis. We also very, very unusual, we are a very large mental health service provider, operating 13 mental health centers that are funded by the state as well as city dollars, which is very unusual for a local health department.

We also have for many years been engaged in policy and legislative activities around access in care issues. In 1997 we created a managed care help line. In 2001 we embarked on a health planning initiative to more systemically monitor the health care system.

The project, I'm going to

present you some data from that. So I'm really going to be doing two things. One is to show you what we have done in terms of safety net issues and our role in assurance and assessment, which is a public health function, and also as a direct provider of services. The data that I'm going to present to you from this report, I have the web site there. There's a wealth of data. If you don't know about it. I will only briefly touch on this data given the time. I recommend and welcome you to look at that.

The objectives of the project is to -- it draws on multiple data sources to track and report on Chicago's local health care system and aims to provide communities, providers, funders, and policy makers with information needed to help focus their efforts to increase access to care. So I hope it is valuable to

this task force.

One of the main tasks of this project is the look at the capacity and utilization of primary care safety net providers who we're talking about today. And while other providers, namely hospitals and others provide a significant portion of safety net care, we have for this purpose defined primary care safety nets as clinics that are community based and share our mission to care for the underserved. And I thought that you all might find some of these useful.

Just to make a note that within this study the publicly operated clinic includes both CDPH and the Cook County primary care sites that Randy had mentioned earlier.

The following slides are going to compare the availability of safety net providers in 1990 and 2002 and look at both capacity and utilization. This is a map of the

sites that we're operating in 1990. And that date was taken, for those of you who have been around tables like this for as long as I have, this was post health care summit taking a look at what we had at that time. And this is 20 sites operated by either the city or county, 20 community health centers and one free clinic at that time.

This is what the system looks like in 2002. You can see there are lots more dots. 18 publicly operated sites, 56 community health centers, and 7 free clinics. And just for effect, you can see them both at the same time. And you can see that there has certainly been a proliferation of sites. In fact, sites have nearly doubled.

Again, this is Chicago only data. And this shows by region of the city. And you can see that there's great variation within the regions of

the city. And I'm not going to be able to really spend any time on that today, but just so you know that that is something that we found.

And while you can see that the capacity has increased significantly, we certainly haven't drawn any conclusions that there's adequate access for all Chicagoans to primary care. But I think it is important for you to see the growth.

And in addition to the great variation you see within the region, we know that there are other significant barriers that we have been hearing about firsthand in terms of language, cultural, and other barriers.

Visitors by provider type. You can get a sense from the folks you have been hearing today that the community health centers according to our definitions that we are using are by far the largest provider, almost

providing 70 percent of the one million or so visits that we're looking at here. 30 percent by county and city, and a little less than 1 percent free clinics.

The next slide shows patient payer source by provider type. And I did notice some discrepancy between some of these figures and what was reported by Dr. Long earlier. It could be because this was a different year. It could be because of how things are counted. But I don't think there's really any question that the public -- that the public providers, namely Department of Public Health and Cook County Bureau, see a disproportionately higher share of self-pay, i.e. uninsured, and community health centers see a disproportionately higher share of Medicaid patients. I think this demonstrates the unique role that both the county and the city play in the

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safety net for totally (inaudible).

For all providers this varies greatly. Of course, as I'm sure you all know, pregnant women are highly insured right now in terms of Medicaid. Children are much higher. The problem as our free clinic colleagues can attest really has to do with the adult population that tends not to be insured. So there's great variation. But this is what we saw in the aggregate when we looked at all safety net providers in 2002 in Chicago.

I wanted to just give you a couple of data now moving, shifting to the Chicago Department of Health as a provider. And these data are for 2005. And again, to remind you that this does not include our STD, HIV, tuberculosis, nor our 13 mental health clinics. Our patients, not surprisingly given the demographics of a low income population, in Chicago

nearly half of our patients are Hispanic, 41 percent are African-Americans. And as you would expect, this would vary greatly depending on the site we're located in. Different communities in the City -- and I don't know if we're still the most segregated city in the country -- but you can imagine there's great variation there.

By percent of poverty -- and it's outstanding to me in some way but not really -- that more than three-quarters of our patients are below the poverty level. These are very, very poor people. And I think that also shows that public provider for whatever reason are considered to be the provider of last resort. And you see the poorest of the poor and the most uninsured people come to our clinic as well as Cook County.

The last slide just shows our total visits for '05. Again,

variations. Some our clinics are smaller, some are larger, some are more comprehensive than others. The total visits with 150,000 or so being what we consider a comprehensive primary visit. This shows the visits by site.

And I think what I'm going -- I'm going to thank Dave for his introduction because a lot of the data that you've seen today doesn't really get into the challenge of what happens once a patient gets into primary care. As the primary care capacity has significantly increased, the goals in the safety net for specialty inpatient and outpatient care have grown even larger.

We are almost -- like the free clinics, like a lot of the community health centers, we are almost totally reliant on county for anything beyond what we do in our primary care clinics. We have

partnerships with hospitals who provide OB with us and partner with other services, but when it's an uninsured population that needs to see a specialist, needs some diagnostic work up, needs inpatient hospitalization, it's very, very difficult for hospitals to be in a position to help us out. So we are, like the other speakers today, totally reliant on county for things beyond primary care.

And I think that I'm glad that Dave highlighted that in his remarks. And I'm sure that you have heard a lot about that. But as you can see from our data of the system, primary care capacity has significantly increased. It doesn't mean that there's enough. As you can see from Dr. Long's testimony that volume has increased. The federal funding that is available has significant increased. But as Dave

just said, there's no counterpart to that for specialty and the diagnostic care.

I want to thank you for the opportunity to share this data with you. And you can imagine that we at CDPH like everyone else in the room and throughout the state look forward to plan the Task Force puts forward to ensure that all Illionoisans are covered with health care.

MR. DAVID CARVALHO: Thank you, Joy.

On the phone we have Miriam Link-Mullison. Miriam?

MS. MIRIAM LINK-MULLISON: Yes. Can you hear me?

MR. DAVID CARVALHO: You're in the middle of the room on a phone, which you'll need to speak up.

MS. MIRIAM LINK-MULLISON: Okay. How about now? Is that okay?

MR. DAVID CARVALHO: It's better. I'll be quiet.

MS. MIRIAM LINK-MULLISON: I'll try to talk loud. That's usually not a problem for me.

I want to thank you for this opportunity to present to you today. I also thank technology for not having me travel for 14 hours to do so. My name as Dave said is Miriam Mullison. I'm the administrator for Jackson County Health Department in Carbondale. And I'm also the president-elect for the Illinois Association of Public Health Administrators.

And the comments I'm planning to share with you are really representative of local health departments throughout the downstate area not just my own health department. It is my pleasure to discuss with you the vital role local health departments play as safety net providers.

Joy has really addressed some

of the ways that we do that. And some of the things that she suggested that she indicated are happening in Chicago are happening throughout the state. But some things are a little bit different. I do have a personal and special interest in this issue of access to health care. Access to health care has been identified as a priority health problem for my county. And I have been actively engaged for a number of years in trying to improve access to care in Jackson County.

In February Jackson County held an educational forum on the Health Care Justice Act for about 80 people. And in March we promoted and then participated in the public hearing that you held in Carterville. I want to applaud you for your time and work and am very appreciative that you are addressing this very important issue in taking the time to hear the

many stories of Illinois residents that have been impacted by this issue.

Since I had two things, there is a fact sheet about local health departments in Illinois that has a map of Illinois as the watermark. And it just addresses generally what some of the services are that local health departments provide throughout Illinois. Those include both population-based programs as well as clinical services.

One of the things that I like to emphasize about local health departments throughout Illinois, sometimes people say if you've seen one health department, you've seen one health department. But I like to emphasize the things we have in common and the fact that sometimes when there's differences between us, it's because we're responding to our own community. Each community has a different set of needs, and the health

department is responding to that set of needs.

For example, in Jackson County we don't provide public dental services, but we work very closely with our FQHC and the FIU Dental Clinic in encouraging the provision of those services. So that's not a service we're going to take on. And you see differences in health departments as they respond to their own communities.

I have also sent you a handout on the role local health departments play in the safety net in Illinois, just highlighting the different types of roles that we play. And I'm not going to read that. You have it in front of you. I just wanted to make a few highlights.

As Joy said, local health departments throughout the state do provide a number of traditional clinical services like immunizations,

STD clinics, tuberculosis care, et cetera. A number of departments -- a small number, but still a number of health departments throughout the state -- do have rural health clinics. There are a number of public dentistry clinics and health departments in the state, family planning clinics. And there are a number of downstate, real downstate in southern Illinois that do provide mental health services in addition to Chicago. Many of the very smallest health departments do provide that service.

We work the ensure access to health care through a variety of different case management programs, assisting clients, navigating the health system, and assisting them in obtaining a medical home. Many of us are also actively engaged in improving access to health care within our communities. There are a wide range of programming going on related to

this that improve coordination of care across agencies that expand community health clinics that may be helping to develop free medical clinics. Several communities are working to contribute a subsidy for subsidized health insurance for small businesses. So there are a number of ways that local health departments are working to improve access care within their own communities.

Efforts to address access to care are being hampered by our shrinking state and local dollars that are going to local health departments. One of the things that we see happening with our county dollars is they are increasingly being used to support state programming because state programming, funding state program has leveled off for a number of years. So we have a shrinking pot to address the needs of our local communities with our local

dollars. And many of us are also experiencing decreases in our local dollars through tax caps or other issues that are going on at the local level.

The categorical nature of much of the funding that we receive through grants is also a further barrier to addressing the needs of access to the care. That service needs sort of sit within the category of the grant.

And then frankly, even if we were very successful in all of our locale efforts, which I believe Jackson County has been quite successful, local efforts are not enough to address this problem. The issue of access to health care is beyond the capacity of local communities to completely solve. The complexity of the problem, pervasiveness of the issue, the level of need are best served by efforts

beyond the local level. However, local health departments do serve an important role and want to continue to be partners in any state or federal efforts to address this vital issue.

I thank you for the opportunity to share these remarks. I'm happy to answer any questions that you might have or to repeat anything. I know I went fairly quickly, but you have some written materials in front of you.

MR. WAYNE LERNER: Thank you very much, Miriam. I realize we're running a little bit over our agenda. We may be able to make up some time a little bit later. But more importantly I think it's very important that these issues are on the table and to hear this perspective. So thanks for your patience on this one.

Any questions of Joy or Miriam? Ken?

MR. KENNETH BOYD: You mentioned

if I heard you correctly, you're one of the few health departments that is also FQHC?

MS. JOY GETZENBERG: Yes.

MR. KENNETH BOYD: Given as Dave Koehler described earlier the summary of things that FQHC can give Medicaid patients, why don't more health departments go that path? Are there disincentives or prohibitions against that? What's the story there?

MS. JOY GETZENBERG: It's very difficult to be a public entity and an FQHC. As Dr. Long noted in his comments -- and I'm not even sure he described a community health center as possibly being a public agency. I didn't notice that. There aren't that many of them, but there are some. It has to be -- the governance of an FQHC has to have a -- it's required to have a consumer majority board. And in most federally qualified health centers, the board is a governing

board just like it is for any other non-profit. It raises the funds. It's responsible for the budget. It approves the budget. It hires and fires staff. Develops personnel policy. It does all of these things. It's very, very difficult for a city agency that has its county or governmental, that has its own levels of accountability to try to match these.

So that's one thing. It's very hard to meet the spirit, even if not the letter, of the governance requirement when you're a public agency. The federal law obviously allows it, but it's very difficult.

The other thing that also in Dr. Long's remarks showed very well, it's a very, very comprehensive model of care. And a lot of -- as Ralph Schubert can attest to, most public health departments got into primary care at all through maternal and child

health. That's historically been a role for local health departments. But it hasn't necessarily been a historical for local health departments to do adult care, to do chronic care, to do other things besides well child care and pregnant women and perhaps family planning. So it's shifting to whole other model. So it's a very difficult process.

We happen to have been in the business of primary care for, I don't know, more than 35 or 40 years. And we still struggle constantly to meet the requirements of the FQHC, especially in the area of continuity of care because of the financial issues that we've been discussing.

And I wouldn't be surprised if your experience in transitioning from a free clinic to an FQHC would have some of the similar problems.

MR. WAYNE LERNER: Just --

MS. MIRIAM LINK-MULLISON: Can I

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respond to that as well? I would also say that as I said some local health departments are choosing not to do that also because there are already federally qualified health centers in their community. That would be something that I would not explore because I already have two agencies providing federally quality health centers in my community.

I do know that there are a number of local health departments now working with their communities to explore the development of community health centers within their community. Some may jointly house them some may work to have it as a separate entity. So I think it's really dependent on the community.

MR. MICHAEL JONES: If we were to move to a system like Massachusetts where all of a sudden there becomes almost no uninsured, what are the implications of that as far as the

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state losing federal dollars? A lot of federal dollars where it's cost-based and reimbursement care from FQHC's or disproportionate share or whatever are dependent upon having a large uninsured population. What happens to those dollars and what is going to look at those dollars in Massachusetts? Has anyone looked at that?

MR. DAVID CARVALHO: As part of what I introduced the subject was any plan you put together ought to take into account what exists both in terms of resources, physical resources, but also financial resources. So in particular the Massachusetts plan very much too into account what federal revenue streams are already coming into the state for one reason or another, what uncompensated care pool exists already in the state funded by, I believe, assessment on insurance policies. And looked at all of those

resources for stitching together a plan rather than coming up with a plan that just wipes all that out and starts from scratch. In other words, they view those as resources for putting a plan together, not as something that was going to be trumped by a universal plan.

MR. MICHAEL JONES: Did the federal government buy into that?

MR. DAVID CARVALHO: That is part of the process. They have luck with Section 1115 waiver for what they were currently doing. And they were negotiating with the federal government for if we do this, can we keep the money? And by present count, that is exactly what they're hoping to achieve with the plan. I don't know if the federal government has finally signed off on it.

MR. DAVID KOEHLER: I think it important for us to anticipate what the impact might be on FQHC's if we do

see a shift.

MR. MICHAEL JONES: Would have to become competitive, which would not be bad.

MR. WAYNE LERNER: It's more intensive than that. My view as a hospital executive is that we have a patch work quilt of not only delivery systems but payment systems and all kinds of other systems. And we've reached some kind of balance even thought we're not able to accomplish all the goals we'd like from a social point of view. Whether you tweak the patchwork quilt or your look for a revolution, we better be understanding of the unintended consequences of all of this. I'm not sure how smart we are, but we ought to be modeling that as part of it.

Margaret? Last question.

MS. MARGARET DAVIS: This is to Joy and to Miriam.

Public health I see is

promoted by nursing. And what I'm seeing not a lot of nurses doing the essential 21 services of public health. I want to know what are you doing to enhance your public health nursing functions of population-based control? And there are so many uncertified public health clinics in our state without epidemiology services, just really akin to free clinics. How should we be looking at that as we address our reorganization of the health care delivery system?

MS. JOY GETZENBERG: The second part of your question, Margaret, was about health departments?

MS. MARGARET DAVIS: Yes.

MS. JOY GETZENBERG: Uncertified health departments?

MS. MARGARET DAVIS: Yes.

MS. JOY GETZENBERG: I'm sure Dave Carvalho is here. I'll defer all questions about certification of health departments. Only to say

that -- of course, I have to say something about it. It is one of my favorite topics.

But that I think everybody in Illinois agrees that everyone in the state should have access to high quality public health services. I think there are some differences of opinion which are, I think, legitimate about whether there needs to be a certain sized health department to provide that adequate level of coverage. But that is an issue that really is being discussed currently in the Illinois Department of Public Health. And I think that that's a very important issue for public health.

In terms of nursing, I can say that we never feel like we have enough nurses. We have a strong public health nursing component, family case management and others. We have, as you all know, a new health

commissioner who is very committed to chronic disease prevention and getting out into the communities. So we're looking to see if that may very well be an area where we are able to expand.

But I think part of the issue, of course like everything else we talked about today, has to do with funding. As Miriam said, our state funding, which provides a lot of dollars for our maternal and child health programs has remained flat for 10 or 20 years, which essentially means that it has gone down. That is a problem not only for our public health nursing related services, but our other public health.

MR. WAYNE LERNER: Miriam, did you have a comment?

MS. MIRIAM LINK-MULLISON: Regarding the uncertified health department, it is my impression that that's more of an issue in Chicago and

not as much an issue in the rest of the state. I'm not aware of any uncertified health departments in the rest of the state. Is that true, Dave?

MR. DAVID CARVALHO: I believe it's suburban Cook.

MS. MIRIAM LINK-MULLISON: I think it's suburban Cook, so that's not as much a downstate issue.

In terms of public health nursing, they really provide the core of services at this local health department and I think at many local health departments. I would say that many health departments are starting to feel a little bit of the crunch with the nursing shortage. We have not had a problem with hiring ourselves, but it has become a little bit -- the pool is smaller each time we do out to look for public health nurses. But we do continue to provide most of our services through public

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health.

MR. WAYNE LERNER: I want to thank Mr. Getzenberg and Ms. Mullison for a wonderful presentation. Thank you very much.

David, want to move us along?

MR. DAVID CARVALHO: Yes.

MS. COURT REPORTER: I'm sorry. I really need to take a break.

MR. WAYNE LERNER: Why don't we move our break up a little bit earlier because of our scheduling.

MR. DAVID CARVALHO: Is someone from the Phoenix Foundation here? I think that presentation will reschedule to another time. That gives us an extra ten minutes. Our next presentation is state agencies, which is Ralph. So perhaps if you all take a ten-minute break. Ralph can do his presentation. And it will just eat into my time at 1:00 o'clock, which is fine.

(WHEREUPON, a break was

taken.)

MR. DAVID CARVALHO: Thank you everybody. Really the theme of today was inspired in some respects as we constructed the set of topics and speakers, by a comment a I hear three years ago at a presentation. I was on a panel. And a legislator, who I will not name and is someone who has been involved in health care for many years and was a Democrat so whatever that means. I heard this person say there really isn't a problem with the uninsured in Illinois because anybody who is uninsured can get their care in an emergency. There's just a problem that that's not a particularly cost-effective place to get care. And I thought, my goodness if somebody who is in a position to know better believes that, then maybe my assumption that everybody knows exactly where the holes are in the safety net and how frayed it is and

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there's a huge gap in specialty care and the fact that your emergency room care is only a requirement if you're in an emergency situation. You can't go there for a mammogram. You can't go there for chemotherapy.

Then it was really important that part of the input into this process was laying out exactly what the safety net was and wasn't. And so by means of transition, I want to thank all the folks from the counties. And I've called it the public safety net even though it's technically private from the clinics and local health departments.

But another part of the safety net of course is at the state level as well. And so we have with us Ralph Schubert, who is head of the Maternal and Child Health Office Division.

MR. RALPH SCHUBERT: Close enough.

MR. DAVID CARVALHO: At the

Illinois Department of Human Services. So I'll turn it over to Ralph.

MR. RALPH SCHUBERT: Thank you, David. It's great to have this opportunity to talk to the Task Force. It has been my pleasure to represent Secretary Adams and the Department of Human Services on the Task Force. And this is the first time I feel like I've been able to make a contribution to the dialogue. So I appreciate this opportunity.

My role within the department -- I was just taking a break -- eight days ago I passed my 20th anniversary working on maternal and child health at the state level. And a little over a quarter of a century in state government. So I guess there's something to be said for experience or you can decide in about ten minutes whether you think so or not.

My role within the department

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is to advise the director of the Division of Community Health and Prevention on maternal and child health. So that includes a whole range of things, including reproductive health. And the division has the state's family planning program, infant mortality reduction, nutrition and child development so we have the WIC program.

And several presenters have sort of tossed out that acronym maybe on the assumption that people know what that is. It's full name is the Special Supplemental Nutrition Program for Women, Infants and Children, which is where the acronym WIC comes from. And it provides nutrition counseling and supplemental foods for low income pregnant or breast-feeding women and children under the age of 5 who are at nutritional risk.

We are also the home of the state's school health program,

including school-based health centers, adolescent health programs including the state's effort to address teen pregnancy, as well as some program work that we do in early childhood develop. That's the maternal and child health part of the division of Community Health and Prevention. It also includes the early intervention program for infants and toddlers with developmental delays and disabilities, known in the shorthand to people in the business as Part C of Individuals with Disabilities Education Act. It also include alcohol and substance abuse prevention and the state's domestic violence program. So we cover a wide array of things under the topic of community health.

I've been working with David and Ashley and Mike to organize a part of the panel discussion at the May meeting to look at other parts of the Department of Human Services and the

things that do. So we'll talk then about our alcohol and substance abuse treatment programs, mental health, developmental disabilities, rehabilitation services, as well as the state's program for children with special health care needs, which is actually part of MCH, but seems to fit a little better in a discussion of special populations than under this discussion of the safety net.

Let me see. Many of the providers who have been represented either in person or in type here earlier in the presentation on the safety net are grantees of the division of community health and prevention for services in any of those program areas.

Three key ideas that I want to talk about in terms of public health generally and maternal and child health specifically. These are all taken from really what was seminal

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report called "The Future of Public Health," published by the Institute of Medicine in 1988, which identified sort of a new presentation of the mission of public health, the substance of public health, and organizational of framework of public health. Or another way of thinking of it is the why, the what, and the how.

And I want to talk sort of interchangeably about maternal and child health as a specific expression or example or application of some broader public health, broader public health principles.

Key Concept Number One. The mission of public health -- I apologize for reading this, but I think they are short and important ideas I think. Mission of public health is the fulfillment of society's interest in assuring the conditions in which people can be healthy. Which talks about the fact that this is a

population-based approach to thinking about health and that it clearly involves a government role because it is society's interests in creating the conditions under which people can be healthy.

Second idea: The substance of public health is organized community effort aimed at the prevention of disease and promotion of health. It links many disciplines and rests on the scientific core of epidemiology. Two or three key ideas. One, again that it is population-based. Second, that it uses a very board definition of health. Third, that it rests on the science of epidemiology. So what we do is data based.

And the third key idea, the organizational frame work of public health encompasses both activities undertaken within the formal structure of government. So things the

Department of Human Services or Public health do as grant programs that are carried about by local health departments, community health centers, hospitals, other kinds of organizations. And the associated efforts of private and voluntary organizations and individuals. It is a systemic look at the way health care is sort of organized, financed, and delivered. And the partnership is the significant part of the way that we get this work done.

The current federal statutory authorization for maternal and child health presently is found in Title V of the Social Security Act. We go all the way back to 1935 where one of the first and one of the oldest expressions of government interest in public health. A couple of other interesting and locally relevant pieces of the history of maternal and child health.

The oldest reference I have been able to find so far to an infant mortality reduction initiative in the State of Illinois goes back to a campaign launched by the Chicago Department of Public Health in 1899. Following that kind of national level, the first sort of federal interest in maternal and child health came in the form of the White House Conference on Children, I think in 1906. It was the first Roosevelt administration. There was additional federal money and the Shepherd Towner Act of 1926. And Mike Jones furthered my education in history the other day by telling me that Illinois was one of two states that passed up the money that was available under the Shepherd Towner Act way back then, what? 75 years ago.

Let me see. The Title V was substantially revised in 1980 to create the Maternal and Child Health

Service Block Grant, which the Illinois Department of Human Services now oversees. There have been additional amendments to that along the way. The MCH Block Grant is one of five that was created in the early years of the Reagan administration.

One of things that are unique about Title V in this entire discussion is that we have a statutory responsibility, meaning that we become a locus of public accountability for the health of all women and children. Not by income, not be health status or condition, but to think about the entire population. And the resources that come with the MCH Block Grant are for us to use to look at infrastructure, to identify and assess needs, and to use those resources as judiciously as possible to fill gaps in the system, the patchwork of services for women and children.

Presently the MCH Block Grant

is funded nationally at $693 million. That is the lowest level it has been at in the 20 years that I've been in this business. At the national level it's authorized funding the maximum Congress can give to it is 750 million. The highest level I can recall off the top of my head is 724. Illinois gets about 4 percent of that or $23 million.

I want to go back to a point that Margaret raised earlier about why women and children and what happened to dads and families anyway? Part of it is really rooted in the history of MCH, all the way back to the White House Conference on Children when child labor was a whole different kettle of fish than it is now. And we have continued to think, as awkward as this sounds in 2006, we have continued to think of women and children as an especially vulnerable population. We still do hear that word used

frequently as awkward as it now feels.

But that's been the historic emphasis of the field. It is shifting to think more broadly about the obvious and central role of fathers and the importance of families in a number of respects.

Let me see. All right. The pyramid, which is kind of the title of my presentation. We think about the services that the Maternal and Child Health Block Grant provides or supports or thinks about as four levels of a pyramid. I'll start with the familiar stuff really at the top under direct health services and work down to the unfamiliar and I think more unique contributions of Title V as a program at the federal, state, and local levels.

Under Direct Health Services, as the name sort of implies, are the kinds of things that you have heard

presented today as other parts of the safety net and by other providers in earlier meetings. For the Department of Human Services, those are grant funds that go to operate our network of school-based health centers. There are almost 40 of those across the state. Our statewide family planning program through our partnership with the Department of Public Health. A dental sealant grant program. So you can see they are targeted, both in terms of population and kind of service. They are gap filling kind of things because these are fairly modest resources.

The second tier down, enabling services, have to do with getting people to the direct services or broader education, risk reduction kinds of intervention. So the things we do there are the WIC program, family case management, which has to do with helping low income families

that have a pregnant woman or an infant get to a medical home and a whole other array of services that they need for a healthy pregnancy outcome and for healthy child development. Our targeted efforts to reduce infant mortality, especially racial disparities in infant mortality. Our programs to prevent teen pregnancy and to support and assist teen parents all fall within that level of the pyramid.

The third, population-based, include things we do in partnership especially with the Department of Public Health. This is where we provide funding for the regionalized system of perinatal care services, which is a bit of MCH service delivery involving all 140 hospitals that provide delivery services across the state. We organize that system in order to link hospitals by the level or degree or type of maternity

services they provide in order to get women with high risk conditions and critically ill newborns to the level of intensity of care that they need to survive. And we have seen over the years as Illinois has maybe one of the best established and best functioning systems of perinatal care in the country, that really has made a difference when you look at the survival rates of very low birthrate infants. They clearly do better when they are born at higher levels of hospitals with higher levels of specialty care. It's been a very important intervention over the last 35 or 40 years in reducing the state's infant mortality rate and one aspect of the way that we organize the system of care that may not be very widely understood or appreciated.

Other kinds of things that we do as population-based services or work in collaboration with the

Department of Public Health on the operation of its immunization program. And mumps certainly has gotten a lot of attention lately. We pay more attention to those childhood infectious diseases now as exceptions to the rule than as common experience because of the effectiveness of immunization as a public health strategy over the last four or five decades.

Our metabolic screening program is part of the maternal child health program led by the Department of Public Health. All you who either were born in Illinois or have had children born here over the last 30 years have donated a little sample of blood at the, shortly after the time of birth to find out whether your child had phenylketonuria or any series of diseases. The identification, follow-up, and linking into the medical care for those

children who have any of those inborn errors of metabolism is part of the Maternal and Child Health Program that are carried about by the state agencies in partnership with local health departments and other service providers across the site.

Finally and maybe the most esoterically, at the bottom of the pyramid are infrastructure building services or infrastructure building activities that we engage in as sort of part of the glue to hold the rest of the system together. So part of our role in the Title V program is to look at the needs of the entire population of women and children, not just the poor ones, not just the ones with the special health conditions. Raise issues and focus attention on emerging problems, use some of these resources to address emerging issues, and form partnerships with other parts of state and local government and the

rest of the service delivery system to address the health needs of women and children.

I've talked some about the partnerships that we have with the Department of Public Health. Within the Department of Human Services we also work closely with our Division of Mental Health. We are working with that organization and with Public Health on getting some federal resources for youth suicide prevention. We work closely with the Department of Children and Family Services on assuring that kids in foster care get access to health care services. We work with the State Board of Education on school health policy. We worked very closely with the Department of Health Care and Family Services in a number of regards.

Illinois Healthy Women, the expansion of Medicaid services

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specifically for contraceptives, coverage of contraceptives is operated in close concert with our family planning program, which is providing similar services. That expansion allows us to serve a population that isn't yet eligible for coverage under Illinois Healthy Women. Our collaboration with Department of Health Care and Family Services was also expressed in the way that the safety net was recognized in the primary care case management model that is being used as a key strategy for implementing all kids.

Let me see. All right. That's a quick walk through the MCH pyramid, the way we think about our organization and delivery of Maternal and Child Health Services.

Why does this matter? Because many of the other components of the health care financing and health care delivery system focus at

the top of the pyramid. And it's our suggestion that to build a comprehensive system you have to pay attention to all four levels including the preventive or population-based services and the infrastructure. As you move down the pyramid, as the focus of intervention shifts from individuals to populations, the role of government in doing all of that work expands.

So maternal and child health is specifically, and publicly health generally, is more than the safety net. It is more than public medicine. And with that I thank you.

MR. WAYNE LERNER: Thank you very much. We have time for a couple questions if anybody has one.

MS. MARGARET DAVIS: Ralph, you remember the time when maternal child was with IDPH.

MR. RALPH SCHUBERT: Yes.

MS. MARGARET DAVIS: So what are

you thinking in terms as we begin to monitor this system and our new configuration, how is that working and what are some of the challenges of having data in two different code agencies? And the other one is you have a very vulnerable population with the DCF children.

MR. RALPH SCHUBERT: Yes.

MS. MARGARET DAVIS: You heard the health centers talk about electric knowledge medical records because they're so mobile. How could we construct the infrastructure building in that area?

MR. RALPH SCHUBERT: Okay.

MS. MARGARET DAVIS: And McHenry County voted not to have Title X service. And the women there report long travel times to get Title X family planning services.

MR. RALPH SCHUBERT: Okay. Boy. Let me take those in turn.

First, I think the

partnership among us and public health, local health departments, and -- I've tossed this in in anticipation of May's panel -- the division of specialized care for children at the University of Illinois in Chicago is working pretty well. So we have our frictions, but by and large the exchange of information among the three agencies has not been a problem. In fact, we, Public Health, and Health Care and Family Services just ratified a data sharing agreement that will make that process easier and faster for all three agencies. As we will be building the capacity of health care and family services data warehouse, and then benefits from that expansion and capacity.

So I think the relationship among the three agencies as it has to bear on -- four agencies -- as it bears on women and children is pretty

good.

Second, in terms of the assisting children who are in the child welfare system, boy, we could say a lot about Health Works of Illinois. It works somewhat differently in Cook County than it does in the rest of the state. Going all the way back to 1990 and the BH Consent Decree. Public health was at the table at the time working with Department of Children and Family Services to figure out how we could do a better job of getting children in foster care linked to both primary and specialty care services. That system seems to be working fairly well. The proportion -- as a couple of examples -- the proportion of kids under school age who are in foster care, which is the majority of kids who are getting fully immunized has gone from the high 40s in 1990 when we started this to the high 90s which is comparable with

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the general population. The same is true for their utilization of preventable well child services.

MS. MARGARET DAVIS: But what happens is that you don't have electronic medical system and you don't have a statewide registry. And so that data is just lost. And that's what I'm just asking. Can you -- you've got your warehouse for data. But can you begin to do what the centers did and join efforts to get an electronic system?

MR. RALPH SCHUBERT: I think the short answers are, A, not yet, and B -- and Dave may be able to talk some about this -- that Public Health is leading and other groups like this to talk about the development of electronic medical records. I didn't mean to put Dave on the spot. But I know that process is going on more under the leadership I think of Jonathan Dobking (phonetic); right?

MR. DAVID CARVALHO: Some of you may even be on his Task Force as well. We are working on that.

MR. RALPH SCHUBERT: And the third part of your question had to do with McHenry County. And part of our role is to respect the preferences of the voters, jurisdiction by jurisdiction. And in that their county board elected not to accept grant funds from us to provide those services, we have to respect that choice. There was -- they made a similar choice with regard to the interest of their county health department in pursuing Healthy Families Illinois or Child Abuse Prevention Grant from us. They elected not to accept it. We can't force them to accept it. So we respect their decision.

MR. WAYNE LERNER: Thank you very much, Mr. Schubert. Now --

MS. TRACEY PRINTEN: Can I just ask a clarification really quick?

MR. WAYNE LERNER: Yes.

MS. TRACEY PRINTEN: Isn't the TOTS program something like that? Tracking Our Toddlers's Shots where you can go in --

MS. MARGARET DAVIS: But they don't talk to each other. TOTS don't talk to Cornerstone. Cornerstone don't talk to TOTS.

MS. TRACEY PRINTEN: But a provider can go into TOTS.

MS. MARGARET DAVIS: But we need a state-wide registry.

MR. WAYNE LERNER: It really begs the issue of what generically is called a Community Health Information Plan so that there's a unified database in the provider's office. All types can gain access to the record anywhere you go. Big issue. So when Mr. Schubert talks about infrastructure, I immediately start think broadly about infrastructure issue that cross over public, private

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providers, clinicians. So that's something that we're going to have to talk about as we start to talk about models.

Let me move along to the last presentation today. Talking about models. The IHA, the Illinois Health Association presented to us at one or earlier meetings and wanted to come back after laying the groundwork for a policy proposal. Last week at the private sector meeting we were the beneficiaries of a series of proposals that we ought to think about as we go forward.

Now Elena Butkus and Teresa Hursey are present to take us to the next step.

So Elena, it's all yours.

MS. ELENA BUTKUS: Thank you very much, Mr. Chair. As this presentation goes forward I just early on I want to quote, it is the antithesis of the single payer system proposal. With

all due respect to Dr. Young as the only Illinois physician to make the top 100 physicians, if he closes his ears and says, la, la, la, I absolutely understand.

DR. CRAIG BACKS, MD: I'll listen twice for him.

MR. WAYNE LERNER: I will not call on Dr. Young at all.

MS. ELENA BUTKUS: Thank you very much. In order to achieve universal coverage, it's been widely surveyed that 21 percent of the population believes you ought to expand Medicaid. After that they believe, I think, 20 percent of the population that there should be an employer mandate. After that in general, everything wanes down to 14 percent of population thinks that there's one possible proposal to cover the uninsured. So at the end of the day what you get is a lot of hybrid plans that need to address specific

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populations and specific states.

This is a hybrid plan and is developed with these principles in mind. It is a frame work for universal and continuous access. You cannot have full access without a series of mandates. We do not have sticks or mandates in this particular proposal except for college students.

And with respect to mandates, what we're talking about is what our board wrested with for three meetings, specifically employer mandates and individual mandates which you may be addressing as a task force at another meeting. So if you don't have those particular mandates, you can probably address with carrots maybe a third of the population. And while our proposal is if you had a mandate, it would address about 1.2 of the 1.8 million uninsured. Without the sticks, it addresses about 30 percent of that.

It is a population-based plan based on statistics the census Bureau that we gathered at the gilia (phonetic) board. It does take into account the Illinois insurance market. As I said it's voluntary compliance. And while we didn't go extensively into funding, there would most definitely have to be a general tax increase in the state, especially because this particular proposal contains a voucher program that we recognize is expensive, but taking into account the type of population that we're talking about is needed.

What's important to remember about this state is that for the most part, 54 percent of the population are at or less than 200 percent of the federal poverty level. They are poor. And while you can try and lay over any system, there is going to have to be different incentives to get these people to take up coverage.

So the IHA building blocks -- at the very back of your report you'll see a chart of how it all lays together -- is that we look at four specific groupings. The largest grouping being the working uninsured. Then children 0 to 18, nonworkers, which include college students, and the unemployed. Here's the chart, Dr. Young.

In general the Illinois population that's uninsured is 1.8 million. Most of those people are working. And in fact, most of those people have full-time jobs. It's only a small portion of people that have part-time jobs that fall into the working uninsured. I would also state that in general with respect to non-citizens, we're only talking about around 280,000 people. While that is a lot, it didn't become the predominant issue in addressing the uninsured.

So I'm going to go through our strategies and solutions that we came up for each of the four categories. Again, the working uninsured where we decided to concentrate is firm sizes of specifically 25 or less and people who are self-employed.

In the rest of firms, what we were finding in general is that large employers especially at a 1,000 plus are offering coverage. Between 100 and 999, the figures are still in the 96 percent range. Below that, the figures are still offering coverage at the 86 percent range. After that it trails down to 31 percent in the smaller firm sizes. They're not offering coverage. And in all those categories, yes, there's uninsured. But people aren't taking up coverage. And people aren't taking up coverage because they in general, they don't fall into the types of categories that

allows them to afford that coverage.

The five solutions for the working uninsured population are: We have two small employer purchasing pools in our proposal. One specifically is one that could be put up straight away by somebody like the Department of Insurance. And it would lay side to side with the comprehensive health insurance pools that are already laid out by the state. In general, it's employer premium and employee cost share. Providers are paid at commercial rates. And what's important to both of the pools is for the first time -- and this wasn't easy for our board -- what we have agreed on was a safety net benefit package to be offered to employers who have not offered insurance for a period of 12 months or more. You have to look at the issue of crowd outs. So that's how we generally decided to gait it.

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The other pool is a pool that would take likely a couple years to establish. And Teresa Hursey, who was Governor Huckabee's right hand on Medicaid established it very recently for Medicaid. And now eight states have applied for the same waiver. But that pool in general is an employer tax for those employers who have not provided insurance for a period of 12 months or more. There is a federal match that draws down off the employer tax. And of course, there is an employee cost share.

That pool is paid at Medicaid rate. Yes. Medicaid rates early on in our report are not sufficient to cover our costs. But we recognize based on all the speakers that we're trying to make use of all the pieces in the spectrum.

What's important about the safety net benefit package is that we worked with Gallagher and Mezro

(phonetic) which are large brokerage houses to try and figure out what could be covered for the population at hand? And what we did was we drew down from our data systems to take a look at what types of services self-pay patients assume, especially on the hospital side.

And what we saw in general was once you pass the top three conditions, which are usually coronary types of conditions, where you're moving to in the top ten conditions are substance abuse, mental health, and then everything else are preventative care type conditions: bronchitis, asthma. And so what we decided, IHA as a group, was that you had to have 100 percent preventative care benefit in this type of package and you had to have some type of major medical coverage.

Our price point based on, based on where the uninsured are at

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federal poverty level was that the product must fall on average at $150 per member per month or less. And so the only way in general to do that would literally be service or unit restrictions or to cap the aggregate limit in any given year.

You could add coverage to that by providing a reinsurance program on top of that. There are reinsurance programs described in here that the state could venture to do, and the state could do it by combining some of its other programs into the reinsurance program. But what this is is minimum level of benefits for people who have never had benefits before.

Past that -- and I apologize. Where we went was an expansion of Medicaid for parents. And it's a smaller expansion. But it's to move them up to exactly where kids are, to 200 percent of the

federal poverty level.

Next, we talked very long about vouchers and who you give them to. Again, half this population is at or under 200 percent federal poverty level. So what the board decided was that in general that based on the basic benefit package that we chose, that a voucher ought to be provided for 25 percent of the coverage. And while we recognize that the voucher program would be expensive, you can give it across the board to everybody at 200 percent or below. It becomes a fairness issue if you're only giving it to the uninsured population. So what we've chosen in our report is to give it to everybody across the board.

Next, three insurance market reforms that are, we believe, are crucial to the cost of the insurance, especially to those in the small group markets. Specifically government funded reinsurance. And that really

works with our basic benefit product to get the coverage levels up to a level that's a little bit more considerable than what we generally could entail. And it generally spreads the risk for anybody, all the insurers participating in the program.

In addition to that, the small group market currently in the state is two to fifty. And there is -- there are rating restrictions to a certain extent, plus or minus 25 percent of an indexed rate. That Act was passed a long time ago. And with the filings that are come into the insurance department, we absolutely believe that there is room to compress the rates in that Act without doing any damage to the market. There is more on that in the report, or I'd be happy to ask questions.

Lastly, there was a Health Purchasing Group Act passed long ago

that allowed certain types of employers to aggregate up to 500. The Act was never used except for once by the Illinois Manufacturers Association. And it's a cumbersome act. We absolutely believe that certain small employers ought to be able to aggregate easily and purchase insurance. We think the General Assembly ought to retake a look at that particular Act and/or the Adequate Health Care Task Force.

Lastly, with respect to the employed uninsured, we heard a lot at the Task Force hearings from people with pre-existing conditions. And the premium for the chip for the high risk pool, not the HIPA pool is extremely high. We absolutely believe that people cannot afford 135 percent of premium. And based on what we've seen in other states and the feds giving money to those states in order to lower that premium substantially, like

by 50 percent, we absolutely believe that the Illinois high risk pool ought to take a look at reducing it for federal poverty levels of at least 200 and below so people with pre-existing conditions who are poor, do not qualify for Medicaid, can access that particular pool that we fund from general revenue.

Our second category, Governor Blagojevich has addressed for us, 283,000 uninsured children, would likely be covered by All Kids. The program rolls out in July.

Our third category, nonworking and college students. Nonworking is a very large category. It's 428,000 people, but 72,000 of those people ought to have insurance. And it's cheap for them. And we don't really understand why they don't have it.

So our two solutions with respect to the college students is in

the state, colleges ought to be required -- this is our one mandate -- to require that entering students in that age group ought to have insurance. And most, many private institution already do this. In fact, that's the institutions represented on our board. In addition to that, an expansion of kid care for students that are college age. Again, it's cheap coverage in general.

Lastly, I would say with respect to this category, the rest of the people fall into retired, disabled, and dependents. We don't have specific actions for them. But we believe that dependants and some of the other categories could be picked up in the other circles that we have addressed.

The unemployed is the last category. There's 73,000 uninsured people who are looking for work in this state. And we have two solutions

for them. Bridge loans that would be offered by the state when you get out of work for a period of time, no-interest loans. And also continuation expansion. In this state, or federally COBRA is offered to employers of 20 or more. Continuation is offered in this particular state to people for a period of nine months minus vision, prescription, and the extra benefits. But the major medical that you have when you're at 20 or less can continue up to nine months. We would suggest that as a start that the Adequate Health Care Task Force or the consultant analyze the expansion of continuation to make it close to the same periods of COBRA.

With that, I would just say that it's been a long process. Anything that we could give to the Task Force with respect to numbers or ideas of how we condensed it into this

report, we make open to you. And we very much appreciate your consideration.

MR. WAYNE LERNER: Thanks, Elena. How about any questions from anybody? Dr. Johnson?

DR. NIVA LUBIN-JOHNSON, MD: Concerning the bridge loans. You're saying that you're saying the uninsured will receive a loan? What is a bridge loan?

MS. ELENA BUTKUS: Bridge loan, when you go apply for unemployment at the exact same time, here's our vision of it, you could also have access to a loan to cover the premium portion of your health insurance, be it continuation, COBRA, whatever. But it's kind of it's a dual process.

DR. NIVA LUBIN-JOHNSON, MD: So how does someone pay the loan back?

MR. WAYNE LERNER: I didn't hear you, Dr. Johnson.

DR. NIVA LUBIN-JOHNSON, MD: If

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you're not working and you get a loan, how do you pay it back? You're unemployed, you're getting unemployment compensation which won't cover all your bills, so how do you pay back the loans?

MS. ELENA BUTKUS: Once you get the job.

DR. NIVA LUBIN-JOHNSON, MD: So when you get the job you've got another bill to pay back.

MS. ELENA BUTKUS: Yes, you do.

DR. NIVA LUBIN-JOHNSON, MD: And for coverage for college age young adults, you're saying the colleges should mandate coverage. Are you also suggesting that coverage be included in financial aid packages also? Because that would be another burden placed on someone who is already having problems going to school. All right. Thank you.

MR. WAYNE LERNER: Ken?

MR. KENNETH BOYD: Great report,

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Elena. And I've been to enough hospital association board meetings to know how tough it was to pull off what you pulled off. I know you consciously tried to stay away from mandates. And yet, Dr. Johnson just mentioned the college kid. Mandating the coverage or the option of the coverage to the college doesn't get you anywhere if the student or the family of the student doesn't put them in the plan. And so I think this is where Massachusetts has moved, there has to be some mandatory push. It happens in my own hospital where we have people who can afford the employee portion of the premium. We pick up 75 percent of it for them. And yet they are young. They think they are immortal and invulnerable and don't take the insurance. And therefore, they're uninsured yet they have got a job. They have an employer who offers it, and they have the

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ability the pay. So I think somewhere, whether in your plan or whatever plan, there has to be some kind of something that says to people, you will be insured. And you to the extent of your ability, you will pay for that insurance because it's a societal burden that everybody should share in.

MR. WAYNE LERNER: I think the issue of mandates in general like any other type of regulatory requirement is something that we as a Task Force are going to debate fore a little while as we start to look at models. I couldn't agree with you more. The real issue is if look at the full continuum of models that we can look at, the issue of mandates is right in the middle. It's got to come up on the table.

Other questions?

MS. CATHERINE BRESLER: I appreciate your comments, and I think

that there are a lot of commonality between what the private, public solutions that we are all going to be looking at. And I run the risk of never been invited to play golf, so say this very tongue the cheek. But I I do have to ask the question.

When we look at the solutions and one of the eight criteria was to consider, you know, kind of community involvement in a broader scope of the problem of access and affordability. And I certainly haven't read the report and there certainly may be some elements in here. But just from your presentation what I notice is a lack of participation -- this is a solution for coverage. And it's not necessarily a solution that would involve provider participation in this scheme. And I just wonder if in the report you considered hospital participation, provider participation, if there's anything on that end that

you think would help contribute to getting more people covered.

MS. ELENA BUTKUS: Maybe not as a separate strategy. But I think the provider community, it's central to the entire proposal because they have to take in all the patients whether it's going into any of the pools that we proposed or whoever people may see to get their coverage. I understand what you're asking. I would just say, Catherine, it's inherent. And I apologize that it doesn't come out as a separate.

MS. CATHERINE BRESLER: I guess one of the things that I think of, one of themes -- this is just a general comment too -- all the presentations today, which were terrific, there's an ongoing theme of consumer responsibility and education and participation in their own health care and then health care decisions. And I was impressed the hear all of that

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today, especially through the community health plans and federally funded plans that I wasn't really familiar with before. I was really impressed with the fact that along with baseline care, there's a real incentive for people to learn about their health and what can make them healthier. I think that's kind of what I was looking for in the hospital's proposal.

MS. ELENA BUTKUS: I would just add we provide $1.2 billion of uncompensated care a year. This proposal absolutely will not erase that off the table. We are there 24/7 for our patients and will continue to be there. So I appreciate your issue.

MR. WAYNE LERNER: Let me take your issue and just spin it a little bit. Issues of responsibility, whether they are community responsibilities, societal responsibilities, personal

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responsibility, responsibility of the hospital community, the doctor community are issues we're going to have to address as you start to put together the model regardless of the financing mechanism, regardless of that. So I think you're keying up exactly the right issue.

I was impressed because I've not been party to the IHA discussions. I'm not on the board anymore. But if the proposal really does say what Clyde said that they're going along with All Kids program and Medicaid rates, that's a pretty significant recommendation from the provider community. So considering Illinois is 46 out of 50 states in Medicaid rates. So we've got to put together a lot of these details as we go forward. But I couldn't agree with you more.

MS. BETH LISBERG NAJBERG: Can I ask a question? You put the self-

employed along with the employer based 2 to 50. I have not seen in any of the discussions including Brad Buxton's plan the other day to address the individually insured. About 600,000 in Illinois. I don't know the number, but I'm sure most of those are self-employed. So you mention it in the plan. I glanced at it, but no solution for us, for the self-employed. That needs to be addressed to.

MS. ELENA BUTKUS: We understand. We also understand how fragile the individual insurance market is. And while we can address a portion of the population, again, this is a building block plan that allows you to see how it works, and then build off of that. We did not put in individuals that do not have any kind of employment status at this time.

MR. WAYNE LERNER: I want to thank you for raising that because you're

right. It was addressed a little bit at the private sector meeting, but again depending upon how the Task Force starts to debate models, we either start to put pieces together to create this quilt or we take up a fresh look at it. But that population group has absolutely to be addressed.

MS. BETH LISBERG NAJBERG: I see that the numbers pretty much national too and the State of Illinois. 5 percent of the population, which is a little over 600,000 in Illinois. So it's not an insignificant number.

MS. ELENA BUTKUS: But if I could just one add the one place we did address them is when we are talking about the expansion of the high risk chip pool.

MR. WAYNE LERNER: And the other thing that's obvious from all of these presentations, all of these, including the Massachusetts discussion we have been having, and we want to tee that

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up, the discussion, the issues of subsidy just have to be on the table. I don't care where the subsidies come from, but they've got to be on the table. Because there doesn't seem to be enough money in the system the way it's currently conceived of to be able to provide what we want it to.

MR. KENNETH BOYD: The only thing you might think about in that regard though -- and Wayne and Elena, I think you and I have talked about it a little bit -- is that both at the federal and state level for instance most employers get a tax deduction for the employer portion of health insurance. And I need to have this conversation with some of the major employers in the State of Illinois. And depending on the deal, they recognize the value there. And they also recognize that if this plan or some other plan goes into place, there's going to be downward pressure

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on their current premium rates of escalation. And so there may be the possibility of trading, you know, elimination of what in essence is a tax subsidy to them now or some other interventions that will see a decline in their employer portion. So I don't think we should jump to the conclusion immediately of additional tax subsidy although in my gut I think you're probably right. Maybe the degree of additional subsidy can be lessened by evaluating some of the other options.

MR. WAYNE LERNER: I want to make sure I'm clear. I didn't necessarily think a subsidy as being coming from one direction or another or that there has to be additional, although we have to debate that. But the issue of subsidy as broadly defined. We can't have pre-existing condition population groups and not subsidize them if those people aren't working. It just doesn't work.

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MR. DAVID KOEHLER: I guess I -- just a comment on her talking about the individual market. You talked about pools in there. And I think that's one area that that could be addressed is how you define the pool. The other I appreciated right off the bat saying that there's a recognition that there needs to be more tax dollars. The one thing that hit me very square right between the eyes when we had some of the folks who were at the opera.

MR. WAYNE LERNER: Yes. The state insurance.

MR. DAVID KOEHLER: The one speaker who said don't think that you can solve this by kind of rearranging the dollars. It's going to take more resources. I think that we have to recognize that.

MR. WAYNE LERNER: Dr. Young.

DR. QUENTIN YOUNG, MD: Thank you. I appreciate you defining your program

as anti-single payer. It's the right juxtaposition. And we welcome the competition. I wanted to ask you, we've been talking about money these last few remarks. And that's a big one, maybe the biggest. And one of the hallmarks of our present system is the huge administrative costs that have to make it run. And I wondered if you'd comment in your proposals. I was struck with the implicit inevitable enhancement or enlargement of administrative costs to handle all these pools. Did your deliberations address that at all?

MS. ELENA BUTKUS: They did in general. We did talk about the administrative expense with respect to administering the Medicaid program, which is much lower than the administration to different commercial programs or even the chip programs for that matter. I don't know the answer as to what admin is going to cost with

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respect to this proposal. We're going to leave it up to Navigant.

MR. WAYNE LERNER: But I think Quentin raises a good point because we have to look at the infrastructure costs and the resources that are used up in the regard.

Any other questions for Elena or Teresa?

Thank you very much. I really appreciate your participation. I appreciate everybody's patience also. I know we're running a little over time. But let's quickly go over any remaining issues.

David?

MR. DAVID CARVALHO: I can be very quick. As I think I reported last time or I maybe reported to the Steering Committee the team of Navigant Consulting with Mathmatica and Millman was selected. We are probably a day away from actually signing the contract. But they've

been generous in working with us to this stage.

We will be working with the Steering Committee this afternoon on issues of the two big issues we've got, which is a process for developing recommended plans to Navigant to analyze. They are sitting ready, willing, and able. We need to process on this end and the Steering Committee has discussed that at prior meetings and will focus on it again this afternoon to develop that process so that proposals can be teed up to Navigant. And also, implications for timing both in terms of your meeting schedule and the subsequent meetings scheduled.

Some of the flavor of, some of the difficulties you can imagine are the iterative nature of the process. We don't want to set up a process where you just tee up six plans with 72 details and they come

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back and say okay, four of these don't work. When an adjustment of six of those 72 details in Plan A might have led to something with very different results. So we've got to build something iterative. And that will be a focus at the Steering Committee this afternoon.

The next meeting, the next hearing is May 11 at Benito Juarez High School in the Pilsen neighborhood. And we'll get you notice of that. The next meeting of the Task Force is May 9th.

MR. WAYNE LERNER: What time? Left it at 10:30.

MR. JAMES M. MOORE: 10:30 to 4:30.

MR. WAYNE LERNER: We start the long meetings now because if you go to -- and we will republish the schedule.

DR. NIVA LUBIN-JOHNSON, MD: I thought the end time was changed to 4 o'clock so the Steering Committee can

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leave before 4:45.

MR. DAVID CARVALHO: Right. It's 10:30 to 4:00. Steering Committee will meet at 4:00. And in case you're wondering, lunch will be provided. We do not expect you to -- we will work through lunch.

MR. WAYNE LERNER: We will repub --

DR. NIVA LUBIN-JOHNSON, MD: I just have another question before you adjourn.

MR. WAYNE LERNER: We will republish the schedule. We had an original schedule that took us through September. We'll republish it. As I was starting to say, the next set of meetings are really long because we've got to do presentations and work on the models at the same time. So we'll be talking about this at the Steering Committee. We've got process issues and we've got structural issues we have got to get going in order to be

able to now start to bring together everything we've heard and said and talked about and read to be able to deal with the model formulations.

DR. NIVA LUBIN-JOHNSON, MD: Concerning the fact that Navigant hasn't signed a contract yet, I'm glad to hear they have been doing some work. Is that going to change any of the time lines that were published in the executive summary?

MR. DAVID CARVALHO: It may need to. And that's going to be something else that we'll talk at the Steering Committee so we can dove tail their work product with your meetings to make sure that we'll be most efficient with your time.

DR. NIVA LUBIN-JOHNSON, MD: Is it -- have you talked with them at all about the time line they published? And do they feel a need to alter anything? Or do they think that they can accelerate the process on their

end? In other words, since they are getting paid for it, they be inconvenienced more than we who are getting paid being inconvenienced.

MR. DAVID CARVALHO: Well, we have talked with them. And we'll bring out of that into the discussions with the Steering Committee because it does dove tail with your time with a time line for analysis. That is exactly what I want to talk about with the Steering Committee this afternoon.

MR. WAYNE LERNER: And the other thing we talked about -- I know we talked about at either and/or the Steering Committee. We may have to add a couple extra days to our work schedule in order to get this done. And so we're going to try and work this through so we don't have to do it and use up more of your time.

MR. DAVID KOEHLER: I think though just to give you my own personal opinion, I think that the discussion

so far has all been that we want to meet our overall deadlines, so if we have to squeeze some things in and do some extra work, then we're going to have to do that.

DR. NIVA LUBIN-JOHNSON, MD: I'd be in favor of more days after May before October 1st rather that extending beyond October.

MR. WAYNE LERNER: I'm sorry. I didn't understand you. Let me go right there. We said between August and October we would be done.

DR. NIVA LUBIN-JOHNSON, MD: Okay.

MR. WAYNE LERNER: We're going to be done. Otherwise Margaret's got to chair.

DR. NIVA LUBIN-JOHNSON, MD: October 1st.

MS. MARGARET DAVIS: And I'll let it go on to next year.

MR. WAYNE LERNER: Any other questions? New business? Old

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business? I want the thank all the members of the Task Force and everybody else who's here. Thank you very much. We're adjourned.

WHICH WERE ALL THE PROCEEDINGS HAD ON THIS DATE.

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

I, VICTORIA SAWYER, a Certified Shorthand Reporter of the State of Illinois and Registered Professional Reporter, do hereby certify that I reported in shorthand the proceedings had at the public hearing, and that the foregoing is a true, complete and correct transcript of the proceedings of said hearing as appears from my stenographic notes so taken and transcribed under my personal direction.

IN WITNESS WHEREOF, I do hereunto set my hand at Chicago, Illinois, this 11th day of May, 2006.

Certified Shorthand Reporter
CSR Certificate No. 84-4573