MINUTES
(Approved by the Committee)
HEALTH CARE TASK FORCE
August 21, 2008
9:00 a.m.
Supreme Court Basement Conference Room
451 W. State St., Boise, Idaho

The meeting was called to order by **Co-chairman Representative Gary Collins** at 9:30 a.m. He asked the secretary to take a silent roll call. Those present were Cochairman Senator Dean Cameron, Senator Joe Stegner, Senator Patti Anne Lodge, Senator Tim Corder, Senator John McGee, Representative Sharon Block, Representative Jim Marriott, Representative Fred Wood, and Representative Margaret Henbest. Absent and excused were Senator John Goedde, Senator Elliott Werk, Representative Carlos Bilbao, and Representative John Rusche. Staff present were Paige Alan Parker, Amy Castro, and Juanita Budell.

Others present were Kathie Garrett, Partners in Crisis; Tim Olson, Therese Bishop and Jim Pinkerton, Regence/Blue Shield; Corey Surber, Saint Alphonsus Hospital; Steve Peterson, Susette Driscoll, and William Hazle, Business Psychology Associates; Delmar Stone, National Association of Social Workers; Heidi Low, American Cancer Society; Julie Taylor and Woody Richards, Blue Cross of Idaho; Kris Ellis, Benton, Ellis & Associates; Robert Tierney, Idaho Association of Health Underwriters; Molly Steckel, Idaho Medical Association and Idaho Psychological Association; Kathleen Allyn and Paul Leary, Department of Health and Welfare; Jayson Ronk, Alex LeBeau, Idaho Association of Commerce and Industry; Bill Deal, Director, Idaho Department of Insurance; Sara Stover, Department of Financial Management; Hyatt Erstad, Chairman, Idaho High Risk Pool; Jeremy Pisca, Saint Alphonsus Regional Medical Center; Colby Cameron, Sullivan & Reberger; Julie Robinson, FMRI & IVC; Richard Burns and Keith Bybee, Legislative Services Office; Patty Tobias, Administrator, Idaho Supreme Court; Rakesh Mohan, Office of Performance Evaluations; John Watts, Veritas Advisors; Benjamin Davenport, Evans Keane; Roger Serber, Capitol West; Denise Chuchovich and Jesus Blanco, Idaho Primary Care Association; Mr. Hyatt Erstad, Chairman of the Board of Directors, Idaho Small Reinsurance Board and Idaho Individual High Risk Pool; Mr. Larin Walker; Ms. Joan Krosch, Department of Insurance; Mr. Ted Roper, Department of Administration; Mr. Steve Millard, Executive Director, Idaho Hospital Association; Ms. Joyce McRoberts, Special Assistant to the Governor on Health Care and Project Manager for the Governor's Select Committee on Health Care; and Mr. Stephen Weeg, Chairman of the Governor's Select Committee on Health Care and Executive Director, Health West Community Health Center in Southeast Idaho.

A motion to approve the minutes of the previous meeting of January 29, 2008 was made by Representative Marriott. The motion was seconded by Senator Lodge. The motion carried by unanimous voice vote.

Chairman Collins then asked **Senator Stegner**, Chairman of the Health Care Task Force's

Mental Health Subcommittee, to give a report.

Senator Stegner said that the Subcommittee met on August 20, 2008, following the Western Interstate Commission on Higher Education (WICHE) presentation on Idaho Behavioral Health System Redesign to the Task Force. The WICHE staff presented to the Subcommittee decision points for consideration.

The first point was whether the system needs a larger, overhaul transformation or just incremental changes. He said the committee had a significant discussion regarding that matter and a motion was made and approved that the Subcommittee recommend proceeding with the concept of an overall transformation. **Senator Cameron** inquired if passage of an overall transformation would prohibit doing a gradual, incremental approach. **Senator Stegner** said with the information presented, change needs to be slow and methodical.

The second decision point the Subcommittee considered was, if a transformation was to be undertaken, whether a workgroup was required to oversee the process. **Senator Stegner** noted that the Interagency Committee on Substance Abuse (ICSA) already exists that has the capability to undertake the transformation workgroup function**. A motion was made and approved by the Subcommittee to recommend approaching the ICSA to determine if it would consider acting in that role.**

Senator Stegner stated that decision points #3, #4, #5, #6, and #7, dealing with the examination of the statutory changes that will be needed, consideration of staffing, creating deadlines and timelines, identification of costs, and the implementation in the different areas, were approved by the Subcommittee by a motion as recommendations as a work plan for the transformation workgroup.

Chairman Collins thanked **Senator Stegner** for his report.

Senator Cameron made a motion to accept the Subcommittee's report and to consider formal action on the recommendations at the next Task Force meeting. The motion was seconded by Senator Stegner. Following a short discussion, Senator Stegner said that if the Task Force approves the motion, the approach ICSA to review the WICHE report and its concept and to discuss ICSA's potential involvement in the transformation workforce process. The motion passed by unanimous voice vote.

Chairman Collins then welcomed **Paul Leary**, Department of Health and Welfare, the Division of Medicaid.

Mr. Leary provided the committee with handouts which he said that he would refer to in his presentation. Attachment #1 is "Idaho SCHIP At-a-Glance, June 2008." Attachment #2 is "CHIP B, Children's Access, and Adult Access Insurance Premium Tax Fund Projection, State Fiscal Years 2005-2009." These handouts are available in the Legislative Services Office.

Mr. Leary gave an overview of the State Children's Health Insurance Program (SCHIP). Idaho's programs are funded by Title XXI (SCHIP) allotments and Idaho's enhanced match rate is 80/20 (four federal dollars matched to each state dollar). Idaho is currently spending the federal allotment at a projected rate of $9 million per quarter. At the current utilization rate, Idaho has enough federal funding to continue its SCHIP-funded programs through March of 2009, when SCHIP reauthorization is expected to be completed by Congress. **Mr. Leary** then briefly reviewed the first six points for Health Insurance for Adults and Children: Access Card; Access to Health Insurance; Children's Health Insurance Coverage; Qualifying factors; Funding; and Changes to Programs.

Mr. Leary then covered activities the Department of Health and Welfare is pursuing. Marketing was done to reach the uninsured who currently qualify for programs. That was accomplished by brochures being distributed to all Idaho school districts, health departments, primary care providers, and other stakeholders. The Department updated premium assistance brochures and also held training sessions with 30 new insurance agents attending. A report of other states' premium assistance programs was shared with the Governor's Select Committee to consider modifications in Idaho. **Mr. Leary** said that coordination with other programs and simplification of the application process had been completed. The child-only application has been shortened from seven pages to three pages, which should reduce some of the barriers. A mailing was sent to 9,200 individuals on the WIC program who qualify for Medicaid or the SCHIP program. The response rate back was less than one percent (1%).

Mr. Leary then reviewed Premium Assistance/Direct Coverage through Title XXI. He noted the number of eligible children from June 2007 was 15,756. Through June 2008, the number was 18,824. Slight increases were seen in the Access Card and Access to Health Insurance (adults and children).

Regarding the Preventive Health Assistance (PHA)/Premium Collection, $888,068 was paid. The number of children currently required to pay a $10 or $15 premium was 14,193. The number of children who have earned points for well-child checks and immunization to date is 9,272. About 50 percent of the children are earning points. When premiums are delinquent over 60 days, letters are sent to notify the parents that there are opportunities for them to earn points with their children by keeping their wellness checks and immunizations up-to-date and keeping their premiums paid. The number of children closed for not paying premiums was 436. There are currently 125 employers participating in the Access to Health Insurance program.

Future Activities will include the renewal process for the HIFA (Health Insurance Financial Accountability) 1115 Waiver. **Mr. Leary** said the Department anticipates some restrictions/limitations of coverage for adults with the current administration. The Department is negotiating Title XIX budget neutrality with CMS to lift restrictions that currently prevent some individuals from participating.

Senator Cameron inquired as to the extent of consideration **Mr. Leary** had given the report from

Boise State and Milliman**.** **Mr. Leary** said the Department has considered that report and is looking for direction from the administration. **Senator Cameron** suggested that the Task Force hear the recommendations from that report at its next meeting.

Senator Cameron then asked about marketing activity of distributing brochures to the school districts. **Mr. Leary** clarified that the brochure also was sent to primary care providers, health districts and health fairs. The Department is also looking at other effective strategies to pursue. **Senator Cameron** said that five percent (5%) of the federal funds can be spent on marketing and asked what percent the Department is spending. **Mr. Leary** said that he would get that figure.

Mr. Leary then reviewed the Healthy Schools 2008 report. Grants are provided to schools that have a high percentage of low income populations to help support a school nurse. These grants fit with Medicaid reform and deal with wellness. Thirteen schools have received funding for nursing services., reaching 15,578 students K through 12 and 336 pre-kindergarten children. Looking at the Healthy Schools Nurses program, the ratio of school nurses to students in the 13 schools is1:1,764. Before the program, the ratio was 1:2,393. The Healthy School Nurses program has helped with the development, revision and/or implementation of policies in the following areas: wellness, medication administration, prevention/control of communicable disease, injury reporting, health record maintenance, provision of emergency care, special health care services, health screening/referral/follow-up/problem identification, immunization requirements, DNR order, and suicide prevention.

Health counseling for students, staff, and families included: Elementary - 2,648; Middle School - 1,195; High School - 2,327; and Pre-Kindergarten - 336. The counseling consisted of: referrals to appropriate health care professionals; 44 home visits; referral of 47 families for Medicaid applications; referrals to Child Protective Services; and 76 pregnancies reported (6 middle school and 70 high school pregnancies).

Presentations made by the Healthy Schools Nurses program numbered 355 on a number of topics. Some medication was also administered: long term - 118; short term - 289; and emergency - 37. During health screening, the following health related conditions were identified and referred out: dental problems - 403; hearing deficit - 98; pediculosis - 12,641; scoliosis - 646; vision deficit - 1,491; incomplete immunization - 412; and other - 732. Screening for height and weight - one school reported that 25 percent of the students fell into the obese category. Beyond the day-to-day cuts and scrapes, the following conditions were reported for this school year: Asthma - 653 students; Diabetes - 41 students (26 receive insulin at school); EpiPens - 27 students; Tube Feedings - 5 students; and Other - 6 students. Emergency care in these 13 schools included 3,435 minor episodes and 71 serious.

Representative Henbest inquired as to the number of children that are eligible, but are not covered. **Mr. Leary** replied that he does not have an absolute number, but thinks about 50 percent of the eligible children are covered.

Representative Marriott asked about the amount of money spent for the Healthy Schools program. **Mr. Leary** said that $400,000 is allocated for the grants annually, but probably the actual amount spent is in the mid $300,000's.

Senator Cameron inquired as to when Idaho started utilizing the Premium Tax Fund for the CHIP B program. **Mr. Leary** said he would get that information. **Senator Cameron** asked several other questions and **Mr. Leary** agreed to respond to the questions posed and would get back to him.

The follow-up responses by **Mr. Leary** to the Task Force are attached to these minutes.

Next to speak was **Mr. Hyatt Erstad**, Chairman of the Board of Directors for the Idaho Small Reinsurance Board and the Idaho Individual High Risk Pool, who gave a broad overview of the High Risk Pool program. Joining him was **Mr. Larin Walker**, Administrator of the program, and **Ms. Joan Krosch**, Department of Insurance.

The High Risk Pool is a political subdivision of the state and has been in place since 2000. During this period of time, there have been 6,100 Idahoans who have taken advantage of the Pool. The High Risk Pool serves individuals who make application for health insurance coverage on an individual policy basis and are declined because of health reasons. Under the statute, such individuals must be offered one of the coverages available through the High Risk Pool by an insurance carrier doing business in the state. It is the individual's election to choose to enter the High Risk Pool. There are currently 1,400 people in the Pool. Since the Pool's inception, it has paid out almost $29 million in claims. The Pool has received its second grant from CMS, which was just under $1 million. The Pool's Board is attempting to be proactive about the program. They have one individual who has been promoting it among the carriers and information going to the brokerage community. Next week, the Governor will announce the success of the program. The ten-member board meets on a monthly basis; all are volunteers.

Mr. Walker provided a four-page report which included the Idaho Individual High Risk Reinsurance Pool's balance sheet as of May 31, 2008; statement of Revenues and Expenditures; statement of changes in the fund balance; and a graph showing Ceded Lives from January, 2005 through April, 2008. These documents are available in the Legislative Services Office.

Representative Marriott inquired as to the amount of the premiums. **Mr. Walker** said that the information is posted on the Pool's Web site and that he will provide that information to the Task Force. **Ms. Krosch** provided the Web site address, which is www.doi.idaho.gov. (double click on "consumer affairs", select "health information", then click on "sample policy and rates").

Senator Cameron congratulated **Ms. Krosch** and the Department for their work and also for the second grant received.

The next speaker was **Mr. Ted Roper,** Department of Administration, Industrial Special

Indemnity Fund and Employee Benefits Insurance Program. He presented an update on the Mental Health Parity Program, comparing what it looked like prior to July 1, 2006 when the authorizing legislation was passed. His PowerPoint, available in the Legislative Services Office, consisted of the following slides and information.

Summary of Mental Health Benefits Prior to July 1, 2006

Generally:
- 200 hours of mental health and/or substance abuse treatment per year.
- $150 per person and $300 per family annual deductible.
- Co-pays of $15 to $25 per billable hour (depending on in or out of Network)

Expanded Benefits Provided by HB 615
Diagnoses of "Serious Mental Illness" are now treated the same as any other illness.
- Specifically Defined Diagnoses are:
  1. Schizophrenia
  2. Paranoia
  3. Bipolar disorders (mixed, manic, and depressive)
  4. Major depressive disorders
  5. Schizoaffective disorders (bipolar or depressive)
  6. Panic disorders
  7. Obsessive-compulsive disorders
- In addition, children with Serious Emotional Disturbance conditions are covered.

Non-Serious Mental Illness and Substance Abuse
- Non-SMI diagnoses continue to be limited to 8 inpatient and/or 30 outpatient visits per year.
- Substance Abuse was not included in HB 615 and is limited to 8 inpatient days and/or 30 outpatient visits.

The membership since 2004-05 has grown 1.9% - active employees; 3.2% - dependents; and total members - 2.6%. Aggregate medical costs for active employees and dependents has grown by 11.4%, excluding mental health. Costs, including mental health, have grown by 11.8%. The average growth for active employee and dependent medical costs, excluding mental health, is 11.4%. Costs, including mental health, have grown by 11.2%. On a per-member, per-month basis, costs (including mental health) have an 8.4% growth average. For fiscal year 2007-2008, mental health services served 156 inpatients, 2,564 outpatients, for a total of 2,720; the total cost was $1,933,024. For fiscal year 2007-2008, substance abuse services served 33 inpatients, 163 outpatients, for a total of 196; the total cost was $160,310. The total cost of mental health and substance abuse treatments was $2,093,333.

Preliminary Conclusions

- This program has been well managed by Blue Cross of Idaho and Business Psychology Associates.
- Their combined "Gate Keeping" and claims management processes have made the plan accessible to those who are properly diagnosed while making sure that only reasonable and necessary care is given.
- Overall costs, at 1.5% of total medical costs for FY2008, are below the 1.8% projected when HB 615 was proposed.

Representative Henbest gave an update and background on the Nursing Workforce Center. In the Fall of 2007, the Governor appointed 22 members to the Nursing Workforce Advisory Council. The vision was, within the Department of Labor, to determine the supply and demand for nursing in Idaho. Congress had earmarked funds for an earlier workforce, but those funds are due to run out. The Legislature passed funding for the Nursing Workforce. There is an aging population in Idaho and by 2016, the population over 55 will increase by 50 percent. The average age of nurses now in Idaho is 45 and there is not a sufficient workforce to deal with this aging population. The task for the Department of Labor is to determine the magnitude of that workforce deficit. The loss of nurses each year is between 500 and 1,000. The Department of Labor has defined the deficit by regions.

The Center has preliminary recommendations and goals which will be taken to the Governor, the State Board of Education, and to the presidents of the universities. The issues and challenges that are in the forefront are faculty pay versus industry pay, recruitment and retention. Another problem is the struggle the Center is having in acquiring data from long-term care. One reason is that the staff is short-handed and cannot respond. The final recommendation has to do with the Center itself. The authorizing legislation will sunset in June 2009, and will have to be reauthorized in the next legislative session, if it is to continue. The discussion has been to extend the sunset for four or six years, rather than two. **Representative Henbest** said the right place to house the Center is within the Department of Labor, which partners with the Board of Nursing. The Department has access to track data, which is important to the program.

Senator McGee complimented **Representative Henbest** for her work on the Workforce. He agreed that this effort needs to be continued and he thinks that the problems are solvable.

Representative Wood agreed that there is an acute shortage of nurses and the Workforce is developing a plan about how to coordinate the educational efforts of the state's institutions and also a plan on coordinating financing.

Senator Cameron inquired about the conversations **Representative Henbest** has had with the Department of Labor. She replied that the Department is supportive and has developed in-house expertise in looking at nursing workforce issues. **Senator Cameron** said the Task Force needs a report from the Department of Labor. He would like to see more structure and direction provided

on work that the Center is doing. **Senator Cameron** also suggested that the Department and Workforce Council work closely with the Executive Branch. **Representative Henbest** reported that **Director Madsen** had made a presentation to the **Governor** last week.

Senator Corder expressed his concern regarding the quality of care, especially in rural areas. **Representative Henbest** said that the scope of work done by the Department of Labor does not

address quality issues. She indicated that she would discuss this with the Workforce Advisory Council.

Mr. Steve Millard, Executive Director, Idaho Hospital Association, was the next speaker. **Mr. Millard** spoke on the "Health of Idaho's Rural Hospitals." Following are some of the points of his presentation:

Idaho Hospital Demographics

24 Governmental Hospitals
- 12 County
- 10 District
- 2 State
- 2 Federal

24 Private Hospitals
- 14 501(c)(3)
- 10 For-profit, including 4 physician-owned hospitals and 3 long-term, acute-care hospitals (LTACH)

Of those 48 hospitals, 26 are designated as Critical Access Hospitals by the federal government, which, by definition, are hospitals that are in HPSAs and that have 25 or fewer beds. **Mr. Millard** used "Critical Access Hospital" as a proxy for "rural" hospital.

The Critical Access Hospitals (CAHs) in Idaho are:
1. Boundary Community Hospital — Bonners Ferry
2. Shoshone Medical Center — Kellogg
3. Benewah Community Hospital — St. Maries
4. Gritman Medical Center — Moscow
5. Clearwater Valley Hospital — Orofino
6. St. Mary's Hospital — Cottonwood
7. Syringa General Hospital — Grangeville
8. McCall Memorial Hospital — McCall
9. Cascade Medical Center — Cascade
10. Weiser Memorial Hospital — Weiser
11. Walter Knox Memorial Hospital — Emmett
12. Elmore Medical Center — Mountain Home

13. Gooding County Memorial Hospital — Gooding
14. St. Benedict's Medical Center — Jerome
15 Minidoka Memorial Hospital — Rupert
16. Cassia Regional Medical Center — Burley
17. St. Luke's Wood River — Ketchum
18. Harms Memorial Hospital — American Falls
19. Oneida County Hospital — Malad
20 Franklin County Hospital — Preston
21. Bear Lake Memorial Hospital — Montpelier
22. Caribou Memorial Hospital — Soda Springs
23. Bingham Memorial Hospital — Blackfoot
24. Teton Valley Hospital — Driggs
25. Steele Memorial Hospital — Salmon
26 Lost Rivers Hospital — Arco

Rural Hospital Data

Based on a sample of 10 CAHs — April 2007 — March 2008

- Operating margin —2.1%
- Level of Care Charges as a % of Total Charges
  Inpatient — 29.9%
  Outpatient —65.5%
  Other (Swing bed, subacute, LTC) — 4.6%

  Based on a sample of 15 CAHs — January — March 2008
- Uncompensated Care - $5.5M
- Medicare Shortfall from Charges —$15.3M (Reimburses 101% of costs)
- Medicaid Shortfall from Charges - $5.6M (Reimburses 96.5% of costs)
- Total Uncompensated Care and Government Shortfalls — $26.3M (25.3% of charges)

Anecdotal Information Based on Recent Visits with Rural Hospital CEOs

1. Most hospitals are doing okay with small margins.
2. Most hospitals have become creative in the services they provide that add to the revenue side and bottom line (swing beds, partnerships, visiting surgeons, etc.)
3. All rural hospitals in Idaho are used to slim or no margins.
4. Most rural hospitals are supported by their communities.
5. The current condition Teton Valley Hospital in Driggs is not an accurate reflection of the face of rural hospitals in Idaho. It is an anomaly due to some bad decisions that were made over the last three to five years.

Continuous and Future Challenges for Idaho Rural Hospitals

1. Capital financing for renovation, improvements and replacements of equipment and facilities;
2. Workforce shortages (aging workforce and aging patient population);
3. Low or red margins;

4. Below cost reimbursement;
5. System fragmentation;
6. Cost of information technology;
7. Increasing regulation.

Chairman Collins thanked **Mr. Millard** for his report.

Speaking next was **Ms. Joyce McRoberts**, Special Assistant to the Governor on Health Care and Project Manager for the Governor's Select Committee on Health Care. **Ms. McRoberts** provided a background on what the Select Committee has been doing this past year. At its summit meeting, the Select Committee developed a package of good recommendations which were presented to the **Governor** in mid-September. He accepted those recommendations with the caveat that the Select Committee would reach out to the public, hear what citizens had to say, and build on those recommendations. The first public hearing was in October, 2007 and the Select Committee has continued to hold hearings throughout the state through April, 2008. Eleven hearings have been held with many people responding. **Ms. McRoberts** felt that the Select Committee had reached a broad variety of people who have expressed a strong hope that something would be done with health care in the state of Idaho. The Select Committee is continuing to gather information, including what is working and not working in other states. Based on the summit recommendations, the Select Committee is developing a vision for Idaho and a road map for action. **Ms. McRoberts** said that Select Committee knows that its recommendations need to be affordable, achievable and sustainable. She will stay in contact with the Task Force and keep it informed as to what the Select Committee is doing.

Representative Block inquired as to what states the Select Committee had been working with. **Ms. McRoberts** replied that they have talked with Colorado, Montana, Oklahoma, California and Massachusetts.

Mr. Stephen Weeg, Chairman of the Governor's Select Committee on Health Care and Executive Director of Health West Community Health Center in Southeast Idaho, then spoke on the recommendations and the direction of the Select Committee.

Mr. Weeg said the one thing they hear a lot is that we are all in this together; health care is not an issue to be solved by government or individuals working on their own, but will involve a partnership with individuals and employers; doing nothing is not an option. Looking at health care outcomes, the United States does not do well, ranking 17th or 18th out of 20 industrialized nations in terms of quality of care indicators. Data indicates that there is a 50 percent chance of an individual not getting care based upon practice standards. There are huge variations in costs and quality in the systems that we have today. Access, cost of care and quality of care needs to be looked at and addressed simultaneously. Chronic care conditions account for 70 to 75 percent of all health care costs.

Regarding the recommendations, there are five categories. The first one is workforce — do we have the primary care and medical staff to meet the needs right now? The answer is no. Idaho is low in physicians per capita and has one of the oldest physician workforces. The Select Committee has looked at comprehensive public/private coverage and the vision is that everyone in

Idaho should have access to affordable quality health care built on a patient center primary care medical home model. Having insurance does not equal having access. Some folks have insurance, but insurance alone does not guarantee access to the proper kind of care. There are some comprehensive public/private partnerships looking at various coverage models that might make care affordable, given the current market. Recommendations are being looked at to see if they should be mandated.

The third major area is prevention and personal responsibility. Obesity and chronic diseases need to be looked at and efforts made to turn them around. Health care is a partnership and individuals can do a lot for themselves.

Innovative services was the next area. Health care is not coordinated and it needs to be connected. Information should flow back and forth between the various doctors and offices. There is emphasis on quality and safety.

The final area is behavioral health issues, mental health and substance abuse. **Mr. Weeg** thanked **Senator Stegner** for his efforts in this area. Historically, mental health care has been separated from physical health care. What needs to be done is to unify that in delivering care, treating it as one person, not as separate entities.

Mr. Weeg then discussed looking at care, building a healthy Idaho, starting out with the individual person and wellness within the family and community. He said it is a work in progress, with a series of reports and recommendations. The Select Committee's goal is to look at each of the items, in keeping with the charge from the **Governor** to review the recommendations, analyze them and either affirm them or develop other recommendations. Healthy kids become healthy adults and become productive citizens. Kids who are sick don't do as well in school and don't succeed in life as well; uninsured sick people do worse. **Mr. Weeg** said that we need to figure out how to cover our kids with affordable insurance. The Select Committee is looking at further developing areas of wellness and prevention to help people on an individual level.

Senator Stegner thanked **Mr. Weeg** for his kind remarks, but said it was a team Task Force effort. He then asked **Mr. Weeg** if the Select Committee was through taking comments and how can the Legislature, or general public, offer additional comments regarding the issues. **Mr. Weeg** said the Select Committee is always open for comments and the best way is to contact **Ms. McRoberts** in the **Governor**'s office.

Chairman Collins thanked the speakers for their presentations. There was some discussion as to the next meeting and it was determined that it will be September 16th from 1:30 p.m. to 5:00 p.m. Another meeting was tentatively set for October 23, 2008. The meeting was adjourned at 1:30 p.m.

Attachment: Responses to Mr. Paul Leary, Dept. of Health and Welfare