Adequate Health Care

March 8, 2006

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HEALTH CARE JUSTICE ACT

PUBLIC HEARING

ADEQUATE HEALTH CARE TASK FORCE

12TH CONGRESSIONAL DISTRICT

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REPORT OF THE PROCEEDINGS had and testimony taken at Public Hearing of the above-entitled matter, commencing March 8, 2006 at John A. Logan Community College, Carterville, Illinois, before Stacey Jenkins Kolb, MO CCR, RPR, IL CSR # 084-0003358, and Notary Public.

APPEARANCES:

Jan Daker

Margaret A. Davis

Jim Duffett

Ken Robbins

David Carvalho

Jim Jordan

MR. DUFFETT: I want to go over some information to give people an idea what this process is. Welcome to the 12th congressional district public hearing of the adequate health care task force under the Health Care Justice Act. It's been well documented that a person's ability to access the health care system influences his or her treatment options and health status. Access to health care is most affected by the ability of those seeking care to afford the services that they need. Therefore, the uninsured working poor, racial and ethnic minorities and undocumented immigrants in Illinois are least likely to be able to afford to pay out of pocket for many health care services they need. Many Illinoisians lack access to the health care system because they lack health insurance. On any given day an estimated 1.8 million Illinoisians are without health insurance. Additionally, a growing number of Illinoisians are under-insured and consumers' share of the cost of the health insurance continue to grow. Even though safety net providers, including private and public clinics, charity care administered by private hospitals that attempt to narrow the gap between the insured and uninsured, many uninsured Illinoisians still lack access to preventive and comprehensive care. The

Health Care Justice Act signed into law by Governor Blagojevich in 2004 encourages the State of Illinois to implement a health care plan with a full range of preventative, acute, long-term health care services and maintain the quality improvement -- also improves the quality of health care services offered to all Illinois residents. The act creates the Adequate Health Care Task Force which has undertaken the task of developing this access plan. There are 29 members of the task force appointed by the governor, the president of the senate, the minority leader of the senate, the speaker of the house and the minority leader of the house. As part of our work, the Task Force has been holding and will be holding at least one public hearing in each congressional district to seek input from the public regarding an access plan which is why we are out here this afternoon. On behalf of the Task Force and Illinois Department of Public Health, I want to thank each of you for coming out this afternoon to take part in this process and encourage you all to stay involved in this process. I would like to also thank John A. Logan College for sharing their space with us this afternoon.

To get started, I want to go over what the basic format will be and then we'll introduce the

individuals on the Task Force that are up here. A couple of housekeeping things. If you've not already done so there's a sign-in table located in the back of this room that we're asking you to sign to put your name on. This will help the Task Force and the department keep track of the number of people who are attending this hearing. There are also two handouts available at this table that provides more information about the Health Care Justice Act, the Adequate Health Care Task force and this public hearing.

Second, if you wish to testify, please be sure to sign up at the table near the entrance to this room. There's this color sheet that if you want to testify and you have not, please go back and put your name on that and then we'll be calling people in order. If you brought written testimony to submit, you may also do in this and place it at the table. When we begin we'll be calling up the list of first five speakers and we'll be asking them to sit in this row right here and then as your name gets called to come up to the microphone and please speak. Before you begin your testimony, please be sure to say and spell your first name and last name for the court reporter and speak into the microphone so that people will be able to hear you and for the court reporter to hear you.

All of this information and other information that the Task Force meetings have been having are on the web site at the Illinois Department of Public Health and you can go back and see additional testimony and minutes from the different hearings we have held. We are going to do our best to keep testimony to three minutes and there's going to be a sign here that's going to show how much time that you have left.

I would like to first start on my left and if people from the Task Force could introduce themselves, what organization they're with and if you can also state who appointed you on the Task Force that would be great.

MARGARET DAVIS: Margaret Davis, Health Care Consortium of Illinois, appointed by president of the senate Emil Jones.

JAN DAKER: Jan Daker representing the United Congregations of Metro East appointed by the governor.

KEN ROBBINS: Ken Robbins. I'm president of the Illinois Hospital Association and was appointed by the house minority leader.

MR. DUFFETT: Jim Duffett. I'm the director of the Illinois Campaign for Better Health Care and was appointed by Governor Blagojevich.

DAVID CARVALHO: David Carvalho. I'm deputy

director of the Illinois Department of Public Health. The Illinois Department of Public Health was assigned the responsibility under the Health Care Justice Act of providing staff support to the Task Force and so tonight I'll hold up the sign that tells you you have one minute left or that you are out of time. We have a gentle clock as our timer. We are trying to allow everyone who would like to speak tonight to speak within the two hours from four to six. However, we will go to seven if there are speakers, so you will not be strictly held to speaking two minutes and 59 and a half seconds but we do want you to keep your remarks to around three minutes so that we can allow everyone who wishes to speak to speak tonight. Thank you.

MR. DUFFETT: I also want to introduce Brenda Green with the Department of Human Services who is here representing that agency. Brenda. Thank you. I would like to first begin with the first five people and, again, if you could come up to this row here, Richard Whitney, Charlie Howe, Hervey Davis, Tess Ford and David Torrence. If you could please come up here, and then Mr. Whitney if you would like to go first, thank you.

RICHARD WHITNEY: Thank you. I do have a prepared statement. Do you want me to bring that to

you at this time?

MR. DUFFETT: Or after you get done, that would be fine.

RICHARD WHITNEY: Good afternoon. My name is Richard Whitney and I'm representing the Illinois Green Party, one of the dozens of organizations that supported the Health Care Justice Act and the campaign for better health care. Since I understand that speakers are limited to three minutes, I'm going to be providing you with a much more detailed position paper but basically I'm here to speak on behalf of the Illinois Green Party as its candidate for governor on behalf of a single payer system as the best way of providing universal health care in the state of Illinois. Increasingly private health insurance is becoming prohibitively expensive for both employers and employees. And the plans that some can afford are becoming more and more limited in coverage with higher deductibles and co-pays so the ranks of the uninsured and the badly insured continue to grow. To design a universal health care system that remains based on private insurance, therefore, simply makes no sense. A health care system based on private for profit insurance is also enormously wasteful because of the insurance companies' drive to reap maximum profits

because it is fragmented and inefficient and because each year it wastes hundreds of millions of dollars paying unnecessary administrative costs. Let's face it, private insurers make money by not paying bills. They have a profit incentive to deny or stall payments through bureaucratic administrative barriers so they can hold on to premium dollars longer boosting their investment income. The efforts of private insurers to avoid paying claims also forces hospitals and other health care providers to spend hundreds of millions of dollars dealing with paper work from the insurance industry. A system based on hundreds of competing private insurance companies also means an inherently expensive fragmented payment structure.

Health care providers are forced to deal with a multitude of insurance plans. One study in Seattle, for example, found they had to deal with 755 different plans in that city alone. Providers must determine each patient's insurance coverage, eligibility, keep track of varying co-payments, referral networks, approval requirements and formulas. And that's not even getting into the appeals process.

In contrast, Canadian physicians send virtually all bills to a single insurer using a single billing form or computer program and may refer patients

to any colleague or hospital. As a result of all of this, the administrative costs of the private health insurance system are almost ten times as great per dollar of health care payouts as the administrative costs of the Medicare system, one example of a working single pair system.

Or to use another comparison, our nation spends over 31 cents of every health care dollar on administrative costs while Canada, which provides high quality health care to all of its citizens through a single payer government insured system, spends only 16.7 cents per dollar on such costs. But single payer does not mean we would have to emulate Canada. You can consider the French health care system, ranked the best health care system in the world by the World Health Organization while the United States ranks 37. It permits all French citizens high quality treatment or the right to choose their doctors resulting in one of the highest life expectancy rates in the world. There is no shortage of doctors in France. There are three doctors for every 1,000 inhabitants in France and three for every 2700 in the United States. The best health care system in the world is a single pair system.

A single payer plan can work in one state like Illinois. One recent study in the

International Journal of Health Services showed that states like Illinois would save more than enough to fund universal coverage without any increase in total health spending. The administrative -- I just finished two sentences. The administrative savings alone, about $12.3 billion, would be equivalent to $7,362 per year for an uninsured resident, clearly more than enough to cover their health coverage.

I greatly urge this panel, this Task Force rather, to please consider a single payer system, look at the study that was done on Vermont that showed that it could work and could apply that to Illinois. We could cover everyone for less cost than they're paying for the inadequate insurance through their private insurance system. Thank you.

MR. DUFFETT: Thank you. Mr. Howe.

DAVID CARVALHO: To the speakers, out of time doesn't mean you have to stop your sentence midstream. We are being a gentle clock here. Just wrap things up. Thank you.

CHARLIE HOWE: Charlie Howe, C-H-A-R-L-I-E, Howe, H-O-W-E. A few years ago I was circulating a petition promoting an amendment to the Illinois Constitution guaranteeing access to health care. It was known as the Bernadine Amendment in honor of the

Cardinal from Chicago who died of leukemia. I came across an elderly woman in Pinckneyville, just north of here, whose circumstances illustrate why we need such an amendment and better health care for all of Illinoisians. We have been forced to take over raising our grandson, she told me. My husband has had to go back to work and his medicine alone costs $300 a month and then this past work the water bill came and it was $110. We can't afford that. What are we going to do? Caught between that proverbial rock and a hard place, these folks illustrates the health care crisis we are in but also the economic process, the problem of how to cope with the cost of living and simply staying alive.

My own case is better than most. Moving back to Southern Illinois in the spring of 1999 I came down with shingles. I immediately sought ER help at the Carbondale Clinic. The doctor prescribed a steroid. I paid for everything out of my own pocket and everything was taken care of. At the Carbondale Clinic right now because of late payments from reimbursements from the State, they are considering laying off 20 to 30 people. Next, being a Vietnam veteran, I enrolled in the VA health care system. There I receive regular checkups and good preventive care all at affordable cost.

Now there are folks out there, especially those who are making obscene profits from the present system, who say socialized medicine is bad and won't work. Well, the VA is socialized medicine and it delivers the services to our nation's veterans both effectively and efficiently. Why can't we have a system like this that covers all of our citizens? Lastly, the Green Party to which I long believes in social justice which in turn compels us to work for affordable health care for all. When one is sick or dying, there is no life, liberty or pursuit of happiness. Thank you.

MR. DUFFETT: Thank you. Mr. Davis.

HERVEY DAVIS: My name is Hervey Davis, H-E-R-V as in Victor E-Y. Last name Davis. I'm the chief executive officer of Franklin Hospital located in Benton, Illinois. Thank you for the opportunity to testify on the subject of health care adequacy. I arrived in Benton on April 15 of '02. At that time Franklin Hospital was scheduled to close on May 21 of that year. The hospital had lost over $2.4 million in the year that preceded that time and the Hospital District Board had essentially no resources to keep the hospital open. The hospital is still open for a number of reasons, including a loan from the USDA, giving the

hospital operating capital to continue the operation. In addition, the hospital became a critical access hospital affording better reimbursement from Medicare and Medicaid programs. By reducing expenses in a dramatic fashion and enhancing reimbursement and eliminating programs that are too costly, the hospital has been able to stay open.

However, time marchs on and with each passing year inflation pushes our expenses up but reimbursement does not keep up with the rate of inflation. Cost base reimbursement from the critical based hospital program brings some comfort but we receive no such relief from the Medicaid program. To cover the costs of the care for the uninsured, Franklin Hospital District imposes a property tax on the residents of the county. We assess in excess of $500,000 each year to that end, and in fiscal '05 we still had costs of nearly $300,000 that were not covered by that for the uninsured.

Franklin Hospital had a net income of $116,000 for fiscal '05. This occurred with 20 percent of our business being Medicaid and another 10 percent being uninsured. For those two classes of payers the hospital lost about $547,000. We made about $663,000 on other business allowing the hospital to be

marginally profitable overall. On operations, in '05 we lost money. Through seven months in fiscal '06 the hospital is braking even and it's possible we may even show a small net income for the year. This depends heavily on our property tax revenues and special reimbursement related to the hospital's status as a critical access hospital. For seven months of fiscal '06 we have written off about $888,000 in bad debts, provided about $145,000 in charity care, and written off $2.4 million related to Medicaid patient revenues.

It is time for real meaningful health care reform. At Franklin Hospital we are forced by the system to collect what we can from people with no insurance or poor insurance. This causes a financial stress to these people and in some cases forces them into bankruptcy. It adds to the cost of doing business in Franklin County and it feeds a vicious cycle creating fewer jobs and poorer health insurance for the residents of the county. The whole point of my testimony is to commend you for the work you're doing regarding health care reform. It is time. These are complex issues that will require business, government and individuals to work together for a meaningful solution. I support the concept of universal health care and I wish you the best as you attempt to come up

with solutions to these issues. Thank you.

MR. DUFFETT: Thank you.

TESS FORD: It's Tess Ford, F-O-R-D, T-E-S-S. Over the past year I've had the opportunity to participate in several health care needs assessments for rural and underserved populations in Illinois, most of those in the southern part of the state. From these needs assessments, issues such as extreme work force shortages of physicians, mental health providers and dentists have been emphasized. Recently a child psychiatrist was recruited to work in Southern Illinois. This is a first and very exciting but this success also points out the extreme need for care as waiting lists to see this provider are months long and children who need care from many counties are turned way because one person cannot serve everyone. Children in Southern Illinois are referred to providers in St. Louis, Springfield and Chicago. The cost to transport the children for care is prohibitive and most lower wage earning families are unable to do so.

Access to care issues include not only a lack of providers but also an inability to access medical care because individuals and families do not have insurance to cover the cost of their care. Medicaid or Medicare is not accepted by many physicians

and ever increasing numbers of individuals have no health insurance. In Illinois, young children, older adults and those with health insurance benefits are generally covered for some care. Growing numbers of young adult and middle-aged women and men who are self-employed, the working poor, unemployed individuals and those who work in businesses who cannot afford to provide health benefits are in dire straits if they need medical care. People without health care coverage usually do not access medical care unless they become so sick that they have to do so. Individuals who have so many barriers to getting medical care wait until they are in a medical crisis to seek care and usually have to use an ambulance which raises the cost even higher.

For those with insurance, coverage is reducing each year. Deductibles and co-pays are increasing. Many families and single individuals must have annual out-of-pocket expenses of thousands of dollars before insurance will begin to cover. A large number of individuals avoid care altogether because they have no insurance coverage. I know of a young man who was bitten by a brown recluse spider. The factory where he works provides no health care benefits. Because he did not have the money to seek medical care,

he asked for advice from a friend on how to care for this wound. Those without insurance cannot afford care, leave hospitals with unpaid bills, and cannot find a provider who will see them without insurance. Individuals with Medicaid are also limited as most providers do not want to take Medicaid.

An issue which especially impacts rural Southern Illinois is the availability of transportation and follow-up care. For example, many times people are not able to get back for follow-up care. I know of a case where a person had pins in their arm because they had a fracture and they weren't able to get back to have the pins removed. This caused severe complications for them. Emergency medical services need to be expanded and thoughtfully addressed for rural emergencies. There are barriers such as staff shortages, needed improvements in coordination to address the regional needs and a lack of equipment. There are barriers to being able to access transportation systems such as a 24-hour wait period for those on Medicaid, no reliable transportation for those not on Medicaid.

There needs to be more psychiatrists, especially child psychiatrists. We have tremendous shortages in this area. There are very few mental

health services for those who are uninsured. Those with the most severe and persistent needs are being provided with basic care at the community level but those services are very limited because there's a waiting list that happens. Upon discharge from a hospital, medications run out. When people get discharged from mental hospitals they're given just a few days supply and it's difficult for them to get into a provider in time to get new medications. There is a need for more specialty providers and we need to remove barriers from mid level providers. There could be tremendous expansion in rural areas to help us provide more services. We need to look at oral care. There's a lack and almost total absence of care for adults. There's some availability for screening and sealants that happens for children but not for adults. Substance abuse services and mental health areas are certainly things that are needed and have a long waiting list. And I finished this up with a list of suggestions and I will leave those for you. Thank you very much.

MR. DUFFETT: Thank you. Dave.

DAVE TORRENCE: Dave Torrence. I'm a case manager at Carbondale Township General Assistance. I've got some stories for you about people. We'll

start with a man in his early forties who has worked steadily since a teenager in the field of agriculture, landscaping and construction jobs. One day he experiences a life threatening upper respiratory infection. This lands him in the emergency room and an overnight stay in the hospital. The next day he's too weak to return to work. And at risk of eviction and having his utilities turned off, also unable to buy the prescriptions that the ER gave him, he came to Township and we were able to help him. For the first time in his adult life he got to see a doctor and got treatment for his condition. He reported a long history of getting sick twice a year in the spring and in the fall. He used to just work through it and recuperate during those times he was laid off. Now what might have been asthma in a younger man has become chronic obstructive pulmonary disorder. Asthma treatment is cheap and effective. It could have extended his working life for many more years. COPD calls for high cost treatment and effectively puts an end to his working life. He may be able to get Social Security and Medicare after a long application process. Now he says he never went to doctors because he thought he just had allergies or a cold. Now they're saying I may need a pacemaker before too long and that carries a

price tag of about 60,000.

A woman around the age of forty, widowed, her own children are struggling to raise their families. She had had a small income from baby-sitting for neighbors. She works as much as she can but starts to feel poorly and is unable to get around as easily as she's accustomed to so her income is shrinking. Her high blood pressure medication is one of the first things off the budget and it's been more than three years since she visited a doctor. She came to Township General Assistance and got help with rent and utilities and is taking her pills again but in the meantime type two diabetes has taken a firm hold on her health and she admits her eyesight is failing and she can't get around as well as she used to. And just as sadly, an affordable child care resource is lost to the community. Treatment could have slowed her decline but it's three years behind.

Now don't get me wrong. Township is not the solution that you're looking for here. We are a small outpost and the wolves are beating down the doors there. We need the big guns of the State to come in and take a look at those working poor people, people who are willing to work part-time at minimum wage with no benefits, people who have full-time jobs but no

coverage. You're going to save a lot of money and a lot of grief for people if they have access when they need it, not when their backs are against the wall and they have no other resource and they have to run up emergency room bills, ambulance bills and just face not a good outcome.

MR. DUFFETT: Thank you very much. I would like to now call the next five speakers up. George O'Neill, Clare McClure, Silvia Frank, Jim Anderson and Diane Goffinet. If you could please take the seats up there and, George, you're up.

GEORGE O'NEILL: Hi. How are you? I'm George O'Neill. I'm the executive director with Shawnee Health Services. Shawnee is the largest safety net provider in this two-county area, Jackson and Williamson County, a population of about 110,000 people overall. We see an unduplicative number of patients of around 17,000 a year. We provided about 65,000 patient encounters last year. About a quarter of our patients are totally uninsured and about half of our patients are Medicaid eligible.

One of the things I was going to talk about have already been discussed so I'm just going to focus my remarks on a couple of issues that I think are rather critical. The first has been touched on. That

has to do with psychiatric care, in particular for children. Up until this past year in this county in which we are located there were 58 children who need assessment and medication management for their behavioral issues as well as their health condition. They have to be literally taken in a van individually by the local community mental health center to Evansville, Indiana or to St. Louis. Each of those trips is two and a half hours one way, in addition to which the issues that have to be addressed in the van with the parents and the child along the way.

We recently were successful as Dr. Ford said in recruiting a child adolescent psychiatrist as Southern Illinois first but we need additional child and adolescent psychiatrists. There is none south of Springfield or to Evansville to the east or to St. Louis to the west. It is a critical shortage. We have an opportunity to recruit a second child and adolescent psychiatrist in 2007, however, that individual who is from Southern Illinois has an Illinois scholarship from the Illinois Department of Public Health and is required when they graduate to work in primary care. She will not be allowed to work off her indebtedness as a child and adolescent psychiatrist. We would like to approach the Illinois Department of Public Health and

ask them to consider a waiver in this case because of the critical need for child and adolescent psychiatry here.

The second issue I wanted to address has to do with dental care. We're in a county, again, with $60,000 people in it. There are two dentists in this county who are accepting Medicaid patients at the moment. There are about 5,000 eligible Medicaid clients at this time. About 4,000 of them are under served. In the two-county area we estimate that 8,000 Medicaid eligible patients are not being served for dental care that otherwise should be. We actually have a clinic with two full-time dentists who see Medicaid patients and patients who are under insured. We can't possibly see all of those patients.

Our program is not a model. We need a real change in the model for bringing private dentists into the Medicaid program. We would appreciate that consideration. Thank you very much.

MR. DUFFETT: Thank you. Clare.

CLARE MCCLURE: Clare McClure, C-L-A-R-E, M-C-C-L-U-R-E. I'm a retired social worker, a member of the NASW campaign for better health care and my professional organization is promoting universal health care. We work on the approach of care for all

residents. It seems that federal government has not been actively seeking to provide comprehensive health care services in a good way. As the Task Force considers testimony from the hearings, I urge the importance of looking for a sure revenue stream for carrying out any plan for accessible health care. At present, revenues are not present to support the programs in place and the ones being planned. Additional revenues could be sought regarding sales tax base without raising the rate. The existing income tax is regressing. We need graduated income tax. Consideration should be given to taxing retirement income for residents with high incomes.

Such ideas are difficult to implement but are needed if we are serious about improving access to health care in Illinois. At present there are too few providers helping Medicaid patients and those who do are forced to limit the number they see. One reason is the inadequate reimbursement rates and the other is a long delay in payments from the State for services already given. The clinics are often pushed to continue providing services when reimbursements are very slow. Clinics and social service and mental health agencies should not have to borrow to continue services while waiting for payment from the State. The

plan needs to provide for adequate payment providers in a timely way. The number of health care providers, primarily primary care providers, mental health providers and dental care providers, needs to be increased in this area. Especially places outside of the metropolitan area often do not have enough of these service providers. Studies show many Illinois residents do not have a primary care physician and many do not obtain dental care. Transportation and communication are also difficult for residents with low incomes in rural areas. As a result, many delay getting health care until the conditions become serious. Use of the emergency room is great for those without a physician and helps increase the cost of health care for all of us.

My social work experience was in the mental health field working with people with major mental illnesses. Although I've been retired for some time, I'm active with a local crew and mental health clinics. Support from the State has not kept up with inflation. We have too few hospital beds, too few community housing programs and many persons with mental illness are in long-term care facilities because they're not meeting support for them in the community. Too many persons are in jail. They have mental

illnesses but are receiving no treatment, and recently Medicaid has placed restrictions on new medications which has been very helpful for some and these people now find themselves unable to get the treatment they need. More mental health providers are needed especially in rural areas. We need plans developed for the Task Force mental health services with other health services. Presently this is not the case. I want to thank you for the opportunity to testify and keep involved in the progress the Task Force makes in developing a plan.

MARGARET DAVIS: Clare, could you talk about the availability of social work help in schools, hospitals and clinics in this area?

CLARE MCCLURE: I'm not that familiar with the schools. There are some social workers in schools. They're not always professional social workers. They may have a BA level. What was the other part of your question?

MARGARET DAVIS: The hospitals and clinics.

CLARE MCCLURE: The local hospitals have several social workers.

MARGARET DAVIS: Is there a shortage?

CLARE MCCLURE: We have a school of social work here. There's somebody here that maybe has more

information on that than I do.

MR. DUFFETT: There's someone there.

CLARE MCCLURE: I think that would be better but thank you for the question. I'll try to learn about it.

MR. DUFFETT: Go ahead sir.

GALEN THOMAS: Galen Thomas. I taught nineteen years of social work training over here at our school of social work.

MARGARET DAVIS: If you could come to the mic.

GALEN THOMAS: Galen Thomas, G-A-L-E-N. I'm signed up later for testimony but I would be glad to help. We have in our southern 27 counties school social workers who have to have a master's degree at least in social work in order to be certified school social workers. We have grown from 18 school social workers for these 27 counties to about 65 at least now but it's still compared with the 3,000 that there are in the whole state, we're very, very under served in this area. The regular education school districts are just now starting to hire their own school social workers. Most of us over the years were hired by special education operatives to provide evaluations to children that were referred for special services to

provide counseling for kids that were already identified as needing special ed. services.

I have to say amen to what everyone else has been saying about the lack of services for children, especially the mental health services. We lost our one pediatric neurologist that we had in the Carbondale area I believe that helped with those assessments that's no longer right there immediately available. I worked with the Illinois Association of School Social Workers state wide and we've been very involved with these efforts throughout the state in trying to define and provide mental health services and trying to reduce any potential duplication of effort from community services as well as the school social workers that are already employed. In Illinois we have over 3,000 school social workers which is more than any other state in the union other than New York. But nevertheless, in our rural areas outside the Chicago suburbs in particular, we are few and far between, unfortunately.

As long as I'm up giving testimony, I would also like to say we are very pleased we've got a pediatric psychiatrist back in the area because that is definitely an area under served for our children and our adolescents. On a personal note, I have a son who

served two years of active duty with the National Guard and after six months of trying to find a job to afford his own health insurance or find one that had health benefits for him and his wife and his child, he's back on active duty in Kuwait primarily for health benefits and that's what we need in Illinois in this area.

MR. DUFFETT: Thank you.

SYLVIA FRANK: My name is Sylvia Frank, S-Y-L-V-I-A, F-R-A-N-K. I'm here today representing the League of Women Voters of Jackson County. In the early 1990s the Jackson County League of Women Voters joined hundreds of other leagues across the state and across the country in studying the American health care system. We reached a number of conclusions at that time that are just as pertinent today as they were then. In fact, they may be even more so.

The situation with health care has gotten worse, not better, and particularly that's the case here in Southern Illinois. Our population has a poverty rate that's much higher than the rest of the state and, of course, that has caused some of the problems that people have been talking about. For example, one study showed that 25 percent of the people who responded in that county did not even have telephones, 65 percent had missed appointments because

they lacked transportation. With little public transportation available, this population has a very difficult time accessing health care services.

It's been mentioned by others that the many providers, especially dentists, do not take Medicaid patients. Well, a friend of mine told me the other day that as a Medicare patient she is now required to pay her doctors up front, so that would be a number of people on Medicare that are not going to be able to afford that and limit their access. It's been mentioned about the lack of health insurance and, of course, with no primary care provider, no insurance and no dentist, more and more people are relying on the emergency room for their health care needs. This is very inefficient. It's expensive for all of us and people do not have preventive or follow-up care using the emergency rooms. Although local and regional agencies have made a valiant effort to meet these needs, they're just not able to meet them all. There are not enough local resources. We need State help in having a health care plan that will provide health care to all of the people of Illinois. And we believe for it to be acceptable to the people of Illinois, any health care system has to meet certain criteria, and as you consider various approaches and plans, we hope that

you will, the members of this Task Force, will judge those plans according to the following criteria. Number one, comprehensiveness. A health care system has to provide access for all Illinois residents to a basic level of care that would include preventive care, primary care, acute care and long-term care. It would include mental health, dental and prescription drug coverage. Consumers should be permitted to purchase additional layers of care beyond the basic level if they choose. Number two, fairness. A health care plan needs to be fair to all income levels. It must be comprehensive, offering to all the same basic package of services. Three, flexibility. Any plan must be flexible enough to allow patients some choice of providers and choice of a form of treatment that they receive. Four, portability. A health care plan must provide for continuous coverage despite changes in employment, residence or income. Sharing of risk. Any plan needs to recognize that we're all in this together. Young and old, healthy and sick, rich and poor, urban and rural. The risk for covering all of us needs to be shared by all. And cost containment. To hold costs down, a plan needs to be able to leverage group purchasing power for health care services. It needs to reduce, not increase, administrative costs.

For example, a state plan needs to emulate or even better Medicare's 3 to 4 percent administrative costs rather than the 25 to 30 percent administrative costs of private insurance companies.

We thank you for allowing us to speak today. The members of the League of Women Voters support your work in coming up with a health care system that meets the needs of all people of Illinois and is fair to everyone. Thank you.

MR. DUFFETT: Jim.

JIM ANDERSON: Hi. My name is Jim Anderson, A-N-D-E-R-S-O-N, and I guess so far I'm about the only person in the room who contradicts what has been said because I happen to be an insurance agent. I'm very passionate about what I've written here and I did not write this letter this week specifically addressing the issue of universal health care but it touches on the All Kids plan which is about to start in the state of Illinois and touches on some other issues. I have thirteen years of experience in the business so I think that, if anything, my voice should be heard, and I would love to be on the Task Force to help you guys. The other thing I'm going to tell you is I spent $6,000 of unreimbursed medical expense out of my own pocket last year. I'm not oblivious to health care costs. I

happened to have chose a high deductible and last year all four of us had an illness of some kind and rang up some claims, so just so you know where I'm coming from.

The first subject, if the All Kids plan, the new All Kids plan sounds too good to be true it's because it is. It does not offer affordable coverage to all kids because just today, and I wrote this two days ago, I called the All Kids line in Springfield and told them I have a plan now with Unicare for my two kids, 14 and 10, and they said the only way I could qualify is to drop what I have for six months and then I could qualify for All Kids. I will never drop what I already have in place because my children have conditions that I don't want to leave uninsured for six months such as asthma, allergies and osteochondroma.

All I hear about is the poor pitiful uninsurable. The truth is, over 50 percent of the uninsured choose not to buy insurance because they want handouts and they won't pay the premium even though they average an income somewhere between 35 and $80,000 per year. The other uninsured have a choice in Illinois between the Illinois CHIP plan, Kid Care, and possibly Medicaid. We currently have all options in the state of Illinois no matter what your income level is.

The new plan should not be called All Kids for everyone. It should be called some kids for the irresponsible. A much easier way to insure everyone is to make them buy regular insurance with some kind of tax subsidy which should be fair to all income levels and it would put the premium in the hands of companies large enough to carry reserves and make claim payments in a timely manner to providers and who will not go broke even though they may get hit with some occasional super high unexpected claims. I for one have no intention of paying into a program that because someone decides to pollute their body with tobacco, drugs or alcohol or someone who chooses not to pay any premium and yet spends their income on cars, vacations or other vices instead of taking care of their own families and their well-being.

The premium may look affordable right now, but just like all health insurance plans, we have good years and bad years. It won't be long before the State of Illinois realizes it's in way over its head. Instead of being two to $3 billion in debt, it could easily be $10 billion in debt. And how can you take away something that important after the citizens trust you to have it to start with? That would be a hard thing to go into debt that deeply and then have to shut

the program down.

In comparison, General Motors Corporation pays in excess of $5.8 billion per year in premiums and now they have to drastically change their benefit plan and drop their insurance because they can't afford it. Insurance is a business of risk but smart companies with a conservative approach take on potential claims and set premium levels to where they are still profitable in good years and maybe a break even point in bad years. Unless you take in more than you're spending, you'll go broke. That's second grade mentality. The State of Illinois doesn't need a quick fix burden that they can never overcome.

The last thing I want to comment on, health insurance was never designed to be free or better yet paying for everything and leaving the consumer with minimal or no out-of-pocket expense. I'll finish up here quickly. The design of health insurance is to pool money together to cover treatment such as cancer, organ transplants and other debilitating diseases, then go on from there. And I talk about the CHIP plan which I will not read. I'm out of time. But let me finish by saying this: The State of Kentucky in 1996 passed a law that guaranteed insurance. I happened to work in Kentucky at that

time. That was the biggest mess that they have ever done. Four to eight insurance companies left the state in one month. That left them with Kentucky Care and Anthem Blue Cross. The rates went sky high. And what we thought would help the uninsured afford insurance, down there it got worse and it's still to this day the worst thing that I've ever seen in the insurance business. I could go on from there but I'll give you my letter. I appreciate the time.

MR. DUFFETT: Thank you for coming. Do you have a question?

MARGARET DAVIS: Uh-huh. When you came in, there was a two-part form that was distributed. We would like for you to look at that and look at the testimony and follow this process along because someone with your background is needed because you have a particular view of this subject matter and we have not heard this view at the level that we've heard other views.

JIM ANDERSON: Right.

MARGARET DAVIS: So we're getting ready to have the products recommended for us to vote on to present to the legislature, and when that happens, we would like your input on it. It will be a lot of information that many of us don't have the professional

background in. Surely we don't want to have a product like Kentucky or Tennessee but we do want a product similar to Massachusetts.

JIM ANDERSON: Okay.

MARGARET DAVIS: So please follow us through, look at the web site, and the court reporter's report is verbatim so you'll know everything we know. And our listing of information and how to reach us is on the web site and just keep in touch.

JIM ANDERSON: I appreciate that. I represent thirty different health insurance companies. I'm not here just for one. I have 1800 clients insured all cross Southern Illinois and I would appreciate that opportunity because it's -- you can't have a quick fix with anything and I think hearing someone, like I said, from the industry. I talk to people eight hours a day every day of the week about health so I appreciate your comment.

JAN DAKER: We do have five people from the insurance companies on the Task Force.

JIM ANDERSON: Are they here today?

JAN DAKER: No. They're not here today but they are on the Task Force.

JIM ANDERSON: How big is the total Task Force?

KEN ROBBINS: Twenty-nine.

MARGARET DAVIS: And our affiliation is there. You can talk to them and get their feed and everything.

JIM ANDERSON: Okay.

MARGARET DAVIS: Thank you for your testimony.

MR. DUFFETT: Diane.

DIANE GOFFINET: My name is Diane Goffinet, G-O-F-F-I-N-E-T, and I'm a staff attorney at Land of Lincoln Legal Assistance Foundation and I specialize in public benefits and I've done so for eleven years. I see my role here today to highlight two problems in the current Medicaid system that I think need to be addressed by the Task Force at the end of this whole process. One is a gap in the current system and another is a breakdown in that system. There is a common public perception that Medicaid is a safety net for all of those who need a way to pay for health care. However, this current safety net has many holes. If you ask the average person on the street what happens to an insured poor person who gets cancer or has a heart attack, the average person would say that Medicaid would be there to step up and pay those bills. The problem is this is not true and this common

misconception that Medicaid is there to help all people who are poor and have no insurance in their time of need appears to not just be among average people. Even those people who have the power to help fill these holes do not understand the limitations of the current Medicaid system.

In reality, in order to qualify today for Medicaid you either have to be poor and have children under the age of 18 in your household or you have to be poor and totally disabled. A person who is employed but has no insurance and has a heart attack and seeks to return to work after a couple of months of rehab has absolutely no where to turn. This is a major gap in the system. Low income persons who do not have children under the age of 18 in their household, such as people in their forties or fifties, have absolutely no where to turn under this current system when they get sick or injured.

Our current system is not designed to help people get over an illness and get back to work. In fact, unless you qualify by having a minor child living with you, our system does the exact opposite. It waits to qualify you for benefits when you are so broken by your illness that you have no hope of going back to work and you are now forced to live off the

government through the receipt of disability benefits. The Medicaid system uses the same definition of disability as the Social Security Administration does when determining if a person is eligible for Medicaid benefits and that definition is total disability. If the person is not going to die within twelve months or be sick for at least twelve months he/she falls through the rather big cracks in the Illinois Medicaid system. That person will not be able to get medication, have access to physical therapy, be able to go to follow-up visits with their doctor or anything else unless this total disability definition for Medicaid is met. This means that a person who has a stroke will not be able to get the therapy they need to help return to their job of twenty years because he or she has no way to pay for it.

Besides this obvious gap in services, another huge problem with the Medicaid system is even if a person wants to qualify for assistance by being found totally disabled, the people given the task of making these disability determinations reject many eligible people. In other words, even if a person is totally disabled and unable to work for more than twelve months, it often takes attorney intervention through someone like myself to get Medicaid for that

person. Employees of the Client Assessment Unit in Springfield, which is the body that makes disability determinations for the Medicaid program, are often ill trained in the law of disability. Treating physicians sometimes go ignored. The disability Grid rules are not understood and are misapplied. People with lesser education who therefore need benefits, elderly people with lesser education who needs these benefits more often are passed over.

The appeals process is ineffective because basically the same people again reviews the previous disability decision that is being appealed and over 90 percent of the time simply rubber stamps the previous decisions because the hearing officers lack training as well. This system could easily be fixed by hiring qualified people to work at the Client Assessment Unit, to provide them with initial and ongoing training in the law of disability benefits, and to have quality control people reviewing and evaluating the cases to make sure the law if being properly applied. These suggestions are not insurmountable. They make sense and will greatly improve the Medicaid system. I thank you for your time.

MR. DUFFETT: Thank you. I would like to bring up the next set of speakers. Williams Sasso,

Donald Darling, Elaine Jurkowski and Miriam Link-Mullison. And, William, if you would like to start first you can.

WILLIAM SASSO: My name is William Sasso, S-A-S-S-O. Here in Southern Illinois we have much to be thankful for, including the presence of many although not enough dedicated and highly qualified health care professionals and the continuing development of health care technology and knowledge. But while we can be thankful for their presence here, we also need to be ashamed that those professionals, that knowledge and that technology remain beyond the reach of so many people here in this region. As an ordained Unitarian minister residing in Carbondale and serving the Carbondale Unitarian Fellowship for the past seven years, I wish to call this hearing's attention to the Unitarian Association's longstanding support of and advocacy for the creation of a just, equitable and universal health care system.

In 1971, 35 years ago, our association expressing its concern about the soaring cost of health care, called for the creation of a national health plan providing a broad range of health care services to all who might need them. In 1979, more than 25 years ago, our association again noted a serious concern that the

health care system here was growing inordinately expensive and inequities and access to that system were only getting worse. We saw that health care was unjustly expensive for the poorest and most vulnerable members of our society, those least capable of affording health care services. Again, we called for a comprehensive health care plan to provide health services to all.

Subsequent to that, in 1992 our association called for a universal health care system endorsing the Declaration of Human Rights and the assertion that all people have a right to high quality health care. We communicated our sense of moral indignation that health care costs continue to rise in the United States while comparable countries such as Canada spend less per capita on health care while achieving longer life expectancies and lower infant mortality rates. These resolutions which can be read in their entirety on the world wide web, and my document has the web site on them, these resolutions were adopted by the Unitarian representatives throughout the United States and Canada.

They call on national governments to take action to create more equitable health care systems. As a Unitarian leader in Southern Illinois, I

call upon your Task Force and upon all of our elected officials and legislature to commit yourselves to the cause of justice and health care. I believe that our state can take a leadership role in this area and that we can design and implement a model health care system, one that can become both a catalyst and exemplar to the other states and great nation of which our state is a part.

And if I have a minute, I would like to invite anyone from the Carbondale Unitarian Fellowship, either member or friend, who would like to join me in supporting this statement to join me if you're able. We have some people here. So I thank you for your service on this Task Force. I wish you success in a very difficult challenge and appreciate the chance to express this. Thank you.

MR. DUFFETT: Thank you.

DONALD DARLING: I'm not sick. I can walk all day and I can sit but I don't stand well. My name is Donald Robert Darling and Donald and Darling are spelled like you think they are. I'm a retired physician. I didn't realize I had needed a carefully prepared statement so I have some notes. First of all, it is not acceptable in my opinion to have any uninsured people in Southern Illinois. I don't now how

you solve that problem but something needs to be done. Secondly, the State of Illinois is frequently, and I know this for a fact, as much as a year late in paying some of its bills. People that are seeing primary care patients frequently have to wait a time. If there is a different percentage of people involved in primary care, they sometimes have to borrow money to pay their help. They eventually get the money. That's not the problem. It's absurd for the State of Illinois to be that late in paying some of its bills.

Secondly, there's inequity what the State and other insurers pay for. The people, the doctors get screwed as the guy doing primary care. The State of Illinois and Public Aid does not pay the cost of overhead for patients, who's seeing a Public Aid patient in primary care. They just don't pay enough to cover the overhead. I figured out we could afford to see them, I was a member of the Carbondale Clinic, if we saw other patients all day and figured them at the end of the day as marginal care, we get more than our marginal expense. But if we saw only Public Aid we would have to close and that's ridiculous in a state as well off as Illinois.

Secondly, we need to increase payment for preventive care. People need to be able to afford

their shots and their regular checkups and things of that sort and the State does not pay people to do checkups and preventive medicine. I think we can hold the cost on expensive surgical and other procedures and cover this without raising a tremendous amount of money. I know a surgeon who claimed he could take out -- he could put in a shunt in a patient's arm, he was going to get renal dialysis and get paid half as much money as he did for taking out gallbladders. This is before they did gallbladders through the skin. But there's a gross inequity in these fees.

Secondly, a major problem, and you haven't had a word on it today, is the malpractice problem. Surgeons sometimes pay $100,000 or more to cover that. I could talk about a hypothetical surgeon who bills half a million dollars a year, collects $400,000 because of these area's problems, pays $100,000 malpractice, paid $150,000 in office expenses and takes home $150,000. You get rid of the malpractice problem and pay us full fees, this surgeon could be making $400,000 a year. I'm not saying they ought to make that. But just think if you got rid of 100,000 in malpractice, they could cut their overhead and office expense in half or a third of what it was. They could cut their fees and the total cost of health

care would go down. They could live on what Medicaid would pay anyway. So I would suggest that you consider some radical malpractice reform. I think it's long, long overdue. Thank you.

MR. DUFFETT: Thank you.

ELAINE JURKOWSKI: Good afternoon. My name is Elaine Jurkowski, E-L-A-I-N-E, J-U-R-K-O-W-S-K-I. I'm here this afternoon representing the Southern Illinois District National Association of Social Workers, Illinois chapter members. I'm also a faculty member at the School of Social Work here at Southern Illinois University Carbondale. So as members of the National Association of Social Workers Illinois chapter in the Southern Illinois district, we believe that the process of developing a health care system that will meet the health care needs of people within rural communities, meet the needs of health care needs of children, families and individuals for the Health Care Justice Act should be a priority. Within this framework, NASW supports efforts to expand health care coverage to both uninsured and underinsured people until some form of universal health and mental health care are achieved. We also support policies which take into consideration economic, social, occupational and environmental issues that play a role in maintaining

one's health, and we also support policies that recognize the interplay between these same factors and the quality and longevity of life. We also would like to ensure that patients and their families receive the necessary and appropriate medical and mental health care and benefits needed in order to maximize their functioning.

We would also like to see that the Health Care Justice Act supports policies that ensure that social work services are available in all health care settings and that these services be carried out by qualified social workers. Social workers should be at the forefront of assessment and follow-up services, particularly for patients that are high risk. We also support the provision of health and mental care for people regardless of their employment status, financially neutral payment systems, and the assurance of consumer protection and necessary care, including social work services. NASW also supports consumer-patient protection to ensure that there's equal access to emerging technology and medication, access, choice of both mental and health services, legislation which guarantees patients' rights and protection. We would like to see that consumers play an active role in the citizens review and participation

in the development and implementation and evaluation of services at the local as well as state levels.

As resources are developed, we also like to see that social workers are employed in all health care settings at either the baccalaureate level or master's level and ensure that these workers are both licensed and from accredited schools of social work. To this end we would also like to ensure that there's a plan that accommodates a prevention component which considers people across the life span, adequate funding for quality services and treatment including medication, funding to compensate for travel to service providers or patients, data driven health policies or policies based on clinical research, and lastly, attention to rural realities and barriers for patients and their families that are imposed because of their rural location.

In conclusion, we strive to assure that the principles of equity and access are a component of our health care system and we look forward to being a part of that process to help to optimize the health for our citizens. Thank you for this opportunity to present today.

MR. DUFFETT: Thank you.

MIRIAM LINK-MULLISON: My name is Miriam,

M-I-R-I-A-M, last name Link, L-I-N-K hyphen M-U-L-L-I-S-O-N, and I'm the administrator for Jackson County Health Department. I want to thank you for the opportunity to give come here this afternoon. And although I've been working with many of my community partners on access to care, as we've identified in Jackson County, access to care is a health problem. I'm going to focus my comments specifically on the role of public health in addressing the issue of access to care. One of the things that we have found in working with my community partners though is despite the fact we've had lots of successes in trying to address access to care as a community, we applaud the State in taking action because this is not a community level problem. This is definitely a state or national problem that requires a state and national solution. So even though we've had a lot of success here, we have still a lot of problem, most of which you've already heard in a lot of detail.

One other issue that hasn't been discussed is the role that public health plays around access to care and what some of our issues are in relation to that so I'm going to cover that. At Jackson County Health Department we do provide a number of clinical services that address the issues of access

to care. We provide case management services for over 70 percent of the families in Jackson County with newborns. We ensure that these children have a medical home and receive well child visits and immunizations and are provided a healthy start in life. In addition, at Jackson County Health Department we provide family planning services to over 1400 women in this region annually, most of whom, 85 percent or more, are low income and uninsured. We have, as I mentioned, worked with community partners but in the provision of these clinical services as well as other clinical services, we have been very much underfunded. The State funding for local Health Department services, for all of our services has been very inadequate and shrinking relative to costs. And ironically, one of the escalating costs that we face like any other employer is providing health care coverage to our own employees. These costs have dramatically increased in recent years putting a strain on our already limited resources and resulting in higher deductibles and less coverage. It's embarrassing for me personally to tell you I have employees who have uninsured children. They cannot afford the coverage of our family plan. As a health provider I find that's embarrassing and appalling.

The State funding that we receive for

our Family Case Management Program has not increased its rate since 1993. Since 1993 we've been getting the same rate of dollars to case manage these women for all of these years despite years of documented outcome at decreasing infant mortality and decreasing Medicaid costs for birth related conditions. In addition, the family planning program has also not seen increases in total grant dollars for many years. Even in trying to limit the number of clients we serve, something we do not want to do, more and more local dollars are being used to support these State programs as well as some of our other services that we provide.

In addition to these funding sources, no funding is being made available to local health departments to address access to care issues despite the fact that we've identified it as a priority and are a community partner in addressing it. And it has been mentioned several times but health departments as providers of care also have slow payment cycles, low payment reimbursement, that sort of thing, and we do see, as Diane pointed out, there are some real changes that need to be made in the current Medicaid system not only in filling the gaps but also very important to provide timely and adequate reimbursement for services. Currently low income persons without children in the

home -- that's already been covered.

The low reimbursement rates have really had an impact on rural communities I think in particular because we have fewer providers to begin with and therefore fewer providers willing to accept that very low rate. And we have in this area of the state very high rates of people who are on Medicaid which puts an additional burden on the system when that portion of their payment does not carry -- does not cover the costs. In some way local health departments have a track record of providing prevention services in a very cost efficient manner and establishing local collaborations to focus on health priorities including access to care. Local health departments can play a significant role in improving access to care in Illinois. Better health care starts with a robust public health system working to prevent disease, protect the public and provide leadership on priority health problems. Thank you so much.

MARGARET DAVIS: I have a question for you, Miriam. Last week there was a hearing for the House Appropriation Committee for Human Serivices for Illinois Department of Public Health and the director, Eric Whitaker, was asked by Chairman Feigenholtz did he feel that the bioterrorism dollars coming from the

federal government was doing anything to assist the Health Departments in their major essential services. What's your take on that?

ELAINE JURKOWSKI: The bioterrorism dollars that we've received, our approach to those dollars has been to try to spend them as broadly as possible for the most potential benefit. So one of the things that we have purchased with our bioterrorism dollars are computers for all of our staff. That has a broad impact across all kinds of programming including issues related to access to care. If we can get on web sites and learn resources and share information, then obviously we're more efficient in our ability to address that issue. It has improved our ability to some extent, yes. But we can't rely on categorical funding that is supposed to be being used on preparedness to address access to care. We need money for access to care or we need money that's not categorical.

MARGARET DAVIS: Thank you.

MR. DUFFETT: Next I would like to bring the next group of speakers up. Melanie Koch, Karissa Howell, Marjorie Parker, Robert Lorinski, and Ella Lacey. And, again, if there's anyone else who would like to testify, there's sheets in the back. Please go

to the table to sign up.

MELANIE KOCH: Hello. My name is Melanie Koch. I'm chief clinical officer at Massac Memorial Hospital and our chief financial officer came with me today, Shelley Kepplinger. Massac Memorial Hospital is also a member of the Illinois Critical Access Network which represents 48 critical access hospitals in Illinois. Massac Memorial Hospital is seated in the heart of the southern seven counties. It's actually on one of the southern tips; Alexander County is on the other. The region is notably poor with a significant population of uninsured and underinsured.

Our overall facility payer mix in the fiscal year 2004 of Medicaid and the private pay insurance was at 25 percent. Year to date annualized for 2006, which ends for us March 31st, we have written off $2,755,000 in bad debt which is 9 percent of our gross revenue. We have also expanded our charity policy this year to include 250 percent of the poverty level. We are a county hospital and we understand our commitment to provide care to all patients in our region regardless of ability to pay. We also, of course, as a leading employer in our county understand that we have to efficiently manage funds and look for ways to reman financially viable to be able to provide

that care in the future.

Over the last two years we have experienced a large growth in the number of Medicaid and uninsured patients coming through our emergency room. And as we looked at those patients, not only did they have poor insurance but they did not have any primary care providers. It affected us in two ways. First off, as a financial drain on our emergency room. Besides that, these patients were typically a high percentage of the time not seeking emergency care. They were coming for primary care for hypertension, for sore throats and fevers, and illnesses that would be much better served in a clinic environment. Because of seeing those needs, we established a clinic this fall in September. We just passed the Illinois Department of Public Health survey in January so that now we are filling those services as a rural health clinic which will help us financially keep the doors open. What we found out when we opened the primary care or the primary care center or the mid level provider as a rural health clinic, we just started scratching the surface. Once we started providing primary care for those individuals, once they're evaluated, they're finding greater needs requiring more specialty care. In the deep south that's hard to find anyway. Our

typical regional referral pattern in the very southern tip of Illinois has been to go to Paducah, Kentucky across the Ohio River. Interestingly enough, in Kentucky those physicians have been okay with taking their percentage and their fair share of all of the insured patients but over the last several years they very much limit their services to Public Aid patients. As a result, we have lots and lots of patients who go unserved by any specialties, primarily orthopedic. I want to give just a couple of examples. I asked my emergency room manager to prepare a list of the patients she had tried to make referrals for in the last two weeks. I had a 43-year-old male with depressed fractures, with a head injury with no neurosurgeon on call in Paducah, and this patient had to go to Cape Girardeau, Missouri but he didn't have any way to get there or a way to get home and so he just refused to go. He was a private pay patient. We had a 50-year-old female victim of domestic abuse that had to be transferred to St. Louis. What's happened with us, these patients end up having to be sent to tertiary care centers in St. Louis, Nashville. If they accept them, then transportation, of course, becomes a major issue. Besides that, we have saturated our tertiary care centers so that when we really have

somebody who requires tertiary care, they can sit in our hospital for hours as we wait on an available bed. These are things that we should be able to take care of regionally. Thank you for your time.

MR. DUFFETT: Can I ask you, I was wondering in terms of if you can use the word border crossing in terms of the relationship, it sounds like you guys have been forced to develop with hospitals in Kentucky and other areas, is there an equal border crossing, are people from Kentucky coming to Illinois for your services?

MELANIE KOCH: No.

MR. DUFFETT: So it seems like mostly the need is folks having to go to the other states to be able to get more specialty care or is that the main focus area?

MELANIE KOCH: Yes. We are a critical access hospital, one of two hospitals in I think two in the southern seven counties. We have seven physicians on our staff. We are fortunate to have a non-invasive cardiologist which is very fortunate for us and an internal medicine. Besides that they're all family practice. If you need invasive cardiology, neurology, neurosurgery, orthopedics is a big hit for us that we don't have available. There are regional referral

centers. The only time when Kentucky is taking our Medicaid or uninsured patients is when bylaws, if it's a dire emergency and they have to be losing life or limb. In that case they do. They have to. They know they have to.

We had a twelve-year-old boy with ten fib fractures today that we couldn't get to anyone because it's not a dire emergency. He's not going to lose the limb because of it. So it's those kinds of issues.

DAVID CARVALHO: You mentioned reminding me, I've had this question for a long time. You were talking about people who were uninsured coming to the emergency room for nonemergent care and I've heard that for twenty years as one of the problems for people uninsured so when I had kids and the first time they had a situation that was out of working hours and we called the pediatrician and the pediatrician said take him to the emergency room and I thought, wait a second. That's what I've always heard uninsured people do and it's bad. Why are you telling me to do it and it's good? It make me wonder how many uninsured folks come into the emergency room is just after hour care which even if they were insured that's what their doctor would tell them to do because the doctor doesn't want

to see the kid at 9:30 at night.

MELANIE KOCH: Interestingly enough, our payer mix that comes through the emergency room, it may have been what you did back then but I'll tell you right now my kids have to be dying for me to take them to the ER because I have to pay for it. Our payer mix through the emergency room, now there's a lot of Medicaid and uninsured, very little on Medicare because that population is also more conservative and you don't go to the emergency room unless you're really, really truly sick and need hospitalization and, again, the insurance is very limited. When we looked at the time frame, it really was not about after hours, although we have tried in our rural health care, we are looking at extended hours so we are meeting those needs. What we found to be the problem with those patients is they did not have primary care. It's still a learning curve because we still have to try and get them in. And what we did at the rural health clinic, you called to get an appointment, you get in, so there's no mistaking that you might go to the ER instead.

KEN ROBBINS: May I ask a question? I've also been meaning to ask this of others. You present a good example. As a critical access hospital and you have a limited number of beds that you're able to have

and retain that status and most of the care I would assume that you provide is I assume you don't provide tertiary care services?

MELANIE KOCH: No.

KEN ROBBINS: So you require out of necessity to transport those patients out. So it isn't going to Paducah or St. Louis because you don't choose to provide that care. You're not set up to or equipped to provide much of that care for the patient you transfer?

MELANIE KOCH: Absolutely. We are there for initial evaluation and stabilizing treatment but for that kind of care they must go elsewhere.

KEN ROBBINS: I know you said Paducah is across the river, but the ones that go to St. Louis, are you bypassing Illinois hospitals because they don't have the capacity or is St. Louis the actual transfer point?

MELANIE KOCH: We're bypassing other Illinois facilities because the providers at those facilities refuse to accept these patients. Now I'm talking about the uninsured and underinsured. They will not accept Illinois Public Aid. That's when we talked about All Kids and providing them theoretically -- I love the idea but right now in Southern Illinois being a card carrying member is not going to open the door for you

because we do not have providers that will accept them. They will not accept it.

KEN ROBBINS: Hospitals will not help transfer of your patients?

MELANIE KOCH: That's a real tricky semantics. The hospital, you know hospitals by law have to help transfers in the course of Palzo but the hospital itself if they have a bed will accept but we have to call an accepting physician to take that patient and if the physician on the other end of the line says no, I'm not going to see that patient because they have Public Aid, then we can't put them in and take them to the door of the hospital or we are in violation because we haven't got the receiving end.

MARGARET DAVIS: I have one question. You're now employing mid level personnel. What has been the relationship between the mid level personnel and the five primary care physicians who are supposed to provide supervision for these practitioners?

MELANIE KOCH: Very supportive. For one thing, what the rural health clinic has allowed those other physicians, their practices that have been saturated. We are able to see the Medicaid and uninsured by the rural health clinic. In fact, with the internal medicine physician and the cardiologist,

regardless of the payer source they will see them for their needs, so it's been very supportive and good supervision.

MR. DUFFETT: Thank you. Dr. Darling.

DONALD DARLING: I would like to address a few of those problems. I'm retired but I practiced in Carbondale. My practice lifetime was from 1962 until the end of '98 and I never refused a patient whether they could pay or not or whether they were on Public Aid or not. When I retired the Carbondale Clinic had over 40 physicians and they now have less than 20. They left because they weren't getting paid. When I worked we had two neurosurgeons who as far as I know never refused a patient that couldn't pay. We now have one and I don't know what his policies are. We had a little bit of a problem with orthopedics but not great. There's a quality group in Herrin. I don't know what their policy is but I never had a problem getting a patient in Carbondale with a broken bone or injury seen. But people are leaving. We're worse off than we were. We had eleven internists at the Carbondale Clinic at our peak. I think they're down to two or three. We have a couple of family docs now that take up some of that slack. And the reason is you can't make money in Illinois on Medicaid or Public Aid and

there are too many patients like that around. If a doctor is already far busier than he wants to be seeing patients paying their bills, he doesn't want to take referrals from Public Aid patients. I can argue with that and say it's not moral but it's hard to make a case for that when it comes down to the situation, a real living situation.

MR. DUFFETT: Karissa.

KARISSA HOWELL: Hi. My name is Karissa Howell, K-A-R-I-S-S-A, H-O-W-E-L-L, and I'm the executive director for the Resource Clinic. We are a free clinic. We provide free health care for Jackson County patients that are low income but do not have insurance, Medicare, Medicaid or any other way to access health care. I also serve on the board of directors for the Illinois Free Clinic Association which represents approximately 34 free clinics in the state, three of which are located south of Highway 64.

Patients that use our clinic have an income that falls at or below 150 percent of the federal poverty level. Our average family size is four and that family has an average income of $732 before taxes. To put that in perspective, if you were to try to live on $732 for a month, taking out taxes, housing, transportation, food, school costs, most of us would

say how are you doing that? Many of our patients can't afford to buy aspirin much less afford to buy prescription medication or pay to see a physician. The majority of our patients are working either at jobs that do not offer insurance or they're work at minimum wage jobs. They're not able to pay for the insurance that is offered. Abundant Health is able to provide services because of the volunteer efforts of area physicians, physicians assistants, nurses, dietitians, counselors and clerical staff. We rely highly on SIU students in the medical and premed field to provide clerical services. We provide services two nights each week and average approximately 90 encounters each month. Since its opening in 2000 we've served 1200 different patients, dispensed $375,000 worth of health care and prescriptions to those patients. We were able to do that, again, because of the generosity of area physicians and pharmaceutical companies. We're able to provide a limited number of lab and procedures because of donations by our local hospitals, and our patients can see area specialists such as orthopedics, cardiologists and other specialties normally at one visit at no charge and then after that the physicians work with the patients to either write off part of that cost or they work a payment arrangement with the

patient for follow-up care.

While we're excited to be able to provide the services we do provide, we are all too often faced with the fact that we are providing the minimum level of care that's needed. Free clinics are not the solution. We are a stop gap but we're not the solution for the problem. When we opened we anticipated that most of our care would be acute: Infection, short-term care, that type of thing. In reality, most of our patients have continuing health care reads that require monthly medication refills, monitoring by physicians. Our top five diagnoses are hypertension, diabetes, reflux disease, respiratory problems and depression. We don't serve mental health cases as a primary diagnosis so to have depression in the top five is significant.

Having worked in health care for over twelve years now, I can see that our health care system is in need of urgent help. I believe all patients, regardless of their situation, should be able to receive equal more than adequate health care. We don't settle for adequate. We want better than adequate health care. I have been in the same situation that our patients face and I understand their worries and concerns about what they will do for health care. They

face the day-to-day problems of how to pay for all of those expenses on $732. As a health care provider, I urge this Task Force to look at sustainable comprehensive health care programs that can meet the needs of all individuals in Illinois. While it's tempting to look at short-term remedies, it is clear that this is a long-term problem that will require a long-term solution. Thank you for your time.

MARJORIE PARKER: I'm here to speak as a person of faith, a member of the United Church of Christ. Since 1975 the national level has passed resolutions in support of health care and I urge you to consider that health care should be the right of every human being. The current health care system in Illinois and in the United States is not just because nearly 46 million Americans are left out of it and therefore is only compassionate to those who are in it. If you believe in justice and compassion, you should be outraged by the fact, and these are just a few of them, that 1,000 Americans die prematurely every year because they cannot afford private health insurance. Communities of color endure major disparities in accessing treatment. Health care costs are a leading cause of personal bankruptcy. Current reforms to Medicare threaten to erode the health care safety net

for seniors and the disabled, and the federal budget proposed to cut billions of dollars for Medicaid and safety net programs that directly benefit many vulnerable adults and children. These facts demonstrate the need to find a cure for our broken health care system.

We should start right here in Illinois. We can be a successful model for the nation. The first step is to acknowledge that health care is a right. The next step is to acknowledge that we can afford it and that we can't afford not to find a solution. Many facts support that conclusion. After all, the United States is number one in health care spending in the world, far above the level of any other nation. How can there not be enough to provide us with universal coverage as it does in every other industrialized nation? Where did the dollars go? We know billions go to insurance, most often through the work place. To our credit, billions go to Medicaid for our poor citizens even though as we've heard there are many, many gaps in that coverage. More billions go to Medicaid for our oldest citizens.

Those statistics I expect you may already know. A figure I want to share with you that the cost of providing health care to people without

insurance, the amount which they do not pay themselves, was over $43 billion in 2005. In Illinois alone the cost will be 1.8 billion. This is from a family's USA report. This clearly demonstrates that we as taxpayers individually are already paying for health care for both the insurance and uninsured. I urge you to consider that the solution may well lie in finding a simpler and more efficient method of delivering health care. I expect you will find that method a single payer system with one entity responsible for administration and Medicare is such a system with administrative costs of less than 4 percent. We do not need multiple complex insurance programs. We do not need endless confusing paper work. We do not need arguments over preexisting conditions. We simply need health care accessible, comprehensive and cost efficient that promotes fairness and quality, that stresses prevention and provides timely access.

I will end where I began, as a person of faith urging you to act with justice and compassion, to ignore all special interests and act only for the common good. Give us health care that treats every one of us as equals. Thank you very much.

ROBERT LORINSKI: Robert Lorinski, L-O-R-I-N-S-K-I, Jackson County Board and I want to

address two points. I'm in agreement with other people that have talked here. I also was a faculty member for 38 years, public administration, mainly personnel selection, recruitment and training. When I first got elected the chairman told me what committee do you want to chair? I said insurance sounds like a no brainer. We had double digit inflation, and finally in the year 2000, 35 percent increase before Christmas, 50 percent increase after Christmas. We are now self insured and we've learned a lot about I won't say the fat insurance companies but the obese insurance companies. But we had to adjust our premiums for our employees. We had zero increase this year but we increased the deductibles for prescription drugs to a thousand dollar deductible and, of course, some of our employees can't afford that.

Interestingly enough, before I came here I showed this to several people; one, to correct my English. But for a family plan it's $1,070 a month. And I showed this to about eight people, nine people. One reaction was, oh, my God, how can somebody live and afford that, especially secretaries. The other one, which I got two secretary educators, how did you find that cheap of insurance? That scared the hell out of me. My point here is, we hear about 20 percent

uninsured, 30 percent uninsured. I don't know if the general public that has insurance really gets the message of this problem. I think because we have to focus on it not statistics but life experiences. You know, as I said, my brief experience, I serve on the insurance committee. I'm also a committee member of health and safety so I see this from all angles. Our employees, people that use our ambulance service, it's a problem.

Secondly, a general matter, the ability to recruit public employees at the local level is being eroded. And also before I retired, about the last eight years some of my best and brightest students who wanted to stay in Southern Illinois or go back to their hometown opted out for the federal government or the State because of the fringes. We're going to lose the ability to serve our public. Thank you.

MR. DUFFETT: Thank you.

ELLA LACEY: Hello. My name is Ella Lacey, E-L-L-A, L-A-C-E-Y. I'm a retired faculty member from SIU School of Medicine. I currently serve my time as an international health volunteer but I guess mainly I'm a resident of Jackson County, Illinois for some 40 years. It is my opinion that the Health Care Justice Act guides us in the right direction toward drastic

Illinois health care reform, then toward a federal universal single payer system of health care. I've come today with just an example, a case example, and I'm using that because there is a common perception that persons 65 years old or disabled are automatically eligible for Medicare and that Medicare is just universal itself.

As a 65 year old who has been certified as ineligible for Medicare, I would like to use my personal scenario to draw the attention of the Task Force to the need to be cognizant of an often overlooked group of persons who may be vulnerable when fluctuations occur in various sets of group health insurance coverage. Personal example, I was gainfully employed for more than 39 years. My first four years occurred from age 11 to age 15 when I was a day laborer in the cotton industry in Missouri. Yes, I attended school but my school year was split in ways to accommodate the local cotton crops. I was able to work and in most cases earn the same amount per day as my father who was also a day labor. These four years were governmentally approved as undocumented work. Thus, no Social Security coverage.

From high school graduation at age 15 to age 17 I worked in several part-time jobs for which I

did receive two quarters of Social Security credit. During the years that I was age 17 to 21 I worked three years for the federal government under a pension system but not under Social Security. From age 21 to age 25 I was mainly attending a university, Southern Illinois University in fact, and engaged in three years of federal work study, time that was not eligible for either pension or Social Security. From age 25 to 30 I was employed by the State of Illinois. There was an employee pension but Social Security did not cover that employment. Age 30 to 32 for me involved a graduate study fellowship for which there was neither pension nor Social Security. From age 32 to age 54 I was a university faculty member employed at Southern Illinois University for which there was a pension but no Social Security benefits. Thus when I retired at age 54 I had more than 39 years of employment but only two of 40 percent quarters of documented Social Security eligibility. As a beneficiary of the state retirement system I qualify for the health care benefits to current employees of the university. The university plan is a good one but it has some vulnerability. In case the university, as a cost saving measure, decides to discontinue health care coverage to its employees as has been discussed, as a retired person I and my

colleagues in similar situations will be without health care insurance. A small scare related to this effect occurred when I turned 65. As my insurance company refused to pay any bills until my alleged primary provider whom they thought to be Medicare had paid or I obtained a certificate of ineligibility for Medicare. In my case the negative occurrence was a very temporary matter and has been rectified. I am concerned because of the vulnerability that I perceive many others may have who are my work cohorts, people who had similar situations to mine but did not -- their employment didn't culminate in a university system that provides the kind of benefits that I receive, so these persons if they don't qualify for Social Security through a spouse and if they are uninsured or they may be uninsured and paying an inordinate amount of their retirement income for health insurance. The Health Care Justice Act should make sure that prior to universal health care there is a provision to remedy this problem. Thank you for indulging me.

MR. DUFFETT: Thank you. We've got several more individuals to give testimony so we'll definitely be going past six o'clock and, again, we'll stay here. I would like to introduce the next group of speakers. Margaret Flanagan, Paula Bradshaw, Fred Bernstein and

Galen Thomas, if you can come forward here. And, Margaret, if could you like to start, that would be great. Is Margaret here?

(No response.)

MR. DUFFETT: Paula, would you like to go?

PAULA BRADSHAW: I'm Paula Bradshaw and I'm a member of the emergency room nurses at Memorial Hospital of Carbondale where not only pediatricians send in patients after hours but so does everybody else. I wasn't going to talk so I just scribbled some notes but I had to laugh at the insurance guy but it's not really funny. He gets up here and feels outnumbered because everyone else is for single payer health care. But don't feel sorry for the insurance guy because the insurance corporations don't have to come to public hearings and testify. They'll have their lobbyists go to the top and get their insane system of for profit health care. Who would make this up that you would take money for your health and give it to, what did he say, 30 insurance companies? And there's hundreds of insurance companies all sucking in health care dollars and their sole purpose is not to pay it to the providers because that cuts into their profits. I think it's insane.

As a Green Party member I am endorsing

patient health care for just common justice for the common good for something that we all should have. We are not a poor country, although we are becoming a poor country but we can afford health care for all and it's a matter of justice.

I would like to say as an ER nurse my hospital does not discriminate institutionally against people on their ability to pay because of the Cobra laws and also as a non-profit hospital but the workers who work there are prejudiced against people who do not have insurance or people who have Medicaid because they think that those people are somehow not worthy of health care. And this kind of prejudice is fed by the system where you have to have a good job to have health insurance. If you have a cruddy job and you work at Wal-Mart or Taco Bell where you either don't have insurance or you have Medicaid and if you have no job then maybe you have Medicaid or if you have kind of a cruddy job and you can't afford health care so you have no health insurance. I think everybody who comes in should be covered without any kind of oh, they don't deserve to be here kind of thing. I think we should have universal health care. People do come to the ER for stupid things. I had someone came in. She had gone to Benton with a sick kid. The kid had a runny

shows and they didn't give her antibiotics so she came to us. She wanted antibiotics. And that's two ER visits for a cold.

So many people come in with colds. So many people come in. A mother chooses to bottle feed her baby and then the baby throws up the formula and she says it's the doctor's fault and she comes to the ER because we're going to fix it. There should be propaganda. A cold is caused by a virus. Antibiotics don't cure it. Breast-feeding is best for your baby. If you're pregnant and you're bleeding, don't go to the ER. We are not going to stop a spontaneous abortion. And we can do something about it. We can't, you know -- you could cut out so many unnecessary emergency room visits if you cut out colds, runny noses, bleeding pregnant people. And the answer at this, the abortion providers have brainwashed --

THE COURT REPORTER: I need you to slow down, please.

PAULA BRADSHAW: I think Miriam pointed out that preventive, preventive care, preventive care for asthma and for pregnancy, it costs a lot more to be treated in the ER and being incubated or have your baby in an intensive care nursery for months than to have preventive care. So we need to work on all of that as

part of a care system.

MR. DUFFETT: If you would like to sign up again to speak after but this isn't going to be a debate and if you guys want to have your discussion maybe in the back would be fine.

FRED BERNSTEIN: My name is Fred Bernstein, B-E-R-N-S-T-E-I-N. I'm the administrator of a community health center system sometimes called federally qualified health system or FQHC. We cover a six-county area and in three of the counties we serve we are the only primary health care provider of any services, medical or dental. They're called primary care services. I would like to remind my staff and funding sources that we serve the four poorest counties in the state of Illinois; Alexander, Pulaski, Hardin and Pope. We have recently opened a facility in Harrisburg. It provides both medical and dental care. We opened the dental care portion of that facility in September. We opened the medical side a little earlier. We did so through the community health center expansion opportunity offered by the State of Illinois. It was an excellent program that provided us that opportunity to create services where none existed.

In Harrisburg we had 120 people listed for a dental appointment before we had either opened

the dental department or recruited the dentist that we were able to recruit. We had become in earlier years the only dental provider for several years in the southern part of the state for HIV positive patients and we had patients coming to Cairo, Illinois, the southernmost point in the state of Illinois that is still the state of Illinois, from Effingham which is 160 plus miles from our service point. We operate four dental clinics. Our fourth dentist is joining us Monday and that will be for Rosiclare and we can't keep up with the need.

So I echo the response that you heard from several other providers that the need is great. We want to reemphasize how important we think that the community health center expansion opportunity is in the state of Illinois, which is again in the budget this year, has been to allowing us to establish the type of services we could offer in Harrisburg. We have heard testimony about Medicaid, its slow payment or its no payment. And in my particular system 60 percent of our earned income comes from Medicaid. We are now in the process of where Medicaid has tried to help us but is slowing down its payments. This has been a cyclical thing, worse during certain administrations. This administration has done what it could but right now

we're receiving almost no payment, considerably fewer dollars than we've earned. We have to struggle for these payments and when your bottom line and your cash flow depend in 60 percent of your gross on Medicaid payments that aren't forthcoming, it's extremely difficult to consider how you're going to recruit the additional provider you need, how you're going to pay the providers you have and how you're going to serve the folks that you're serving. I'm talking about the Medicaid population is about a third of our patient population and we serve more than 21,000 users with something in the neighborhood of 80,000 visits a year. More than a third of them qualify for and are offered a sliding fee program and that's the federal money we are given but the federal money we are given is less than 25 percent of our gross product each year. So these are the kind of challenges we face that we ask the state to earnestly look at.

The closing comment I would like to make is that I've heard some observations here earlier this evening that we can't afford the programs we have in place now. What are we thinking about when we talk about All Kids? I respectfully submit that we cannot afford not to initiate a program such as the All Kids program. Every dollar that we spend in prevention and

early care, early adequate health care, saves us tens of thousands of dollars per an individual in the course of a person's lifetime. And that should be self-evident. Thank you for this opportunity.

MARGARET DAVIS: I ask you, Fred, are you getting any 330 dollars?

FRED BERNSTEIN: We do.

MARGARET DAVIS: And that's the 25 percent?

FRED BERNSTEIN: In our case it's about 22 percent.

MARGARET DAVIS: 22 percent.

FRED BERNSTEIN: And that's what enables us to offer the sliding fee discount. We regularly slide off, as you say, discount about a million and a half a year.

MARGARET DAVIS: Can I get the name of your facility?

FRED BERNSTEIN: Certainly. Community Health and Emergency Services, Inc, or CHESI, and our main facility is in Cairo, Illinois and we serve six counties with twelve facilities.

KEN ROBBINS: Fred, you've been at this a very long time. I know many instances it has seemed like a very lonely fight in Southern Illinois. As you have listened to what's been said here today and based

also on your own experience, do you have a systematic recommendation for how to resolve the kinds of issues that you deal with on a daily basis? Not just a little more Medicaid here but a systematic approach?

FRED BERNSTEIN: If I was choosing a systematic approach, I would certainly endorse a universal health care system. It is both cost effective and fair and equitable.

KEN ROBBINS: Do you think it can be done on a state-wide basis as opposed to a national basis?

FRED BERNSTEIN: I think it would be difficult but I think it would be heroic to attempt that. As you say, we've had a difficult time but we have managed to survive for the twenty some years that I have been involved, although I'm sure I look much younger than that.

KEN ROBBINS: So do I.

FRED BERNSTEIN: Thank you. Absolutely universal health care because then we're eliminating the disparity of access because everyone has the same entitlement.

KEN ROBBINS: Thank you.

FRED BERNSTEIN: Thank you.

GALEN THOMAS: Galen Thomas, G-A-L-E-N, T-H-O-M-A-S. I'm a full-time school social worker in

Williamson County Special Education based out of Marion. I made most of my comments earlier. There were a couple of things I would like to add. I appreciate the inquiry of availability of school social workers because we are required to have a master's degree in social work and many of our members, especially working in regular ed districts, are providing early intervention services. Those that are working with helping to establish full school wide positive behavior systems are reducing the number of kids that end up developing more severe problems later on. Those that do not, services from our local mental health clinics because they can't afford to go and receive private counseling services out in the community, sometimes have very extended length of time before they can work through the waiting list unless it's an emergency crisis situation. And availability of mental health care is a major issue for our school association, for our kids.

The other comments I think I already made and already are on the record. The only other thing, I live with a wife who works with the kidney dialysis. She's a nephrology social worker and she is every week mentioning her anxiety over we better be ready to come up with $500, 600 out-of-pocket expense

for medications if we ever develop this as a problem later on and she sees people that seem to be have to decide whether to eat or whether to get their medications. And they just seem like they're thrilled to have a five-dollar gift certificate at Christmas so they can have a chance to purchase something other than basic necessities for themselves. Thank you.

MARGARET DAVIS: Again, also if you can ask your wife to write us about the elimination of rejection drugs after three years of being on a transplant, that is another big problem that's going to be costly.

GALEN THOMAS: I will ask her about that. She is continually agonizing over the financial problems that she sees folks having and the unavailability of things.

MARGARET DAVIS: We're going to be in Collinsville if she wants to come and testify but she could also submit it in writing.

GALEN THOMAS: I appreciate that. I did want to mention that most of our school social workers which are LCSW and we are licensed social workers and we are capable of providing independent private practice and getting third-party reimbursement for our school services if that's what it takes.

MR. DUFFETT: I would like to bring up the next set of speakers. Sandy Davis, Bruce Fasol, Jesse Smith-Fulia and Amanda Trent. And, Sandy, if you would like to go first.

SANDY DAVIS: Okay. My name is Sandy Davis. S-A-N-D-Y, D-A-V-I-S. I'm a citizen of West Frankfort and the state of Illinois. I come to you today on behalf of the West Frankfort Emergency Health Care Search Committee and I'm the committee clerk for that committee. Our committee was formed in May of 2004 and is made up of local citizens in the West Frankfort and the southern Franklin County area. The group is exploring all possible avenues to establish an emergency department located in West Frankfort to meet the emergency medical needs for those in the West Frankfort and southern Franklin County area. The current available emergency services have been determined inadequate and the population underserved in comparison to similar nearby communities. The community also recognizes that the current status of emergency health care delivery in this area threatens future economic growth, prosperity and optimum quality of life for all. The committee resolved to make use of any and all resources available to design a model of quality emergency health care services to best meet the

needs of the currently underserved population in our area. Retired Congressman Kenneth J. Gray is our chairman of this committee.

In 2001 Union Hospital in West Frankfort closed its doors for the final time. In the ensuing years, it has fallen into disrepair and been overrun with mold and asbestos. Emergency medicine is practiced with great care on a daily basis by the West Frankfort Fire Department Ambulance Service in our area. Our firefighters double as medical personnel in a costly and complicated system. However, it is the stability that they give us that we most appreciate. Ambulance service across Franklin County have been adequate at best over the past few years. Multiple times county residents have awakened to find that private providers have suddenly disappeared. Still, the West Frankfort Ambulance Service remains to serve its residents in Denning and Frankfort Townships, an area of approximately 72 square miles.

However, this system also has its drawbacks. Currently, local emergency medical technicians cannot dispense cardiac drugs. These are the ones with the West Frankfort Fire Department Ambulance Service. A typical cardiac case might see the West Frankfort Fire Department ambulance pick up a

patient, innovate and then begin transport to the nearest hospital which is the Franklin Hospital located in Benton some seven miles way. But from the time that someone has an onset of a medical problem and calls an ambulance, it can take as long as 20 or 30 minutes to reach the Franklin Hospital. But many times during the journey to the Franklin Hospital the private ambulance service is called upon to lend assistance and many times they will stop along the road and they will have to get on the West Frankfort ambulance to administer cardiac drugs.

Anyway, training is currently underway to raise the level of accreditation for our local crews so they will soon be able to administer cardiac drugs. But right now the State does not have a mechanism for the testing. The previous testing system was disabled by the State after an alleged cheating scandal in the State. It is one of the many broken parts to the health care system. Even with the close proximity of the county hospital, we recognize that there were problems such as transportation, delivery problems stemming from flooded country roads to blocked train tracks. Once delivered, a patient would then possibly wait to be seen in a crowded emergency department. It all seemed to add up to a challenge from the time of

onset to actually being assessed in the emergency room.

We felt there had to be a better way. That is when we began looking as a committee at the use of telemedicine. Health care industry expert Barbra Dallas, now retired, suggested that we contact Kirby Hospital in Monticello. They are on the cutting edge of using telemedicine in emergency department situations. We went to central Illinois and viewed their operation firsthand. We were told there that lives were being saved in emergency rooms staffed by physician assistants with the aid of telemedicine. They are linked to Carle Hospital in Champaign. The folks from Carle Hospital have come down here and put on live demonstrations of how the telemedicine link works in an emergency room setting. We came away even more convinced that telemedicine provided a technological link, the portability, the expansion possibility to meet not only our rural needs but rural and inner city needs across Illinois.

We began our model with telemedicine as its anchor. With each element we chose for the model we also addressed hurdles that may be encountered. We identified a lack of technical continuity in Southern Illinois. To summarize, efforts that we initiated have led to the point where Southern Illinois has an active

working group to achieve broadband capability for the entire region. This effort has identified health care as one of its chief beneficiaries. Ancillary needs such as provider costs and actual equipment desired have also being addressed by our committee. We identified staffing as a core need as well. In doing so we felt that we might be able to draw physician assistants to our facility and keep them through a special crafted local incentive plan. We are also addressing the need for nursing and have contacted the Collegiate Common Market which is a consortium of community colleges in our region. Congressman Gray addressed them, coming away with a willingness on their part to create a program that would utilize students/instructors in a hands-on laboratory situation with our facility.

MR. DUFFETT: You're pushing on six minutes. Can you end? And if you've got that typed up you can --

SANDY DAVIS: Yes. I'll wrap that up right now. Anyway, we feel the system of two, maybe three of these types of emergency department centers could be created and utilized throughout the Southern Illinois area. And we've also received a lot of cooperation from some of our state legislature and lieutenant

governor who has also been following this project and has been a friend of us here. So anyway, that pretty well wraps it up for us but we do want to thank you for allowing us to submit this.

MR. DUFFETT: Thank you very much. Bruce.

BRUCE FASOL: My name is Bruce Fasol, F-A-S-O-L, and I'm the administrator for the West Frankfort search group and we thank you again from that aspect of this opportunity to speak before you today but I would like to speak on something of a more personal nature. I would like to speak on access, access to people that make the decisions about access. I would like to thank you for this chance and it's laudable that you focussed on access to health care. It's one of the aspects of the system that's broken in my estimation. I would like to offer my support for the Health Care Justice Act. I'm not a person who easily advocates governmental activism where I believe private sector responsibility lies. However, in watching events flow for the past few years, I'm a two-time heart attack survivor, it's become abundantly clear that for whatever reason some of the private sector continues to squander opportunities to be innovative leaders. It's difficult for me to ascribe to a system run by state government. However, it's

more reprehensible to see friends and neighbors and fellow Illinois citizens blocked out of the process. Lives aren't meant to be statistics. And we see problems in the health care industry sometimes reduced to percentages and statistics. There are real humans involved. For the past three years I've advocated the health care equivalent of the Citizens Utility Board be established. That would give the public the opportunity to have a say. I believe we need a seat at the table. I've advocated the creation in letters to the editors across the state and contacted a lot of law makers. I have furiously bugged, I mean lobbied, Lieutenant Government Pat Quinn to recreate the same type of program he pioneered in the past. Last week he came out publicly saying that he would do just that and legislation is being introduced. It's not that people deserve a place in the process but that the process will benefit from participation.

A woman in Perry County needed to be treated for a neurological problem. There's not a specialist in Southern Illinois. She did locate one in Chicago. She was reportedly told her insurance would not pay because she was out of the district. That's one catch 20/20 thinking that does not serve the public. It's a two-sided coin. As we all know there

are many facets to the health care system. We must agree that there are numerous problems besetting the industry. The fact is there is such a basic need in our society of a critical nature. Normal lives and partisanship and even ideology are at work. In whatever form this commission sees fit, it's my hope that the spirit of inclusion permeates. We have divided, excluded and ignored the public view for as long as we can. Let us be inclusive by including public participation in the process like the hearing today.

Finally, let us be inclusive geographically. Believe it or not Illinois doesn't end at Springfield. We can't properly be represented by someone from the metro area either. I call for greater representation for what we consider the deep south, south of I-64. We have unique needs. We share common problems. We urge that you allow us to participate in the system. We are unique residents being able to vote. The last two hospitals to close in Illinois closed in Southern Illinois. That's a primary reason we have a designated medically underserved area by the federal government. It's a reason we need our voices heard. Thank you.

MARGARET DAVIS: Bruce, I met with Lieutenant

Governor Pat Quinn last week. He is moving actively on establishing this utility board. I personally feel that it is going to help us get something happening once we have a product to present to the legislature and the governor. Having that citizen voice behind any movement will evolve into some type of permanent legislation. So whatever you can do in Southern Illinois to help with the momentum, we greatly appreciate it.

BRUCE FASOL: What would you suggest?

MARGARET DAVIS: I would think getting people signed up, just like you did for the citizen utility board with cards and the payment of a small nominal fee of $5.00, $3.00 to establish the committee. You know, I think we need to meet with them to establish the mechanism.

BRUCE FASOL: I believe we need to take the fight from the board rooms to the bedside of the hospitals. Thank you for the suggestion.

MR. DUFFETT: Thank you. David.

DAVID CHRISTENSEN: I am David Christensen. David spelled the usual way. Christensen is C-H-R-I-S-T-E-N-S-E-N. I'm a retired SIU professor and I thank you for this opportunity and I will be very brief. I will be late for a 6:30 meeting in

Carbondale. I want to bring up one point that I don't think has been brought up yet and I call it cost sharing, cost shifting. The idea behind it is that we could add people to health care in Illinois or the United States if it was chosen to be at that level with no addition to the cost of the care. How do I say that? It's been commented here that we are already paying for health care for those who are uninsured through the rates that are paid by those who have health care. All right. It's already been pointed out that I think Mr. Whitney and one other person commented about 25, 30, 35 percent administrative costs in the manner in which health care is now delivered through various private insurance companies. This includes, of course, costs of advertising and promotion and profits and of course shareholders benefits as well but we know, of course, through Medicare that it can be far less. Somebody, Marge, had said 4 percent. I think it's less than 4 percent through Medicare.

Clara McClure had mentioned various sources of other dollars but I don't think we need to look for other dollars. I think if we simply can look at the concept of this, we are now paying for health care in various ways. If those same dollars were sent, were put into a single payer system through a federal

or regional agency, we would be paying no more. And as I said, we are already paying for the uninsured. I leave you with one final idea. We accept public basic education. Why can't we accept basic health care also as a right of citizenship? Thank you.

MR. DUFFETT: Jesse.

JESSE SMITH FULIA: My name is Jesse Smith-Fulia. Jesse, J-E-S-S-E, no I, Smith. Fulia is F-U-L-I-A. And I wasn't going to share testimony but I think you've heard a lot about people's personal stuff and the cost of health care. What I want to talk about is I took a sociology class in college and it really kind of changed me. I noticed that our entire culture seems to be against our health. To one makes any money when we are healthy so nobody pushes that with the amount of dollars and the amount of emphasis. We push junk food and we teach that rest is for the weak and that health food is for the rich and that everybody should be on their own. And on the other hand, our stores sell our food devoid of nutrients. I live on an organic farm. We lace our cereals with petroleum based vitamins that our body can't absorb. Our fastfood restaurants are federally subsidized. Our water contains chlorine. We push that anxiety and lack of sleep shall be treated with pills instead of sleep.

Our schools push soft drinks.

And I mention I wasn't crazy about the idea of a universal health care system like the person that was before me, two persons before me, but I feel like nobody is looking out for the whole picture. Everyone is looking out for their own financial interests and it's kind of tearing away from the whole. If you had a plan that looked at the whole, our whole health care, our normal health as a state, at least we could start there and say that when we are unhealthy, our state loses money. We are less productive. We're healthy. Our families fail, fall apart. So if we had a health care system where someone was saying we can't do that, we can't poison our air and poison our water because that's going to cost us more money next year, it would be a direct incentive to say no to the corporate dollars that come much more place in Washington. Not Washington but in Springfield than we do here. And put emphasis on prevention and have incentives to come up against corporations.

I understand people who say that universal health care is like universal car care and that it discourages self care, but on the other hand, what we have going right now isn't working and we're paying for it if not in direct health care costs but in

crime and lower job productivity and lower life expectancy. There are also so many other health solutions that aren't pushed. For instance, herbal medicine. Other cultures have really effective medicine, much more effective than ours is but no one is making a lot of money on those so nobody is pushing those. The general public isn't learning about those. Our school children have soda machines in their schools so those are being pushed. No one is pushing the benefits of healthier water, stuff like that, juices.

In conclusion, I feel like the problem stems from greed and either the system we have now is failing because of it and the system that hopefully you can create is going to fail or succeed based upon if you can eliminate greed out of it. And also I had a question. What happens after these meetings?

MR. DUFFETT: After these meetings are over, the Task Force, we have been having a number of experts in different policy arenas and different perspectives have been coming in and educating us more. There's an independent consultant that will be hired any day soon and then there's going to be several plans that will be suggested to this person to look at and then this entity will then come back with us looking at the variations of the costs, how to do this, do that and

then we as a Task Force will have to make a recommendation by October 1st to the General Assembly on what we believe the State should proceed on. Thank you.

AMANDA TRENT: Hi. My name is Amanda, A-M-A-N-D-A, Trent, T-R-E-N-T. And mine is more of just a personal story. I personally am in support of the All Kids program.

MARGARET DAVIS: Speak into the mic.

AMANDA TRENT: We had Kid Care at one point and my daughter was dropped from Kid Care because they said we made too much money. In January of '05 I was diagnosed with multiple sclerosis. They say we have too much money but they don't look at how many medical bills that I have. Right now we don't have insurance. Well, my husband has insurance for my daughter through his work but we have to meet a $1,500 deductible before the insurance will pick her up. I currently have no health insurance except for through SIU and my medication for multiple sclerosis averages around $1,500 a month but currently the pharmaceutical company is paying for it but I graduate in May. I will not have health insurance. My husband's insurance will not pick me up because I have a preexisting condition. So from my personal standpoint I feel that universal

health care would, I mean, be a benefit for, I mean, my family not only but I could see for other people.

The insurance guy is not here anymore but he said that people were just wanting a handout and they were too busy spending their money on vacations and cars. I don't know the last time I took a vacation. My car is not new. My money goes to pay for my medical bills and trying to make it through. I mean, I'm working on my master's in social work to try and help other people. So I don't know. That's just -- I'm not good at speaking.

MR. DUFFETT: Thank you very much. The next last four speakers please come up. Sarah Buila, Beth Connell, Floyd Cunningham and Denza or Deenaz Patel. Sorry about that. Sarah, the floor is yours.

SARAH BUILA: Thank you. My name is Sarah, S-A-R-A-H, Buila, B-U-I-L-A. I work as a crisis counselor with Southern Illinois Regional Social Services which is the county mental health center. I've done that since 1993.

JAN DAKER: Can you speak up to the mic a little bit?

SARAH BUILA: Yeah. Is that better? But anyway, as a crisis counselor I spend a lot of time in the emergency room and I wanted to share with you some

of my experience with that. Some other individuals brought up the issue of prejudice. I think it's a bias or stigma that I have seen that people who have either self pay or Medicaid are stigmatized by the emergency physician and other personnel. And I hate to say that. I mean, they're dedicated to health care but they're frustrated. They're frustrated because of issues with what they're treating in the emergency room that could have been prevented and because of malpractice. And the bottom line is it affects how our patients are being treated. And this is uncalled for and that there's a stigma that somehow this belief that people who are uninsured or underinsured or have Medicaid are somehow in that predicament because of some failing or some fault of their own and that you all are charged with the task of going up against that. And that my guess from my own experience and from what I hear from clients is that that is not the case. Yeah, there might be some, you know, individuals who take advantage of the situation.

My own personal experience of being underinsured had to do with taking a position at the university as an adjunct instructor for nine months. That means during the three months that I was not teaching I had to come up with a way to pay for my own

health insurance at the same time I was not getting any income. So that meant my husband, who is a farmer, and myself took on other jobs and whatever we could, borrow money so that we could keep our health insurance over the summer. And I did that for four years, accumulating debt in order to keep our health insurance. I tried to apply for Kid Care three times and I got -- the first time I got a medical card at the end of the summer which did me no good because I had already paid for the insurance. And the other times I was denied because I'm a state employee which they somehow missed that the first time, or the second time.

And the last thing I wanted to share with you is I just recently had a psychiatric patient who had been discharged being treated for depression. She was discharged on a medication called Seraquell and her medical card wouldn't cover it. So five days later she's in the emergency room, suicidal, devastatingly depressed. Medicaid paid for her transportation from Carbondale to Harrisburg to be rehospitalized, a hospitalization that will last three to ten days instead of paying for her medication. I have no more to say. Thank you.

MR. DUFFETT: Beth.

BETH CONNELL: My name is Beth Connell,

C-O-N-N-E-L-L, and I missed the first part of this but from what I've heard in the last half an hour I don't want to repeat all of that. I do want to add my feelings that there is a lot of Illinois south I would say of I-70 and I would like to remind people of that. But I would also like to say that I'm feeling that there's very little services even if you do have insurance for the physically disabled that are younger than 60 years old in Southern Illinois. Cities have things but not in Southern Illinois. But more than that, I'm going to offer a suggestion or a solution that I've seen work in the past for dental care particularly. When I was a registered nurse working in Champaign-Urbana we always had people coming to the ER with teeth that needed something done, in horrible pain. We could medicate them. We couldn't treat them. What they came up with was a solution that I think really worked. They had a group of dentists from as far away as 60 miles away from Champaign who agreed on an anonymous basis so they wouldn't get inundated with patients who couldn't pay to take a month of call. We would tell the patients that we could fix them up with a dentist who would treat them but they wouldn't know the name of the dentist until they actually went there and they had to agree that they might have to go as far

away as 60 miles. That's the way we could get them treated. If you could offer incentives for dentists or doctors to do something like that, I think it would be greatly of assistance and keep people from having unnecessary visits to the emergency room.

I really do have a broad base of nursing experience and I would help with that in any way you needed. I would also like to know how or where in Southern Illinois we could help people who have physical disabilities and need services that are not provided in rural communities. That's all.

MR. DUFFETT: Thank you. Floyd.

FLOYD CUNNINGHAM: Floyd Cunningham. F-L-O-Y-D, C-U-N-N-I-N-G-H-A-M. I did not come prepared to speak today.

MR. DUFFETT: Pull the microphone up closer.

FLOYD CUNNINGHAM: Sorry. I did not come prepared or with the intent of speaking today. These are very dynamic issues being discussed and a couple of them I do want to respond in more on principle of the issue. One of them, the first one has to do with use of the word universal health care, single source payee, socialized medicine. For brevity I won't use the word socialized because it's the intent I'm talking about, not necessarily the structure or the mechanism by which

it would be delivered. We have a socialized education system. Public education is made available to everybody because we feel it is essential to the individual, to society and to our country. We have a socialized highway system because we feel mobility is essential to the individuals, society and to our nation. How can we justify giving less priority to health care, the health and health care of our individuals? I think when it comes to some judicious allocation of our limited resources, we have our priorities wrong here and we do not make a basic array of essential services available to everyone regardless of their need, their ability to pay. I'm all for some kind of sanctions against abuse or misuse, for safeguards being built into it but I feel -- I'm not asking for justification on how did we get here because I'm afraid the tendency would be for somebody to come up with an answer of how we got here and drop it. I'm saying there needs to be a change because it reflects something very negative about our priorities. I'm not trying to distract from education or mobility but we give more priority to that than we do our health care system.

The other issue I wanted to address has to do with the State's acknowledgment that they owe

certain debts which they say we're not going to pay them for awhile and what this has done to both consumers and providers. I retired over ten years ago. We did a lot of contractual work and purchase work for the State of Illinois and I can give you endless anecdotes about the tragedies inflicted on individuals as well as what you've heard here, providers and resources that went out of business. To me it is, no matter how they try to dress it up, the State is demanding interest free loans from providers and consumers when they say that they are going to -- as consumers and providers we are basically having to loan the money to the State until they get caught up with no interest whatsoever. To me this is not only unconscionable, it is really an ethical question which I feel needs to be best addressed legislatively to be certain someone cannot just transfer the damage which otherwise would be there, transfer it to some other individual without any kind of compensation of the resources that are having to pick this up and carry it. Thank you.

DEENAZ PATEL: Hi. Good evening. My name is Deenaz Patel. I'll go ahead and spell that. D-E-E-N-A-Z. Patel is P-A-T-E-L. I'm an MSW student here at SIU. I don't have a carefully crafted

testimony today but I do have a story myself. I'm a first generation American. I have parents that were a wonderful, extremely hard working story, success story that lived in northwest suburbia today. One of the things they always told my sister and I is that in this country what we really do is work really hard for health care. And I never totally grasped what they truly meant until probably, you know, quite recently. And I guess I should give a background. They didn't have anything more than a high school degree and now they're middle class and they just stuck with United Airlines and Motorola as their career path. Health care was an issue. Even when they were struggling with their job they stuck with it because they knew they needed to provide health care for the family.

Really what I want to say here is I am really dismayed and I think it's dehumanizing and also humiliating that health care has become a commodity in this country. It shouldn't be that way and we shouldn't really look at the socioeconomic status of the people and also their job choices. Thank you very much for your time.

MR. DUFFETT: Thank you. Charles.

CHARLES WALLINGER: Hi. My name is Charles Wallinger, W-A-L-L-I-N-G-E-R. I'm a school bus driver

here in Southern Illinois, make about 8,000 a year so I would have to make ten times that amount to afford health insurance. I'm a diabetic and have heart conditions. I've worked for Social Security back in 2001, logged thousands of calls from people about their health concerns and stuff so I've heard a lot of things. That was back at the beginning when drug companies were starting to do prescription drug programs. We didn't get any training on prescription drug programs. While I was looking up the people's medications on the Internet through our computer data base, I was finding that the drug companies were offering on the web site so I was offering the information to the people on the phone and it was making a huge difference in their lives. I mean, they were calling in crying how could they get their medicine. That was in 2001. It's vastly expanded now. I'm taking medication through the drug systems program. I'm on sixteen medications right now. They're planning on expanding two more plus insulin. And getting to a point about two and a half years ago I had an ailment where I went to the emergency room, the local hospital. I almost drove past and went home. I have a high pain tolerance. I didn't think too much about it. But when I went in the emergency room my blood sugar was around

700 which is critical and they said my appendix had ruptured so they scheduled me for emergency surgery. They said don't worry about it. You don't have health insurance. We have a charity care application you can fill out afterwards. And I spent a week there. I filled out the charity application. It had a 15-day application processing but before they would process the application I had to apply for medical coverage under Medicaid through the Department of Public Aid which had a 45-day waiting application period. Well, they knew they weren't going to be covering me because they knew I would expire their 15-day requirement to get the application processed before Medicaid ever decided anything. So it went through courts, billing, collection, finally filing bankruptcy and now it's going to the Illinois state's attorney Lisa Madigan for an investigation. I don't think this is the best way to spend health care dollars fighting in courts or forcing hospitals. I can understand a $30,000 hospital bill to take my appendix out was an exorbitant amount of money and they had to absorb it. But at the same time, we need some kind of health care coverage for our citizens so that they can work and continue to raise their kids. I have three kids that depend on me. Not only that, I have 115 kids that ride my school bus

which I consider my own kids because I'm with them every day and you get to learn their names and learn their little songs and I have fun at it. It's the best job I've ever had but I had to quit three days ago because my blood pressure has gone out of sight. It's a complication of diabetes. I forced myself to stop working because I was taking the kids best interest to heart. With no income coming in, I go to Shawnee Health Care Alliances. They do a great job. It's a clinic so they have limited resources. We need hospitals to do the major things. Like I may have to have heart surgery. I don't know. He wanted me to go have a stress test at the hospital. I said, I can't do that. We have to consider -- I had to consider what the ramifications were. I can't go through the courts and be put in jail and all of this stuff just because I simply can't afford to pay them.

Universal health care, I've talked to people in Spain, in Canada through the Internet. The UK, Australia. They all have similar types of universal health care. The UK has a health insurance system but it's similar to universal health care. It has low premiums. Everybody pays so everybody is covered. I'm probably the only person in this room that's even mentioned talking to other people in other

countries how their health care is. People in Australia get their blood work done at home. A nurse comes to the house and takes their blood and does it that way. It's under a universal health care system. It might work here. I don't know. The insurance industry has a lot of lobbyists that's going to fight this because it's going to cut into their profits. That's basically all I have to say. I didn't write anything down because I have visual impairments and I can't read text. I pretty much just talk.

MR. DUFFETT: Thank you very much. That's the end of the speakers. And on behalf of the Task Force, we deeply appreciate many of you who stuck around for the nearly three hours and for you coming and giving testimony and listening. Thank you very, very much.

State of Missouri

SS.

County of St. Louis

I, Stacey Jenkins Kolb, a Notary Public in and for the State of Missouri, duly commissioned, qualified and authorized to administer oaths and to certify to depositions, do hereby certify that I attended the public hearing held by the Adequate Health Care Task Force, in Carterville, Illinois, on the 8th day of March, 2006; that the foregoing pages correctly set forth the testimony of the aforementioned speakers, together with the questions propounded by the Task Force and remarks and thereto, and is in all respects a full, true, and complete transcript.

Witness my hand and notarial seal at St. Louis, Missouri, this 15th day of March 2006. My Commission expires September 2, 2008.

Notary Public in and for the
State of Missouri

COURT MEMO

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Adequate Health Care Task Force Public Hearing

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