STATE OF ILLINOIS)
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COUNTY OF K A N E)

ADEQUATE HEALTH CARE TASK FORCE PUBLIC HEARING
14TH CONGRESSIONAL DISTRICT
DECEMBER 14, 2005

REPORT OF PROCEEDINGS had and testimony taken at the public hearing of the above-entitled cause commencing on December 14, 2005, at 4:00 p.m. at Aurora Christian School, 2255 Sullivan Road, Aurora, Illinois.

As Reported By: Linda M. Radecki
Certified Shorthand Reporter
CSR No. 84-002799

PRESENT: ADEQUATE HEALTH CARE TASK FORCE

MR. DAVID KOEHLER,

MS. PAMELA MITROFF,

MR. JAMES DUFFETT,

MS. ROSALIND WALLS,

MR. JORGE RAMIREZ.

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MR. KOEHLER: I'm David Koehler, and I'm the vice chair of the Adequate Health Care Task Force, and with me are other Task Force members.

On my far left, Jim Duffett, and to my immediate left is Pam Mitroff, and we have a court reporter, Linda Radecki, who is to my right, and all the testimony today will be taken verbatim and made part of our proceedings as we do our work.

I want to read a short statement, and then I'll talk a little bit about how we're going to proceed here.

I just want to welcome you to the 14th Congressional District Public Hearing. We're doing one of these in each Congressional District throughout the state, and this is a public hearing of the Adequate Health Care Task Force that was created under the Health Care Justice Act.

It has been well-demonstrated that a person's ability to access the health care system influences his or her treatment, outcomes, and health status.

Access to health care is affected most by the ability of those seeking care to afford the services they need. Therefore, the uninsured, working

poor, racial and ethnic minorities, and undocumented immigrants in Illinois are the least likely to be able to afford to pay out-of-pocket for many health care services.

Many Illinoisans lack access to the health care system because they lack health insurance. On any given day, an estimated 1.8 million people in Illinois are without health insurance. Additionally, a growing number of people are also underinsured, and the consumer's share of the cost for health insurance is growing.

While Illinois has many safety net providers, including public and private clinics, public hospitals, and charity care that's administered by private hospitals, in an attempt to narrow the gap between the insured and the uninsured, many uninsured Illinoisans lack access to a usual source of preventive and comprehensive care, and that's why we're here.

The Health Care Justice Act, signed into law by the Governor in August of 2004, encourages the State of Illinois to implement a health care plan that provides access to a full range of preventive, acute, and long-term health care services and one that maintains and 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 process of really developing this plan. We are 29 members strong in terms of Task Force membership. We were appointed by the Governor, by the President of the Senate, by the Minority Leader of the Senate, by the Speaker of the House, and also by the Minority Leader of the House.

As part of our work, the Task Force will be holding, as I mentioned, at least one public hearing in each Congressional District to seek input from the public, and that's why we are here this afternoon. In addition, we have three other hearings planned just to make sure we have geographic coverage throughout the state.

So it's on behalf of the Adequate Health Care Task Force and the Illinois Department of Public Health that I would like to thank each of you for coming out this afternoon, especially in the snow, and for taking part in this process.

Before we get started, there are a couple of housekeeping items that must be addressed. First, if you have not already done so, please sign in out at the table so we know who you are in terms

of attendance.

Also, those who wish to speak and give testimony, there's a yellow-colored sheet that you can sign right back there with Ashley. Ashley Walter is from the Illinois Department of Public Health in the back of the room at the table there.

There are two handouts available at the table when you came to sign in. There's a little more information about the Health Care Justice Act, about the Task Force itself, and about this public hearing.

If you brought written testimony to submit, you may do so, as well, and you might give that to Ashley at the back table, and that will be made part of the record, also.

I'll call speakers up one at a time. If you would be ready to go. We're going to give you three minutes. We're a smaller group. We're going to try to be a little flexible on that. If you could try to address us in a three or four-minute time frame, we would appreciate that.

Also, another housekeeping issue. The bathrooms, if you go out in the hall and all the way down to the left, the women's is first, and then

around the corner is the men's restroom. We will try to take a break in about an hour to give our reporter a chance to rest her fingers a little, but we're ready to begin. Anything else I have forgotten, members?

The first speaker is Tim Selz, and I'll just read the next speaker, so if you'll be ready. Clersida Garcia, Luis Garcia, and Margaret Kirkegaard. So Tim, if you would come up.

First thing I want you to do is pronounce your name and spell it so that we can get it recorded accurately in the testimony. So welcome.

MR. SELZ: Good afternoon. My name is Tim Selz, S-e-l-z.

MR. KOEHLER: I'm sorry, one more housekeeping issue. We wanted to wait for the camera to get back, too, but we also have an interpreter.

So if there is anyone that is not understanding or able to speak English in the audience, I guess you wouldn't be able to understand what I'm saying; but Ashley, has anybody requested any of the translation equipment at this point? But we do have a translator available, if we need. So I'm sorry, Tim, go ahead.

MR. SELZ: Good afternoon. My name is Tim Selz.

Members of the Adequate Health Care Task Force hosting this hearing, thank you for listening to our views and concerns in this critical issue involving providing access of quality health care.

I have submitted written testimony, but I'd like to underscore three points concerning the testimony. First of all, Provena Mercy Medical Center serves health care needs to people in our communities regardless of the ability to pay or citizenship status.

We treat patients at the medical center 24 hours a day, seven days a week, 365 days a year. At Provena Mercy Medical Center during 2004 our charity care was provided at a cost of $2,332,000. Through September of this year we have provided over $1.2 million of charity care to the communities we serve.

Second point I'd like to underscore. At Provena Mercy Medical Center we have a financial assistance policy. To be eligible for 100 percent reduction for billed charges, the patient's household income must be at or below 120 percent of the federal guidelines. Patients whose household income exceeds 120 percent, but less than 300 percent of the current

federal guidelines will be eligible for a sliding scale.

Provena Mercy Medical Center reviews patients who have no insurance coverage for eligibility requirements for Medicaid assistance. We placed a firm in our hospital to work with our employees on campus in terms of patients eligible for Medicaid assistance.

A third point. Today two out of every three hospitals in Illinois are losing money taking care of patients, and more than one in three hospitals in Illinois have negative operating margins. At the same time, much of the revenue sources pay less than the cost of providing care for the average hospital.

Two examples of costs continuing to go up for Provena Mercy Medical Center. In 2004 pharmaceuticals cost 4.4 million. That cost this year rose to 4.6 million. Our malpractice insurance cost in 2004 was 2.2. million. In 2005 it's 4.4 million.

Final point. Provena Mercy Medical Center is a faith-based organization, and we truly see health care as a right. In order for us to fulfill that obligation to provide that right to our citizens, we need adequate access to health care. Thank you very

much.

MR. DUFFETT: I was wondering, Mr. Selz, if you have seen in the last year or two years a different grouping of people who are seeking help through your charity care program in terms of the different levels that you have. Are you seeing maybe more in the upper level people needing help? I just kind of wondered from your experience what have you seen change in the last few years?

MR. SELZ: Jim, I just don't have that information. I don't know.

MR. KOEHLER: Thank you very much. And to the technicians in the back, and I did want to also thank Aurora Christian High School, as well, Steve Anderson and Brad Showalter, who have helped us to set this up. We have volunteer Randy Hall, who is also assisting us on this.

Also, Barb Sorgatz is here from the Department of Human Services, the Regional Consultant. So Barb, I don't know where you are, but welcome. And I wanted to also mention that Sarah Lauzen, who is the wife of Senator Chris Lauzen, is here. Sarah, thank you for joining us.

Could you hear all right when Tim

was speaking? Because it's very hard to hear up here. Can you turn the bass down a little bit on that? It's very hard for us to hear up here.

And our next speaker is Clersida Garcia. So if you would come and speak directly into the microphone because, like I say, it's hard to hear. Welcome.

MS. GARCIA: My name is Clersida Garcia, and I represent the Illinois Association for Health, Physical Education, Recreation, and Dance. I also represent Northern Illinois University.

This is my first time speaking at a public hearing, so I'm a little nervous, but I'm going to do my best to express our concerns, the concerns of my organization.

The issues that bring me here today are issues that are related to some of the principles you mentioned in your health care justice campaign. In the principles you talk about this health care is going to be accessible for all Illinois residents. I applaud you for that.

Second, you talk about quality, and that's what really caught my attention when you talk about promotion, prevention, and early intervention. I

think that's a key aspect and needs to be addressed by any health organization, including us, you, and anyone that have the name of health in the name.

With health prevention we are concerned about not just when people are ill, but before they get ill. What can we do to prevent people from getting sick. And in that respect, the reason why we have that is because this impacts both quality of life and health status of all Illinois residents. And second, because costs and expenses in health can be reduced not only today, but in the future.

So in relation to the key aspect that I called your attention to in terms of prevention is the obesity and physical inactivity crisis that is right now affecting all of us in Illinois. Physical inactivity contributes to 400,000 preventable deaths. That means 17 percent of total deaths per year in the United States. We are nearly close to the deaths by tobacco.

Overweight among children have doubled. So now we have 15 percent of the children today are obese. And if we look at adolescents, we have tripled the number of overweight adolescents today. If we look at African American, Hispanics,

and Native Americans, then we are talking about 20 percent of those children being overweight.

Type II diabetes is another major concern among young children, which in the past was called adult onset of diabetes. We thought that only adults would get it, and today we are having even more children with this type of diabetes.

Then I want to call your attention to other factors that affect obesity. More than 20 percent of U.S. children eight to 16 years old watch at least four hours of TV, and Illinois requires that physical education be provided to all students throughout the elementary, junior high school, and all through the school years.

However, according to a statewide survey of physical education shows that 91 percent of districts do not adhere to the law. So this create more obesity in children, which also will become obese adults. Therefore, obesity cause 70 different kinds of illness as adults, 70 to 90 different causes of illness.

So in summary, what I want to call your attention to is what do we want to do about that. I think this is a problem not just yours, ours, it's

all the community. I think we need to enforce the physical education mandate in all schools of Illinois, and we need your support on that.

We also need to educate parents throughout not only the schools, but also in health institutions, which will provide some sort of promotion and support for that, and we need to include the community in general, because this is a problem that is affecting all of us.

So even the community has to be involved in many different ways to prevent and avoid these causes and these high health costs in the future. Thank you for your attention.

MR. KOEHLER: Thank you very much. And I had a chance to talk with Mrs. Garcia before the hearing, and it's one of the things that certainly is near and dear to my heart is the whole issue of prevention, and I'm hoping that we can get more statistics in the Task Force as we deliberate about certain populations and diabetes and some other things that are going to become epidemic. So thank you.

Luis Garcia. After that, Margaret Kirkegaard, Janet Craft, and Eleanor Lukazeuski. Welcome.

MR. GARCIA: Good afternoon. I want to congratulate what you guys are doing here. Also, I like the fact that you have some information in Spanish.

MR. KOEHLER: Spell your name, if you would.

MR. GARCIA: Luis, L-u-i-s; Garcia, G-a-r-c-i-a.

I like the fact that some of this is in Spanish, which is very good. I just want to follow kind of the information that the previous speaker was talking about, but my point is mainly about rights, the right that people have to be healthy, and this is one of the things that we take it to mean.

The State of Illinois is the only state that require to have a mandate for children to do physical education, which is the only space that children have to move. Once you look at the issue of movement and you look at the neighborhoods, there are poor neighborhoods. Children don't have no space to do anything, because of crime, drive-by shooting.

So when you look at the issue of movement and the issue of what might help the health of the state, something invisible is going on that tends to disappear from the school. What I mean by that is that even though we have a mandate, we have

many schools that do not receive adequate number of minutes for physical education, and this is the only time children have the opportunity to move.

Movement, therefore, translate into health, and I'm sure I don't have to explain that, because that's what you guys are experiencing. So there is a need that everyone in this room here, and including you at the table, that we move together, because there is an emergency.

We didn't do anything in the '70s, in the '80s, and the '90s. We have a crisis right now. If we don't move now, then we're going to pay a bigger price. So physical education is one of the biggest tools that we have available, and it's right there. The children are right there in the school.

So this is one way to deal with the issue of health care. In other words, to save money for the future. That's my main message, and I believe that we all have a right to have that given to us. Thank you.

MR. KOEHLER: Thank you very much. Margaret Kirkegaard.

MS. KIRKEGAARD: Good afternoon. Thank you for allowing me to testify today. My name is Dr. Margaret

Kirkegaard. I'm a family physician. I also have a degree in public health.

I'm here today to advocate for a system of health care delivery that will provide comprehensive health care to all people and improve the quality of health care and reduce administrative waste. Namely, I'm an advocate of the single payer system or state sponsored health insurance.

Through my work as a family doctor, I'm in continual contact with patients who lack access to medical care. I'd like to tell you about a few of these patients.

I recently cared for a woman named Susan while I was volunteering at the DuPage Community Clinic serving uninsured patients in DuPage County. Susan was laid off from her job about a year and a half ago. When she lost her job, she also lost her health insurance.

When I saw her, she had joint pain and swelling, and I confirmed that Susan had developed debilitating rheumatoid arthritis. Susan now has difficulty walking and cannot type on a computer. Her physical problems make it difficult for her to search for a job in her former field.

Her lack of employment means that she cannot obtain health insurance, so she cannot obtain the care necessary for treating her rheumatoid arthritis. Susan is caught in a vicious cycle of no job, no health care; no health care, no job. Susan's situation shows us we need a health care system that is not tied to employment status.

In the clinic where I work with residents we see a lot of Medicaid patients. Theoretically, these patients are pushed through the Medicaid program and are not counted among the 40 million uninsured Americans in the United States.

Recently we saw an 11-year-old boy named Sam who had fallen during a soccer game and sustained a fracture to his wrist. We could not find a pediatric orthopedic surgeon who was willing to accept Medicaid payment to see Sam for his broken wrist.

We ended up sending Sam to the emergency department of another hospital where he would likely wait for several hours before a pediatric surgeon would be called to the emergency department to see him. Of course, sending Sam to the ER likely doubled or tripled the cost of placing a cast that

could have easily been applied in the orthopedic surgeon's office.

Our fragmented system of health care delivery cannot care for patients like Sam. The Bush administration's proposal of increasing the number of federally qualified health care centers also suffers from the inability to provide needed specialty care. Sam's case shows you we need a coordinated system of health care delivery that provides equal access to specialty care and does not create unnecessary waste.

Let me also tell you about another patient named Bonnie. Bonnie has been trained as a paralegal. She also suffers from mental illness. Primarily because she's been unable to get appropriate medical care for her mental illness, she is homeless now.

She spends many nights sitting in the chairs next to the pharmacy department at an all night Jewel, because she has nowhere else to go. We need a health care system that ensures access to mental health services and that regards mental health as an integral component of overall well-being.

Our current health care system is broken. Over two million people in Illinois lack

health insurance, as you all well know. Currently our market-based system wastes approximately 25 percent of our total health care dollars on administration, whereas Medicare, the insurance program for elderly patients, has an overhead of only three percent.

We need a health care system that does not treat health and well-being as a commodity. As a society, we have to find many other goods and services that cannot be provided through a market-based system. Take clean water, for example.

If we relied on the market to ensure access to clean water, drinking water in California would cost $1,000 a gallon. Or our national highway system. If we relied on a market system to determine where we build highways, North Dakota and Wyoming would have no roads, because there would be no economic incentive to build them.

We need to recognize that health and health care are an important national resource that requires a system of management that can ensure universal access to care, coordination of care, and access to specialty services and mental health care.

A single payer plan has been shown to reduce administrative waste, reduce paperwork,

improve patient and provider satisfaction, while at the same time providing universal access to health care.

Two hundred years ago many fire departments were privately owned companies. When an alarm would sound, all the various fire companies would rush to the site of the fire. If the burning home was registered with another company, firefighters from the other companies would just stand around and watch the home burn to the ground. This system was ultimately abandoned in favor of community fire departments.

Our system of market-based health care is burning to the ground. I strongly urge this committee to consider a single payer health care system to offer all people in Illinois. Thank you.

MR. KOEHLER: Thank you. Janet Craft.

MS. CRAFT: Good afternoon. My name is Janet Craft, C-r-a-f-t. I'm representing the League of Women Voters of Geneva-St. Charles.

The League of Women Voters of Illinois maintains that a basic level of quality health care at an affordable cost should be available to all U.S. residents. For this reason, the League supports the work of the Health Care Justice Task Force and

drawing up a plan to bring affordable health care to all Illinois residents.

Unique state solutions to health care access are gaining currency across the country, and Illinois has a chance to be a pace setter with the state-initiated commitment to health care.

In the 14th District here we have areas that are federally designated as maximally underserved, yet others have a wealth of health care resources and sources for payment. But even in those higher income, well-served areas, all is not rosy.

Families U.S.A. found a couple of years ago that small businesses offering health benefits dropped to 42 from 65 percent in the last two decades. The Fox Valley is not immune from this trend as major employers downsize, move, or relocate portions of their operations offshore.

It now hurts people all of us know: Family, friends, and neighbors. Our reliance on health coverage tied to employment is breaking down. Fewer jobs include health benefits, and retiree health benefits are being eliminated or curtailed. And the state League has developed a number of criteria which are in my written testimony, and I'll just review them

briefly.

First of all, we would like to ensure that sharing of risk, that it's fair to all income levels. We'd like to emphasize purchasing power. Does whatever approach you use leverage group purchasing power of health care services.

And comprehensiveness, which the previous speaker brought up. Does the approach ensure that all covered individuals have access to preventive care, prescription drug, and mental health coverage.

And I'd like to add parenthetically that among our membership and a lot of feedback we have gotten on mental health coverage, that is just a very chronic need.

Inclusiveness. Does it ensure that it does not arbitrarily exclude certain groups such as migrants or immigrants. Cost containment. Does the approach contain health care costs. And continuity. And again, portability of coverage, which we run into when it is tied to employment.

The League applauds the Task Force for your work in planning for better health care in our state, and we hope our criteria and our comments will be useful in developing whatever plan is presented to

the state legislature.

MR. KOEHLER: Thank you. I'm going to read some more names, but Eleanor Lukazeuski is next. Theresa Heaton, Representative Robert Pritchard is here with us today, as well. I wanted to introduce you, but he'll be speaking.

Reverend Wayne Miller, Tim Selz, I have you down again. Are you still here and wishing to speak again? I think he's already spoken. And then Robert Reeder.

So Eleanor Lukazeuski, and then we'll have Representative Robert Pritchard after that.

MS. LUKAZEUSKI: Good afternoon. I represent the Fox Valley Health Care Coalition. We're mostly from the tri-cities. I just remembered something that I should have put in my written testimony.

We go back a long way many years working on health care. The most remarkable was the Bernardine Amendment, which some of you may remember, which was named after the Chicago archbishop, and his request was that all people have access to health care. We managed to get that on the ballot in Kane County, and it passed by 61 percent. So I think it shows where most people's thoughts are.

Anyway, my written statement is that we, the citizens of Illinois, actually do not have a system of health care. Local public health departments provide infant and children immunizations, and the Governor's recent proposal for child care is promising, but not yet enacted.

Adults receive their health care through their employment, and coverage varies greatly. Employer-based health care profoundly affects people's lifestyles by restricting them from changing jobs and possibly job advancement.

The business community is also impacted by carrying the burden of health care costs. These two factors alone impact the state of the overall economy. Universal health care for all people is the only fair and economic method.

Speaking for myself as a senior citizen, I find costs continue to rise. Each year the cost of Medicare Part B increases along with the Part B supplements. Many seniors are in managed care plans, because they appear to be the least costly. These costs are also rising in monthly premiums and also in co-pays.

Obviously health care costs are and

have been rising out of control. So it seems this is a totally broken system beyond repair due to be replaced. Thank you very much.

MR. KOEHLER: Thank you. And with us is Representative Robert Pritchard.

MR. PRITCHARD: Thank you and welcome to the 14th Congressional District. My name is Robert Pritchard, P-r-i-t-c-h-a-r-d. Good evening.

I am State Representative Bob Pritchard from Hinckley of the 70th District. I come to give voice to residents of DeKalb, Ogle, and LaSalle Counties who are struggling with the dream of quality, affordable health care.

The Illinois health care system is melting before our eyes like the snow that is accumulating outside will be melting by March or April. I would like to document some of that deterioration and offer strategies for recovery that I encourage you to consider in your final report to the Governor and the General Assembly.

New life is critical to the survival of a family or community. Pregnant mothers are finding it impossible to find a relationship with an ob/gyne in our communities. In DeKalb alone we've gone from over

15 practicing ob/gynes to just two in the past year.

Doctors are struggling with the cost of medical malpractice insurance and have made a business decision to move to another state, stop delivering babies, or retiring.

Medical malpractice insurance rates of over $100,000 are common, which requires delivery of dozens of babies before the doctor can start paying other bills for their practice and earn a decent income for their families.

Reforms passed by the legislature this past session may stabilize rates, but they will not bring relief to the cost of insurance any time soon. In the meantime, fear of litigation has forced doctors to prescribe more tests than may be necessary to provide legal defense that everything possible was being done. The cost of health care, as a result, continues to escalate.

The cost of health insurance for families has also continued to escalate forcing more and more businesses and families to drop insurance. A community college professor recently wrote to me saying he could not afford to continue paying over a thousand dollars a month to insure his child with

special needs. Because he has insurance, he will not qualify for the new All Kids Program. Many working families are in the same predicament.

Medicare patients cannot find doctors or dentists in my district to give care. The State's policy of delayed payments and heavy discounts have placed a burden on the health care system for the low income upon the medical community. Doctors, dentists, clinics, hospitals, and long-term care facilities cannot continue to carry the financial burden of the State.

The recent $1 billion short-term borrowing did not even pay the current backlog of payments estimated at $1.5 billion at the time, and does not address the long-term need to cut the rate of growth in Medicaid payments estimated at over 5.6 percent per year.

Medicaid patients have to travel 30 to 50 miles to get care in Rockford, Elgin, and Aurora. The two largest clinics in DeKalb County stopped accepting Medicaid patients several months ago and not a single dentist accepts new Medicaid patients.

The State's Medicaid program needs

reforming. I have been part of a coalition calling for some reform of managed care to reduce the rate of medical costs for the state. But instead, the Governor and the legislative leaders have approved expansion of coverage and only token efforts at teaching citizens to manage their health care.

Unless we slow the rate of growth in Medicaid payments, this item will grow from 26 percent of state and federal funds now to over 60 percent by the time children today reach the work force.

Two of every three senior citizens in nursing homes is on Medicaid. One in seven citizens is on Medicaid. Two of every five babies born are delivered by Medicaid care. The outstanding Medicaid payments to my local hospital has grown from $800,000 to 1.8 million in just the past year.

It is obvious that families without insurance don't get routine medical care. They delay seeking the health care of a doctor until the situation is acute. They go to the emergency room of hospitals.

Care is more expensive at the ER compared to local doctors' offices, as we've already heard. Real emergencies must now be worked into a

packed ER reception area, and the cost of care is higher for those treating more acute situations.

The trend in medical specialization and urban practices means that rural communities can no longer attract doctors and clinics and are under-served. Economic development is steered away from rural areas to cities where health care for workers is better.

I've noticed a marked deterioration of the health care system in my district in the past decade, and the forecast is for further deterioration. My community is building a new hospital at a cost of over $100 million, but it wonders if it will be able to attract and keep doctors necessary to use that facility.

I encourage you to include in your report strategies for correcting the current situation of inadequate delayed health care. First, the State must find ways to stabilize the growth in health care and Medicaid costs. Like Kansas and other states, Illinois must find ways to drive down administration, regulation, and insurance costs.

We must better educate consumers to manage their health and reduce obesity. Healthy

lifestyles would reduce complications from diabetes, heart attack, and joint deterioration. Realistic expectations about doctors' roles and abilities might also reduce litigation.

Third, the State needs to encourage the medical community to do more to prevent medical injury. I was impressed to learn that Dreyer Medical Clinic here in Aurora has a new computer system that prompts doctors to follow up with patients to see that medications and recommendations are followed, to coordinate care within the hospital, and to use computer-aided checks of medications so every possible human error is prevented or caught in time.

And finally, the State needs to shoulder the cost of Medicaid and pay providers prompt and fair levies. Health care is a major concern of citizens. As our standard of living has developed, expectations have grown for better health care. Our current delivery system is imploding, as we've heard. Lest we fiddle while Rome burns, the State must address the crisis now and take action.

I look forward to your thoughtful report and stand ready to help with needed legislation to address this critical issue. Thank you.

MR. KOEHLER: Thank you. Theresa Heaton.

MS. HEATON: Good afternoon. I'm Theresa Heaton. Thank you for the opportunity for presenting this afternoon.

I am testifying on behalf of the Kane County Health Department and the Kane Community Health Access Integrated Network along with a partner who is not here, Deb McElroy, the project director for the Integrated Network.

Kane Community Health Access Integrated Network, K-Chain for short, is a coalition of health providers comprised of the area hospitals, federally qualified health centers, free clinics, private practitioners, and the health department.

We are funded primarily through a federal grant right now titled Healthy Communities Access Program. Our goal is to increase access to primary and specialty care, improve the quality of health care, and integrate key health system functions in order to leverage existing resources to serve the uninsured, underinsured, and the publicly insured residents of Kane County.

The need for primary and specialty care for the uninsured, underinsured, and publicly

insured in Kane County is tremendous. We are currently implementing a new patient navigator advocate program in all five hospitals in Kane County.

Data we have collected from just one of the five hospitals over a three-month period indicated that 2,221 people did not have a primary health care provider they used for their routine health care. Instead, this population is utilizing hospital emergency rooms for their health care needs.

K-CHAIN has been able to place so far 251 of these patients into the local federally qualified health center and/or other medical homes for their routine care. While providing care for all of our residents is a challenge, Kane County has a relatively good infrastructure for primary care. Specialty care, however, remains a significant problem in this county.

Kane County has multiple barriers relating to meeting the specialty care needs of its uninsured, underinsured, publicly insured residents. Currently there is not a publicly supported hospital or access system available for Kane County residents. No centralized system of referral to physicians that accept uninsured and publicly insured patients, and

the delivery of care is facilitated through informal strategies.

Within one month of having a dedicated K-CHAIN phone line, we began treating the uninsured and publicly insured and provide timely treatment plans for those in need. K-CHAIN does not currently have the resources to address the needs of specialty care for the uninsured and has had to refer this specific population to resources outside of our county.

Although beneficial, these resources sometimes place an additional burden on these needy patients in terms of travel, additional daily expenses, and many times their medical needs are not resolved in a timely and effective manner. Some examples regarding this need.

A nine-year-old child had a liver transplant in Madison, Wisconsin. The transplant was covered as part of a Wisconsin Public Aid Emergency Care program. The family moved to Elgin to be closer to relatives due to work and child care needs. Child was denied Public Aid in Illinois due to documentation status. The child desperately needs a doctor or a hospital that can continue his medical care.

A second example. An Elgin resident is a renal dialysis patient at Children's Memorial Hospital. Inpatient services are being provided under their charity care program. Children's Memorial Hospital referred the patient to K-CHAIN for continuous follow-up. We were able to connect him with an FQHC for his primary health care, but have been unable to provide specialty care follow-up in Kane County.

A 22-year-old uninsured male is suffering from gastrointestinal issues and uses the hospital emergency room weekly for pain management. K-CHAIN was able to connect him with an FQHC for his primary health care, but his specialty needs are still being handled by an emergency room.

A 35-year-old male was diagnosed with seizure disorder after an auto accident. The patient had health insurance, but had recently been laid off. The patient is utilizing the emergency room for medication and follow-up care. K-CHAIN was able to connect him with an FQHC for his primary health care, but his specialty needs are still unmet.

And finally, the last example. A middle-aged female diagnosed with lymphoma, uninsured. K-CHAIN had to refer this patient outside of the county

for assistance with her treatment.

We support and look forward to the efforts of this task force. Thank you.

MS. MITROFF: One question. You specified early on about 2,221. Was that out of total patients, or how many were the total patients? Maybe you can clarify that.

MS. HEATON: That was data that was collected from one hospital over a three-month period of people that had come in through the emergency room who did not have a primary health care provider that they used for routine primary care.

MS. MITROFF: So we don't know how many patients there were overall, we just know there are 2,221 that did not have --

MS. HEATON: Yes. And I'm sure that could be updated. In fact, our project will be doing that over time with all of our five hospitals.

MS. MITROFF: And it's K-CHIN?

MS. HEATON: K-CHAIN, like the word chain, and it stands for the Kane Community Health Access Integrated Network. It's an acronym.

MR. KOEHLER: Just a question, as well. The federally qualified health center does not have access

to specialty physicians?

MS. HEATON: They are funded for primary care. The federal streams do not cover either pharmaceutical or specialty care.

MR. KOEHLER: Do they have a 340b program for pharmacy in place?

MS. HEATON: 340b programs are being initiated in several of the FQHC's in Kane County.

MR. KOEHLER: Thank you. Reverend Wayne Miller.

REVEREND MILLER: Thank you. My name is Wayne Miller. W-a-y-n-e, M-i-l-l-e-r. I'm the senior pastor of St. Mark's Lutheran Church here in Aurora.

I don't think that this afternoon I can really offer much in terms of documentation or statistics that you haven't already heard from other people, but it seems to me it would be helpful for you to hear a perspective on why I think this issue is so very important to the religious community.

In the tenth chapter of the Gospel according to St. Luke, Jesus commissioned his followers to enter the world with the following mission: Whenever you enter a town and its people welcome you, eat what is set before you, cure the sick who are there, and say to them the Kingdom of God has come near you.

From that day to this, the Christian community has pursued this commission to enter the world as healers, and I believe that's a role that is foundational to our identity and true as we understand it.

The reason for our commitment to be the agent of Christ's healing is not just to make life longer or more comfortable for a few lucky souls. It is the uncontrovertible witness of our Scriptures that Jesus brought healing as a concrete demonstration of his mission to restore those who have been marginalized by the conventional power structures of that society and to reclaim as God's beloved children those who most people regard as irrelevant and expendable.

Pursuit of healing and wholeness in the religious community for the disenfranchised takes many forms: Prayer, laying on of hands, emotional and psychological support, all being of central importance. But in my particular tradition of Christianity, spirituality and healing have always been complimented by a passionate investment in the practical art of medicine.

We Lutherans, along with the United Church of Christ, have worked in partnership with what

I believe is the largest faith-based health care system in the state, and we like those who are directly for advocate health care derive both a deep sense of satisfaction and a deep sense of responsibility from this healing work that we consider to be a sacred trust directly from God.

We have quietly and steadfastly continued in this work through many rises and falls in the government's commitment to provide the same gift of healing to its own citizens. But increasingly, we are entering a time when the government's attitude and behavior concerning health care is not just benignly passive.

Systems of disproportionate advantage for the advantaged are becoming entrenched in our society by what seems to be a stubborn insistence on using medicine as an instrument by which conventional power marginalizes the already marginalized and renders the weak irrelevant and expendable. Our culture is rapidly becoming an obstruction to the Biblical vision of God's mission and God's kingdom.

The indifference and neglect of public leadership over the years in this matter not only declines to relieve suffering, it has become

the actual fact of the cause of unjust suffering.

Because of public policy or what has been lack of public policy, faith-based health care systems are finding it virtually impossible from an economic point of view to provide the care that we are called and commissioned to provide, especially to the unemployed, the underinsured, and the working poor.

With a few noteworthy exceptions of public health care facilities and hospitals, in general the public sector offers nothing to provide what they are effectively preventing the private and religious institutions from providing.

I could be wrong about this, but when Jesus said to his followers eat what is set before you, I don't think that what he had in mind was for the religious community to sit by in passive silence while the government abdicates its mission, which I understand to be the mission to defend and serve the commonwealth, not to transform the commonwealth into private wealth for a few.

The health care system, as we have heard today, and as I think we know, is broken. It is no longer serving the commonwealth adequately. Time for change, I think, is upon us.

In any case, as pastor of a church, I feel I have some responsibility to do what small amount I can to awaken both the church and the society to embrace a change that must come for our sake and for God's sake. Thanks.

MR. KOEHLER: Thank you very much. Robert Reeder.

MR. REEDER: Good afternoon. My name is Robert Reeder, R-e-e-d-e-r.

I've been a family physician and geriatrician in the St. Charles, Geneva, and Batavia area for the past 30 years. I've always tried to keep my practice open to all patients of all income levels.

Two years ago I had to close my practice to Medicaid patients due to the outrageously low reimbursement levels and the slow turn around in payment, sometimes up to a year. Unfortunately for these patients the system has failed them, because they cannot find adequate care.

In addition, Governor Blagojevich has recently signed into law the All Kids Plan to give an additional 253,000 uninsured children in Illinois access to affordable health coverage. Regrettably, due to the State's history of poor management of the

Public Aid system, I, my practice, will be unable to offer care to these children. My overhead and expenses continue to rise. I am not in a business where I can set my own prices. I'm told what I'm going to be paid.

Physicians are now facing a proposed 4.4 percent cut in Medicare reimbursement for 2006 with a total proposed cut of 26 percent by 2011, this in the face of my rent and other expenses increasing at least three percent per year. That's a spread of over six years of 44 percent. 25 percent of my patient base uses Medicare as their primary insurance. A decrease in reimbursement of physicians will decrease patient access to health care.

At a recent practice manager meeting that my office manager attended, there were 20 other managers present. They were asked how many practices will continue to accept Medicare patients with the proposed cuts in Medicare payment if they go through. Only one manager raised her hand out of 20.

What will these Medicare patients and Medicaid patients do if there is no one to give them health care. Thank you.

MR. KOEHLER: Thank you very much. We're going to take a five-minute break and will then reconvene.

(Recess taken.)

MR. KOEHLER: Our next speaker is Mary Shesgreen followed by Bill Small and Gene Dempsey, but Mary Shesgreen. And would you spell your name for the reporter.

MS. SHESGREEN: It's spelled like she's green, S-h-e-s-g-r-e-e-n. I thank you for the opportunity to speak here today, and thanks for moving me up.

I am an Illinois licensed marriage and family therapist. I've been in private practice in the Fox Valley for 25 years. I see a broad range of people of all ages and economic backgrounds, and I'm especially concerned about the fact that the availability of mental health services is so profoundly unequal.

My wealthier clients often have excellent health insurance with good mental health coverage, or they can pay out-of-pocket. Those clients with low wage jobs have inadequate health insurance or no insurance or insurance that does not cover mental health.

I can adjust my fee downward, and I often do that, but that's taking it out of my own pocket. And since my work is my only source of income,

I can't do that as often or as much as is needed.

A few of my clients have recently lost their jobs and lost their health insurance at the same time. One such person, a 54-year-old woman, has terrible physical health problems. She was depressed before this happened, and economically she was hanging by a thread before this happened. Now she has faced real intense suicidal depression over the loss of this job.

And she has to choose which of her psychiatric medications she can take, because she cannot afford to pay for all of them in spite of the fact that some of her physicians give her samples. I'm able to see her free of charge for a while, but I really fear for her life.

Many insurance plans, even if they include mental health coverage, do not include coverage for marital therapy. This is ironic. We ask couples to stay together, but if they lack the tools and the help to work through their conflicts, their emotional pain can become extreme and can spill over and impact their children.

My clients tell me that their health insurance is inadequate to cover their physical

problems, as well as their mental health problems. And again, it is grossly unequal. My wealthy clients have access to all the tests and treatments they want. For those in the middle class or among the poor, health care is sometimes a luxury.

As a self-employed person, I too have had difficulties getting health insurance. I've talked with my legislators about this in the past, and I've been told that our current system is wonderful, because it gives us choice. I find that this argument that we the consumer have choice about health care is bogus.

If I go into the grocery store to buy a bottle of ketchup, I have a choice. I can buy any brand I want. Nobody says that because I have a preexisting condition I can't buy this particular brand of ketchup. When it comes to health insurance, they can say no to me, and I'm stuck.

I have had the experience of being turned down by several health insurance companies myself on the basis of preexisting conditions, ordinary ones that I think -- I believe that most people over 50 have a couple of health care problems. So I think this notion that we have choice is really false. We take

what we can get.

Therefore, I would like to see the State of Illinois adopt a single payer system of health insurance coverage that would provide a basic package of health care to all Illinois residents. I have read studies which show that this would be no more expensive than what consumers and employers pay in premiums now.

I see the present system of private health insurance as expensive, wasteful, inefficient, and grossly unequal. I believe that everybody deserves access to good basic health care. Thank you.

MR. KOEHLER: Thank you. Bill Small.

MR. SMALL: My name is Bill Small or William Small, S-m-a-l-l. I'm a resident of Oswego Township and a township trustee.

I wondered if perhaps some of the people here might not be aware that catastrophic health insurance is purchased by townships on a voluntary basis, but it is available for township residents who may not have other forms of coverage. This information can be obtained from townships or from the township officials of Illinois who have an office here in the community.

I thought I could report at least

on my own personal situation since I'm an uninsured individual, as well. Approximately 15 months ago I ran out of COBRA coverage. I, as the previous lady, am finding that because of health care issues that neither I or my wife can receive health care benefits because of preexisting conditions. I take six medications and she has 11.

Frankly, I'm of the opinion that next week when she goes to see the doctor because of a spot on her back we probably will be in a situation where it will be time to sell the house. I'm one of those who's the lucky ones. I still have my house after all these years. But in order to pay bills, of course we get down to the situation where we will have to take care of the bills as they come due.

About 22, 23 years ago in 1982 I lost a job in the insurance industry. I was in an executive position. And at that point I thought it was because of my knowledge of insurance I was chosen by Denny Hastert and Dallas Ingemunson to write a study for the State of Illinois on the catastrophic health care issue.

I don't know what happened to that report, but I think we're still studying and discussing

some of the same issues today. And although I'm not in agreement with a single payer policy, because I do think we are entitled to choose who we would like to receive our benefits from, I do think it's important that people feel some dignity in this process, and that is my overriding concern now.

I think we're going to be less and less dignified, and I'm probably not going to be able to continue to live in the community, at least not in the area where we live currently. Thank you for your time.

MR. KOEHLER: Thank you. Question for you, Mr. Small.

MS. MITROFF: Before you go, just a quick question. Did you say that your COBRA coverage is exhausted?

MS. SMALL: Yes. That was exhausted in October of 2004.

MS. MITROFF: And did you investigate at all signing up for the CHIP plan?

MR. SMALL: I did. The CHIP costs were ranging around $2500 both for my wife and I. And private insurance, which if I could incorporate and develop a business of my own, then with two employees, my wife

being one employee and myself, then we would qualify for group coverage that ranges around $1250 a month, but those still are really not affordable when you don't have a job.

MS. MITROFF: Thank you.

MR. KOEHLER: Gene Dempsey, please.

MR. DEMPSEY: My name is Gene Dempsey, G-e-n-e, D-e-m-p-s-e-y. I am president of the Aurora Chapter of the Coalition of Citizens with Disabilities in Illinois.

My personal health care concern is mostly that my doctor does not accept Medicaid. They accept my Medicare and write off or absorb the 20 percent that I don't have.

My disability is a mental illness, and I'm pretty stable. I've been stable for 11 years now, but if I need chronic care, I would end up in a nursing home, because Medicare has limited coverage.

One of my chapter members has had a mental illness for 30 years. He has fallen through the cracks. He has Medicare, but has too high of a spend down from Medicaid. The supplementary insurance that he has been paying for will become too expensive come the first of the year. He came to me and says I can't

afford to get sick. And I says yeah, I know what you mean.

I also have another chapter member that uses alternative preventive medicines that are not covered by health care systems at all. Because of the alternative medicines, he seems to have less medical problems.

Another chapter member suffers from chronic fatigue and hepatitis and is unable to get Social Security, because they are not recognized disabilities, and she has to totally depend on Medicaid herself, which takes forever to pay, like everybody else has testified, if at all. That means that she's constantly switching doctors and not getting very adequate health care.

I want to thank you for coming to Aurora and holding this hearing, and I hope that the campaign of better health care does more aggressive work here in the Fox Valley, especially in Aurora, because we are the second largest city in Illinois. Thank you very much.

MR. KOEHLER: Thank you. We have two people that want to go next, Amanda Kijac and Elise Halajian. If you could each give us your name again and spell it

for the reporter.

MS. HALAJIAN: Hi. My name is Elise Halajian. E-l-i-s-e, H-a-l-a-j-i-a-n.

MS. KIJAC: I'm Amanda Kijac. A-m-a-n-d-a, K-i-j-a-c.

MS. HALAJIAN: We are both second year medical students at Midwestern University Chicago College of Osteopathic Medicine in Downers Grove and thank you for the opportunity to come and participate here today.

We both serve on a committee at our school which participates and helps run a student run evening and free clinic in Chicago on the near west side, which is a clinic that serves the uninsured. We have had an opportunity to be involved there since last year.

And since that time it's been my experience to really have much more exposure to the real need that's out there. There are so many people who just don't have access to health care. And as future physicians, that's something that we find very important to bring up.

In my personal experience, I'm originally from Michigan. I'm here for medical school, but it is something I've thought a lot about. I've had

conversations with students in my class about facing the malpractice premiums as a physician or the issues as a physician here in Illinois.

It's a reason that I'm considering maybe not staying in Illinois to practice medicine is because I'm not sure how affordable that will be for me as a physician staying in the state.

There are a lot of other states that have programs that are a little more affordable for physicians. So it's just an issue that I wanted to bring up.

MS. KIJAC: And then I'd just like to share an experience I recently had at the clinic.

About two years ago I was able to participate in the care of a 56-year-old Hispanic female with a medical history of severe hypertension, high cholesterol, things like that, and she had not been to the clinic in two years.

I don't know what kind of health care she had in those two years that we hadn't seen her, but she came in, she wasn't taking any medication, because her meds had run out, and during the course of her visit we discovered she had a new onset of chest pain, which is a definite red flag for any patient who

comes in.

So after discussing her case with our attending physician, we realized that this woman could potentially have a serious heart condition due to her chronic illness that hadn't been taken care of at all.

We were able to fortunately give her medication that we have at the clinic where Elise and I volunteer. We were able to provide free medication, free labs to our patient, and we were also able to refer her out to Stroger Hospital for some heart workups and to see a cardiologist.

However, we don't know when she'll be seen, and I just want to share a couple statistics about current wait times at Stroger where we refer our patients for specialty appointments.

For an endocrine appointment you're waiting about five months; gastroenterology is five months; neurology, nine months; CAT scans, six months; MRI, five months; endoscopies, 15 months; and screening colonoscopies are currently closed. So patients who refer aren't able to have that opportunity to go there for that care.

When our patient was leaving when we

gave her the appointment and sent her on her way with her medication, she was so grateful for the care we had given her that she left with hugs and was almost in tears.

And I've really been thinking about her for these past two weeks, because I don't know how many other people are out there like her that don't have the opportunity to have good health care, don't have the opportunity to come to our clinic, because we can only take so many patients, and I don't know how many other clinics there are in the area to serve the uninsured patients of Illinois.

As a future physician I'm worried, because I don't know how we're going to be able to find these patients, and I don't know what we're going to be able to do to get them the care they deserve.

MR. KOEHLER: Thank you very much. Let me introduce to you Rosalind Walls. Welcome. You're representing Margaret Davis.

MS. WALLS: First I want to commend you all for what you are doing, and the first question I want to ask is where is the clinic at?

MS. HALAJIAN: The clinic is at 2611 Chicago Avenue. It's off 290 off the Sacramento exit. It's

on the near west side.

MS. WALLS: And the second question I had is how do you all advertise this free service? How does the community get to know about this free clinic?

MS. KIJAC: Right now I think it's more of a word of mouth. The clinic was founded in 1992, so it's still relatively new. It's grown a lot.

They've recently moved into a new, bigger facility, which is wonderful for the patients, but I know this past summer we had to turn patients away. So I think it's a volume issue, too. I'm not sure about what other advertisements we have.

MS. HALAJIAN: I think we did have to close new enrollment for about six to eight weeks this summer, because we were just flooded with people. Our patient population is predominantly Hispanic and Polish.

So actually, the way the clinic operates is each medical school in the Chicagoland area has a student run evening at the clinic, and there are also some residency programs that participate. In addition, there are also volunteer physicians who also staff the clinic when the students aren't there.

But basically it's just word of mouth between family members and community members.

Because of the communities we're working with, it really -- they'll tell friends, and it will usually spread that way.

MS. WALLS: Thank you. That's really nice.

MR. KOEHLER: Next we have Joan Sheforgen.

MS. SHEFORGEN: Thank you. My name is Joan Sheforgen. I'm the chief executive officer of PrimeCare Community Health, a federally qualified community health center system on the northwest side of Chicago. I am also a member of the Board of Directors for the Campaign for Better Health Care.

What the people of Illinois ask for in health care justice should not be anything new to anyone. Since 2000 the federal government has called for 100 percent access to health care with zero disparity by 2010. Why would the State of Illinois seek for its residents anything less.

I come today before the Adequate Health Care Task Force to thank those members present today, as well as those who were present at past hearings, for making these hearings a priority.

I'm here today as a CEO, as a board member, and as a consumer to request the following: Members of the Task Force, please continue to communi-

cate with your colleagues who were appointed to this Task Force and encourage them to be active participants in the hearings.

All Task Force members were chosen to eventually make recommendations to bring health care justice to all who live in Illinois. So don't those members have a moral and ethical obligation to fulfill their duty to the people of Illinois by being present at these hearings?

No. 2. We ask that the Task Force recommendations ensure that health care is accessible to all who live in Illinois. We ask for health care without barriers. That is, health care that is comprehensive, primary and specialty care, dental, vision, behavior health, in-home care, long-term care.

Health care that encourages more collaboration among all providers in the health care system: Public, non-profit, and private to provide continuity of coverage and care. Health care that provides the consumer the right to choose a provider. Health care for all; those with special needs, those living in urban and rural areas, those who are unserved and underserved. In other words, everybody in and nobody out.

No. 3. We ask that the Task Force recommendations ensure that health care for Illinois be affordable, and that the system ensures timely payments to all providers in order to guarantee continued access to providers.

No. 4. We ask that the Task Force recommendations ensure quality of service. We recommend the adoption of the Healthy People 2010 standards, as well as the Joint Commission standards as the criteria to be met by all providers in the health care system. We ask that Task Force recommendations ensure that health care for Illinois is cost efficient spending the maximum amount of dollars for direct patient care.

Lastly, we ask that the Task Force, which is comprised of members who have chosen a career of service, to embrace this challenge, to put politics aside, and to bring health care justice to all in Illinois. Thank you very much.

MR. KOEHLER: Thank you. Larissa Melton.

MS. MELTON: My name is Larissa Melton. L-a-r-i-s-s-a, M-e-l-t-o-n. I'm an employee of the Gilead Outreach Center, and I'm here tonight as an observer for the Metropolitan Chicago Health

Care Council. However, this testimony is about me, a private citizen of District 14.

Throughout my entire life I've had a spotty insurance history. My family was plagued with medical problems. Just within my own family we have congenital heart problems, we have cancer, we have renal failure. There's five members of my family, and that doesn't include the normal high cholesterol and overweight issues.

So about the time I was twelve I was experiencing problems with not having insurance. Fortunately, when I went to college, I was forced to enroll in student insurance. I'm sure that the Task Force is aware that those with student insurance would generally fall under the underinsured population.

In 1999 I began to experience some aches and pains in my right side. Not a big deal. I was worried about class, I could put it off. And I put it off and it got a little numb, and I put it off, and one night I woke in screaming pain and the student clinic was closed. So we waited until morning.

They rushed me to the emergency room at Kishwaukee Hospital here in the district, and they thought that my appendix had ruptured because I

had waited. Fortunately it didn't. That wasn't the problem. They were unable to resolve my health care issues.

My overnight stay in the hospital was pretty average. Most would say it was adequate. I saw the attending physician twice, once when I was admitted to the hospital and once when I was dismissed from the hospital. He never gave me an idea of what I was dealing with despite the frequent ultrasounds that I had over the 24-hour period that I was in the hospital.

I was told when I was dismissed from the hospital to call back if the pain recurred. The pain recurred, so I called back. I was transferred to his partner since he was not available.

His partner, with just a phone conversation, was able to give me a better idea of what I was dealing with than a physician who had saw me in person twice. That to me is not adequate health care for people who are not insured or who have a lack of insurance for good health care.

Simply because I became a charity case I feel my health care, my health, my livelihood was threatened because I wasn't taken seriously. That

situation exists all over the State of Illinois for rural communities, for urban communities.

That aside, the issue is that I put off my health care because I did not have proper insurance. I was afraid to seek help despite weeks of concern about the pain in my right side. Primary health care is not accessible for people who do not have health insurance.

We had this discussion over and over and over again in training sessions with people that I work with through the Gilead Outreach Referral Center. We get scolded, why didn't you seek care earlier. We can't seek care earlier.

If you try to get a health care appointment because you want an annual physical, you're turned away frequently. Underinsured students cannot get into the health care clinics without symptoms, and that's a problem.

We have situations where even with insurance we end up covering preventive tests. I was so excited when I got my first job. I had health care insurance. I was going to get a physical. I went in and got the works. I had a cholesterol test, I did the stress test, I did everything.

The big surprise was when I got a bill, a huge bill for me on a first job where I was making about $11 an hour. My bill for that primary health care physical that was supposed to be covered by my new insurance was $300. It was outrageous. I paid it, because I didn't feel I had a choice.

But those tests were worthwhile. They were worth $300 to me, because even though I found out the tests themselves didn't do anything for me, they gave me the information. I knew I had high cholesterol. Now I can start watching my diet, I can start exercising.

Perhaps because I spent that $300 for that cholesterol test I'll avoid a heart attack 20 years down the line where it will cost $30,000 or $300,000. Preventive health care is the essential element for health care for Illinois, and I really hope that that message comes through. We've heard it several times tonight, and I wanted to echo it again. Thank you.

MR. KOEHLER: Shirley Flaherty.

MS. FLAHERTY: My name is Shirley Flaherty. I'm here as a resident of Aurora, but also as a representative of the United Electrical Workers Union,

District 11.

We have an urgent need to provide a system of universal single payer health care for all Illinois that's not tied to jobs. The number of jobs per lifetime rises into double digits now. Employer provided health insurance is a burden for commerce in Illinois. It also can lead to long periods without coverage, private physician exclusion, and even loss of jobs if you're considered a high risk.

The cost of health insurance has become a major disincentive for job creation in Illinois. Companies would rather outsource or hire part-time temp workers to avoid the cost of benefits.

The United Electrical Workers Union has previously endorsed universal single payer national health care, and that's what we really need, but let's start with Illinois. A program for all Americans. We really need to have everybody in and nobody out. Thank you.

MR. KOEHLER: Thank you. Ruben Zamora.

MR. ZAMORA: Good evening. I am Ruben Zamora. I stand before you now not only as a resident of Aurora, but also as a member of the Greek Elite Group running for Congress.

I'm running for Congress in this district, and I believe in universal health care. I believe that this district has suffered so much from lack of health care and increased costs not only to our premiums, but also in the form of our taxes.

Right now in DeKalb, for example, there are two pediatricians for the City of DeKalb that actually handle all the births in DeKalb at this moment. And as of what I've been able to adjust, they have performed 700 births and have not been paid for them.

And so what I'm encouraging this group is to provide universal health care so that physicians can do physicians' work. They are not benefit administrators, they are not collectors. They are physicians, and physicians should be allowed to do their jobs.

We must also be wary of providing benefits that are inadequate. Coverages are increasing in terms of premiums, and people just cannot afford these premiums. We must be able to make sure that even the poor have an opportunity to have coverage.

My encouragement is that we must have preventive care built in at all costs. An ounce

of prevention is really, truly a pound of cure. It's worth more than that, but the fact is that we have so many different individuals, working folks who are losing their coverage because they just can't afford it.

I've got research here from Robert Wood Johnson Foundation, and it's detrimental. 21 percent of the increased costs of premiums to employers are being placed onto employees, and here it has an increase from 2003 to 2005 of 29 percent for individual costs being passed on as an increase to individuals, and for their dependents a 32 percent increase.

What are we doing? We are not putting people first, but we should. We are not letting physicians do their jobs, which is their work. We must make a change. We must have universal health care not only for this state, but for across the country, but starting here is a good start. Thank you.

MR. KOEHLER: Thank you. We have two, Steve Bruesewitz and Donna Johnson is after that. So Steve Bruesewitz.

MR. BRUESEWITZ: Stephen Bruesewitz. I'm a resident of Kane County in the 14th District.

Kane County about ten years ago voted on an advisory referendum to pass the burden by over 60 percent. Universal health care, it's not just something people feel we should have, it makes good economic sense.

We pay twice as much for health care as every other industrialized country, and we have less health care or less health care outcomes than Cuba. That's just embarrassing. We have the ability to give health care, but we give health care to too few people.

People don't die from a lack of health care in an emergency room. They get health care there. What happens is the cost gets shifted to other people that have insurance. Where we lack health care is things like high blood pressure and diabetes go untreated, and people die prematurely from that.

The cost shifting itself is a whole problem, because what happens is the cost for those uninsured have to be tracked and monitored by the hospital. There's a lot of overhead costs in that. Plus, then the cost gets transferred to the insured. It costs more for employers to have other companies be

uninsured or have uninsured employees.

I think universal health care is the way to go. The question is how do we get there from here. I think what we need is some sort of pay or play. There's no sense in giving up the 60 percent people who are insured now. What we need to do is require those companies free riding on everybody else to provide insurance for their employees.

To those who work part-time, to pay into some sort of universal state Medicare program so they have some sort of base from which the government isn't supplying all their care. Most people do work at least part-time who don't have insurance.

I think eventually if you have a state fund, especially for -- perhaps we could also have small employers buy into this, because oftentimes if you have a small employee base and you have one or two people with serious health care costs, insurance is currently unaffordable.

I think over time this would lead to essentially what Canada has, which most people understand it as the state running their health care, but basically the state runs the insurance program. That's what Canada has, and I think that's what we

should work for, and we would end up with Medicare for all. So thanks for your time.

MR. KOEHLER: Thank you. Donna Johnson.

MS. JOHNSON: Good evening. My name is Donna Johnson, and I am a school social worker in the East Aurora School District 131 where I've been employed for 32 years. I live in DuPage County, but we are a representative here.

I also represent this evening the Illinois Association of School Social Workers where I have served on the board for 14 years, and I'm now the co-chair of our legislative committee. I've written a statement, so I'm going to read it so I don't rattle.

I'm here tonight to share some of the concerns for the students I serve. Some of the students I see are on Medicaid and benefit from health services through that service.

Unfortunately, many of the students that would benefit from the health services provided, our mental health services, come from families that have sort of fallen through the cracks. Those families work hard, make minimal incomes, and have little or no health care benefits. Medical, vision, and dental care benefits are all areas of concern.

A child will have difficulty learning if they can't read a book, see the board, or review their assignments. A child may also be distracted or act out because of the pain caused by their teeth or other medical issues not dealt with due to the lack of resources available to the family.

As a social worker in the schools, interventions with the acting out child will often disclose that the underlying cause of their behavior or poor success at school is a medical issue. Some of those medical issues have some quick fixes.

A trip to the eye doctor can produce a pair of glasses. A trip to the dentist can relieve some teeth problems, and often just one trip to the doctor can offer a solution or an opportunity to focus at school. Unfortunately, the mental health area is a major concern in our district and in our schools that does not offer a quick fix.

Many of our students or their families need individual and family therapy outside of the school for depression, posttraumatic stress disorder, bipolar disorders, and other serious mental and health disorders. Many of our students would benefit from psychiatric evaluations and ongoing

medical and therapeutic services.

Because of poor mental health insurance, many of our students who are referred for hospitalization and ongoing services can only afford that quick fix, and those of us who work in the field know that there is no quick fix for mental health disorders that impact our children's academic success.

Those students are often failing in school, are absent from school, and lack the motivation or goals to be productive members of the community. Change your thoughts, change your world can be a pretty powerful message to the children that we serve, but it becomes somewhat cliche when your world doesn't provide the resources to change your thoughts.

Our children need better health care and services to succeed in school and in their future. Please help change their world. Thank you.

MR. KOEHLER: Thank you. We'll take a five minute break again, and we'll come back and see if there's anyone else that wishes to testify.

(Recess taken.)

MR. KOEHLER: Joining us, as well, is Senator Chris Lauzen. Senator, we want to welcome you to the hearing.

We have two speakers left and then we'll see if there's any more, but Barb Bollenberg and Andrew McNamara. And if you would state your name and spell it for our reporter.

MS. BOLLENBERG: I am Barb Bollenberg. I work in the emergency department. I come to you wearing many hats.

I represent the Illinois Nurses Association. There are 40,000 nurses in Illinois, and all of us have seen through the years a real problem with our patients having access to quality care, and so that's something I bring to you on behalf of the nurses.

On behalf of the V.A., this is my 32nd year as a V.A. nurse, and I can tell you that we think of ourselves as a safety net for veterans, but you may not be aware that we are not free care for most veterans.

I don't know what the exact figure is now, but if you made more than $25,000 a year, you had to do a co-pay; and if you were hospitalized, it was a fairly significant amount of money.

And I don't think $25,000 a year is something that -- Congress passed this, it wasn't

a V.A. decision, but it's a significant amount of money when you're making a salary at that level or have an income of that level, and you may wonder how that affects people.

Well, even in the V.A. system most veterans or many of our new veterans coming to the facility are coming because of prescription benefits, because a prescription of any kind is $7 co-pay for our veterans.

One gentleman came to the emergency department and said my medications are $1200 a month. And I'm like oh, my gosh, that's terrible. How do you afford that? He said well, my wife's are more.

How do we see this in the emergency department? Well, they walk in and they're looking for dental care. 98 percent of veterans are not eligible for dental care. And again, thank you Congress. They come looking for psychiatric and substance abuse care.

We have a six ward psychiatric and substance abuse unit at our hospital, but because of funding costs only one unit is open. It's a combined psychiatric and substance abuse unit. And the patients no longer have the famous 21-day program, they have the six-day program, and it's often very difficult to get

into that program.

People come seeking hearing aids, they come seeking glasses, and most of them are not eligible for that kind of care. You may say that's great they have the V.A., but we are not everywhere, and it is not readily accessible.

I was working one night, and they brought in a gentleman from Aurora right in this area, and he tried to kill himself. And I'm like oh, that's too bad. We'll take his blood pressure, we'll have the psychiatrist see him, talk to him about this.

He had no palpable blood pressure, he had no palpable pulse. He had stabbed himself in the chest multiple times, and the family brought him all the way into Hines, which was at 5th and Roosevelt, because of the cost issues. We were able to save him.

We had another gentleman the wife drove him in, and she said he quit talking to us in Lisle. If you know where Lisle is from Loyola, it's a pretty far distance. And when he got there, he was dead.

She said well, when he was last talking to me I think it was like Westmont he said something. And we said oh, if you had only gone to

the closest hospital. And she said he has no other insurance. We couldn't take him anyplace else. This happened to him once before. We brought him in, and you were able to save him. They were able to take that chance, and that did not pay off.

I cannot tell you how many veterans have driven from Springfield. They've driven them from two or 300 miles away and there are times when they are dead when they get to us, because they have no other choice of health care. Also, if they're a V.A. patient and they do go to the local emergency department, we do not pay for it unless it's for a service-connected problem.

If they were injured in the service and they now have that arm that starts to hurt again and they go to the closest emergency department for that, we will cover that cost; but if they have a heart attack, nope, sorry, we will not cover those costs, because it's not related to their service-connected issue.

Wearing my last hat, I would like to talk to you about my daughter. Pass that picture down, if you will. That is my lovely daughter, and when she finished all her course work in college and only had to

finish her internship to get her degree, she decided to take a break from college. And parents, you know what that's like.

So she was working for a physician. She did not have health care through him. We arranged for a Blue Cross Blue Shield policy, and we were paying for that on the side.

I was finishing my dissertation in addition to working full-time and had asked my husband if he would mind paying the bills while I finished that dissertation. It was 200 plus pages. And he said sure, no problem.

And she had some tests done and so things were coming in. She went to a Taco Bell, ordered, and passed out at Taco Bell. She stood up again, passed out again. Didn't have insurance. Drove herself home, and the next day she's telling me I passed out twice at Taco Bell. This had never happened before.

So we started putting her through the tests. They did an EEG, and they thought they detected a brain mass. So she had to have an MRI, she had to have a PET scan, she had to have an ambulatory EEG, she had to have you name it, every test under the

sun. And meanwhile, she had to have a tilt table test.

And after all that was done they decided she had some kind of neurovascular intermittent orthostatic hypotension, which just means it was no big deal. They just told her to drink more water and eat more salt, and that's all she needed. It was $15,000 in health care bills.

We found out that my husband had inadvertently not paid her health care premium. He thought it was just one of these reports of you've had this test and we've submitted it to the doctor. He did not pay it, and she was uninsured. They had dropped her.

And when she had the tests, the providers were unaware that she had no insurance. They never told her she had $15,000. She was never able to repay that amount of money. She just couldn't do it. So her credit as a young person starting off is nonexistent.

She went back and finished that internship. She's got a job, she has insurance now. She met Mr. Right and is living happily ever after, but the uninsured are not just people living under bridges. These people they're us and they're you, and

it can happen to any of us, and we need to make sure that everyone in Illinois has access to quality care. Thanks.

MR. KOEHLER: Thank You. Dr. Andrew McNamara.

DR. MCNAMARA: My name is Dr. Andrew McNamara. I'm the president of the Kane County Medical Society, which means in another few weeks I'll be there. I'm currently serving as the vice president. My last name is spelled M-c-N-a-m-a-r-a. The first name Andrew, A-n-d-r-e-w. I'm reading a statement on behalf of the medical society.

For over 140 years physicians in Kane County have championed the health of citizens of our county. We currently represent 343 physician members whose goals are to promote the public health and educate the medical profession in various methods and delivery of health care including socioeconomic aspects.

In its long, rich history Kane County Medical Society has been a part of shaping health care views. Our physician members and patients confront problems of health care delivery on a daily basis.

Often it is the most needy and

vulnerable individuals who are victims of these problems. In a climate which has become increasingly difficult and hostile, our tradition and desire of putting patients' needs first is becoming economically untenable.

While the problem of health care delivery today is varied, our group has seen tremendous damage done to our medical infrastructure. Illinois liability medical coverage began to really get out of control in the year 2002. Large increases in damage awards caused insurance to often triple in less than 18 months, and I can personally attest to more than that.

Many physicians who cannot afford or obtain liability coverage at any price have been forced to retire or leave the state. Since 2002 our county has lost three neurosurgeons in the Elgin area, and several physicians retired or left to practice in less litigious states. Many of our physicians have limited types of care they render at a great inconvenience to our patients. And again, I can personally attest to that.

Our physician colleagues in other neighboring counties tell us the health care access

issues cut a wide swath in the state and are continuing to be a problem. Some physicians in neighboring states have refused to care for Illinois citizens due to our liability climate. To those who say that there is no medical litigation crisis, we say our experience and those of our patients speaks for itself.

The monopolistic nature of governmental insurance programs, large commercial insurance carriers, and HMO's in pricing physician services makes it impossible for us to pass those costs on to our patients. Physician services are not priced in a manner that corresponds to the ever increasing costs of providing those services.

While many have noted large increases in medical insurance premiums in the past five years, I can assure you that virtually none of those increases have been given to physicians and the medical staff that we employ on the front lines of health care delivery.

While Senate Bill 475 passed in the Illinois legislature last May, the effects of the crisis are far from repair and its effects are still present. Increasing regulatory burdens still discourage new malpractice insurance companies from

entering the state. The lag between the time the claim of medical malpractice is filed and resolved, which is now four to five years in our county, drives up costs.

The vow by medical malpractice attorneys and plaintiffs to derail the form of Senate Bill 475 has not reduced our burden in this Bill's passage. Therefore, the State's elected officials and governmental body should not think the medical liability crisis has magically been resolved with the stroke of the Governor's pen.

Our members constantly tell us the amount of wasted service they perform to protect themselves from potential liability claims. Again, I can personally attest to that. Would not these resources be better spent reducing costs of medical insurance and providing funds for those individuals that cannot afford insurance?

We believe the cost of unnecessary care and testing in defensive medicine is in the billions of dollars per year and far exceeds what the government has claimed in fraud in the health care system. Again, this is an ad lib. Listening to her story, $15,000 was spent, a good part of it to protect

from liability.

We advise you not to be complacent. We don't believe the crisis is over. The system of liability coverage for the state's physicians is still critical. The damage to the state's medical infrastructure took a relatively short time to create. It will take years to recover only if physicians can be assured of relief in this area.

We'd ask the legislature and the regulatory agencies of the state to be circumspect at a time of proposing new regulatory rules and unfounded mandates and challenges by special interest groups bent on undermining the liability reforms in place this year.

On behalf of my members, I would like to thank you for the opportunity to give our views.

MR. KOEHLER: Thank you, Dr. McNamara.

All right. We're at 6:25. There is no one else signed up to speak tonight. We are advertised to be here from 4:00 until 7:00.

Ashley will be here until 7:00 to collect written testimony, if there's any that comes in; but at this point, seeing that no one is requesting

to give testimony, then this means we're wrapping up.

So I want to thank you on behalf of the Adequate Health Care Task Force, and the members present here tonight thank you for your participation, and we mean that.

All the input that we're getting in these hearings is taken very seriously as we deliberate and try to come up with something that's going to work for the State of Illinois. So thank you for your participation.

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STATE OF ILLINOIS)
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COUNTY OF W I L L)

I, Linda M. Radecki, CSR No. 84-002799, do hereby certify that I reported in shorthand the proceedings had at the hearing of the above-entitled cause and that the foregoing Report of Proceedings, Pages 3 through 82 inclusive, is a true, correct, and complete transcript of my shorthand notes so taken at the time and place aforesaid.

This certification applies only to those transcripts, original and copies, produced under my direction and control; and I assume no responsibility for the accuracy of any copies which are not so produced.

IN WITNESS WHEREOF I have hereunto set my hand this 21st day of December, 2005.

Certified Shorthand Reporter