1 16TH CONGRESSIONAL DISTRICT PUBLIC HEARING
2 OF THE ADEQUATE HEALTH CARE TASK FORCE
3 UNDER THE HEALTH CARE JUSTICE ACT
4
5
6 MEMBERS OF THE ADEQUATE HEALTH CARE TASK FORCE PRESENT
7 Kenneth Robbins, Chair
8 Ruth Rothstein
9 James M. Moore
10 Quentin Young
11 Joseph Orthoefer
12
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14 Transcript of proceedings of the meeting of the
15 Adequate Health Care Task Force for the Illinois Department
16 of Public Health, heard at Northwest Community Center,
17 3325 North Johnson Avenue, Bingo Hall, Rockford, Illinois,
18 on March 22, 2006, at 4:00 p.m.
19
20
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23
24

1 KENNETH ROBBINS: My name is Ken Robbins, and
2 I'm going to be chairing this meeting. I'm a member of
3 the Adequate Health Care Task Force. I have with me Ruth
4 Rothstein, who is also a member of the Adequate Health Care
5 Task Force. And as others arrive, I'll let them introduce
6 themselves.
7 Let me be sure that we all are on the same page
8 of our purpose here today and the purpose of the meeting.
9 I want to welcome you all to the meeting of the 16th
10 Congressional District Public Hearing of the Adequate
11 Health Care Task Force.
12 It has been well demonstrated that a person's
13 ability to access the health care system influences his or
14 her treatment outcomes and health status. Access to health
15 care is most affected by the ability of those seeking care
16 to afford the services that they need; therefore, the
17 uninsured, working poor, racial and ethnic minorities and
18 undocumented immigrants in Illinois are the least likely to
19 be able to afford to pay out of pocket for many health care
20 services.
21 Many Illinoisans lack access to the health care
22 system because they lack health insurance. On any given day
23 an estimated 1.8 million Illinoisans are without health
24 insurance. Additionally, a growing number of Illinoisans

1 are underinsured, and the consumers' share of the cost of
2 health insurance is growing.
3 While Illinois has many safety net providers,
4 including public and private clinics, public hospitals and
5 charity care administered by private hospitals, that attempt
6 to narrow the gap between the insured and uninsured -- many
7 uninsured Illinoisans lack access to a usual source of
8 preventive and comprehensive care.
9 The Health Care Justice Act signed into law by the
10 Governor in August 2004 encourages the State of Illinois to
11 implement a health care plan that provides access to a full
12 range of preventive acute and long-term health care services
13 and maintains and improves the quality of health care
14 services offered to Illinois residents.
15 The Act created the Adequate Health Care Task
16 Force, which has undertaken the task of developing this
17 access plan. The 29 members of the task force are appointed
18 by the Governor, the President of the Senate, the minority
19 leader of the Senate, the Speaker of the House and the
20 minority leader of the House.
21 As part of its work, the task force will be holding
22 at least one public hearing in each congressional district
23 to seek input from the public regarding the access plan,
24 which is why we are all here this afternoon. On behalf

1 of the Adequate Health Care Task Force and the Illinois
2 Department of Public Health, I would like to thank each
3 of you for coming out this afternoon to take part in this
4 important process. I would also like to thank the
5 Northwest Community Center for sharing their space with
6 us this afternoon.
7 Before we get started, there are a couple of
8 housekeeping items that must be addressed. First, if
9 you have not already done so, please sign in at the table
10 located just inside of this room. This will help the task
11 force and the department track the number of people who
12 attend this hearing.
13 There are also two handouts available at this table
14 that provide more information about the Health Care Justice
15 Act, the Adequate Health Care Task Force and this public
16 hearing.
17 Secondly, should you wish to testify, please be
18 sure to sign up at the table near the entrance to this room
19 on the gold-colored sheets. Individuals will be called to
20 testify in the order in which they sign up. If you brought
21 written testimony to submit, you may also do so at the
22 table.
23 We will begin the hearing by calling up the first
24 five speakers. Please sit where you are instructed in the

1 order in which you are called. I will ask the first five
2 when I call your name to come up and sit in the front row,
3 and then we'll simply take you one by one.
4 Before you testify, please be sure to say and spell
5 your first and last names for the court reporter. And
6 please be reminded that oral testimony will be limited to
7 three minutes. We may be a bit generous on the three-minute
8 count, but we would like to be sure that everybody has an
9 opportunity to speak who wishes to do so.
10 Before we begin let me ask the folks who just
11 joined us to identify themselves to everybody here, please.
12 MR. ORTHOEFER: Joseph Orthoefer. I'm on the task
13 force.
14 KENNETH ROBBINS: Right. Why don't you let the
15 folks --
16 MR. ORTHOEFER: Well, a lot of people here know me.
17 I was formerly health officer here and -- anyway, I'm -- I
18 still work part time at the School of Medicine. Many of my
19 friends are welcome here.
20 MR. MOORE: I'm Jim Moore with the OSF Healthcare
21 System, a member of the task force.
22 KENNETH ROBBINS: Okay. And let me now call the
23 first group up. Janet Ellis, Linda Niemiec, David Rivera,
24 Earl Pescatore and Barbara Smith. And, Janet, perhaps you

1 could begin.

2 JANET ELLIS: I'm Janet Ellis, J-a-n-e-t E-l-l-i-s,

3 and I'm the director the Northwestern Illinois Area

4 Agency on Aging. Our agency serves the nine counties of

5 Northwestern Illinois, an area with more than 111,000 people

6 over the age of 60.

7 Older adults have high rates of chronic disease and

8 high out-of-pocket health costs. We have the most expensive

9 health care in the world, but according to a study reported

10 in the New England Journal of Medicine on March 16, '06, we

11 all get equally mediocre care.

12 Using life expectancy as an indicator, in spite of

13 what we pay, the United States is 48th in life expectancy

14 and 29th among sovereign countries. Andorra has the highest

15 life expectancy, 83 years, while in the United States life

16 expectancy is 77.

17 Our country has been reluctant to re-examine

18 our system of long-term care. In Illinois approximately

19 80 percent of public funding is spent for institutional

20 or nursing home care while only 20 percent is spent on

21 community-based home care.

22 Community and home care is decidedly the preference

23 of those needing long-term care, and it is cheaper. We need

24 to move our long-term care system to one of choice where

1 public support and services are available to the individual
2 in the least restricted and most desired setting.
3 Our agency is involved in a "Home Again" transition
4 project where aging people have been moved from nursing
5 homes to home- and community-based services. These services
6 are costing considerably less than previously paid for the
7 nursing home care.
8 More individuals could return to the community if
9 long-term care resources were switched from institutional
10 care to supporting a more comprehensive community-based
11 service system that includes meals, emergency response and
12 medication management technology and access to periodic
13 monitoring by qualified medical personnel.
14 Long-term care needs to be personalized. It needs
15 to fit the individual. We need to stop trying to fit the
16 individual into the system and, instead, let the needs and
17 preferences of individuals determine where to invest our
18 public resources.
19 Prescription costs are known to be an increasing
20 contributor to the cost of health care. The new Part D
21 of the Medicare Modernization Act is no solution to this
22 problem. It prohibits price negotiation and has created a
23 confusing and complex private bureaucracy limiting patient
24 access.

1 Implementation has been flawed, and older and
2 disabled persons will be penalized if they can't get through
3 the maze of competing private drug plans by May 15th. Drug
4 prices have increased since the program started January 1.
5 Insurance companies have harassed seniors, and scams
6 continue to develop.
7 Access to quality, affordable health care needs
8 to begin with the needs and the desires of the individual.
9 Seniors consistently use less service than they're eligible
10 for when they determine the service package themselves.
11 Doctors and other medical professionals need to
12 bring their expertise to the needs of their patients. They
13 should not be spending their time defending their decisions
14 to insurance companies and pharmaceutical companies' drug
15 plans.
16 Health care cost would decrease if that was all we
17 were really paying for.
18 KENNETH ROBBINS: Thank you.
19 Linda Niemiec, please.
20 LINDA NIEMIEC: Good afternoon. My name is Linda
21 Niemiec. My last name is spelled N-i-e-m-i-e-c.
22 I'm the vice president of development at Crusader
23 Clinic, and I'm here today to advocate for the awareness
24 of community health centers which provide accessible,

1 affordable, quality primary health care to the medically
2 underserved of our state and the nation.
3 Crusader Clinic is one of over 900 community health
4 centers across the nation that started over 40 years ago
5 during the legacy of L.B.J.'s War on Poverty. The focus
6 was to break the cycle of sickness and poverty.
7 Crusader Clinic's mission is to serve the Rock
8 River Valley area with quality primary health care for all
9 people in need. Health care is provided to all regardless
10 of ability to pay as services are available on an affordable
11 sliding discount basis.
12 Crusader Clinic exemplifies a quality-oriented
13 health organization with an emphasis on prevention and
14 chronic disease management. Without Crusader's services
15 to over 42,000 individuals served each year, 50 percent
16 of whom receive Medicaid and 37 percent are uninsured,
17 health care for the poor and uninsured would be greatly
18 reduced resulting in patient failure to obtain care as
19 well as elevated use of hospital emergency rooms.
20 Last year Crusader Clinic served the health care
21 needs of 42,422 individual patients. On average we see
22 a thousand new patients that register for our care on a
23 monthly basis, and we serve about 40 percent of Rockford's
24 uninsured.

1 The clinic experienced a 30 percent increase in
2 the number of patients served over the past three years.
3 With corporate downsizing and employers scaling back on
4 their health insurance plans, while more physicians refuse
5 to accept Medicaid patients because of inadequate and late
6 reimbursements, demand for Crusader's services are expected
7 to increase. To help respond to this demand for care, we've
8 been increasing the number of providers. Right now we have
9 51 health care providers that includes 24 board certified
10 physicians.
11 An advanced access appointing system was developed
12 last year that aims to provide same-day and next-day
13 appointments for care, and the clinic is focused on
14 creating more efficiencies to enhance our services.
15 I hope that in plans to address health care justice
16 that the critical role of community health centers in
17 providing access to affordable, quality health care is
18 recognized as being part of the health care reform both
19 here and in Illinois. Thank you.
20 KENNETH ROBBINS: Thank you.
21 David Rivera.
22 DAVID RIVERA: I'm David Rivera, R-i-v-e-r-a. I'm
23 an ob-gyn physician. And thanks for meeting.
24 I'm interested in this because I take care of

1 patients who don't have insurance and they have to make
2 decisions on their care. I've also spent seven of the last
3 ten years with no insurance.
4 Lack of insurance coverage and the cost of health
5 care are related, but they're two distinct problems. Coming
6 up with an equitable and sustainable solution is going to
7 require globally addressing the two problems.
8 People are uninsured for several reasons: their
9 employer doesn't offer insurance, they can't afford the
10 insurance premiums, they're independent contractors or
11 part-time workers and they're not eligible. Small business
12 owners can't find insurance. Some people have an ever-
13 expanding list of conditions that include them permanently.
14 The problem is when the uninsured are sick, they
15 don't disappear. They avoid care. They present much later
16 with more advanced illnesses. About 18,000 people die
17 prematurely. People who have chronic illnesses become
18 adept at hiding them so that it doesn't appear in their
19 MIB file.
20 The cost of treating the uninsured doesn't go
21 away, either. The cost is borne by the taxpayers, about
22 75 percent of that; and the rest is written off by the
23 health care system. The problem is we all end up paying
24 for it eventually.

1 Undertreated and untreated children risk
2 developmental delays. A disabled breadwinner may need to
3 rely on the social safety nets that are already stretched
4 thin.
5 Providing universal coverage is theoretically easy.
6 It should be continuous independent of employment. Premiums
7 should be affordable. No one should be excluded. We should
8 all have access to high quality health care while being able
9 to afford it all. The problem is predictably nagging
10 details, fiscal reality and political wrangling often
11 obstruct the best of intentions.
12 The idea of expanding Medicaid is somewhat tenuous
13 because, as noted, there are many physicians who don't want
14 to see Medicaid patients, which is unfortunate. At least
15 one former gubernatorial candidate likened government
16 programs to the old Soviet Union. I think there's potential
17 for solving the problems, but it's not going to be easy.
18 Thank you.
19 KENNETH ROBBINS: Earle Pescatore.
20 EARLE PESCATORE: Good afternoon. My name is Earle
21 Pescatore. I'm an ob-gyn physician also practicing here.
22 I'm here on behalf of the Illinois Osteopathic Medical
23 Society, for which I am the president this year. I am in
24 private practice here in Rockford, Illinois, with Rock

1 Valley Women's Health Center.
2 The state of Illinois has approximately 2,000
3 licensed osteopathic physicians. Osteopathic physicians
4 have had full practice rights in the state of Illinois for
5 approximately 50 years. Additionally, the state of Illinois
6 has one of the oldest osteopathic health medical schools,
7 Chicago College of Osteopathic Medicine. CCOM, or Chicago
8 College of Osteopathic Medicine, is part of Midwestern
9 University and is actually located in Downer's Grove. The
10 school has been here for well over a hundred years.
11 Osteopathic physicians are focused on primary care,
12 with the majority of us being located in family medicine,
13 internal medicine, pediatrics and women's health.
14 Osteopathic medicine primarily focuses on less populated
15 areas, particularly rural areas in the state of Illinois.
16 When considering these two factors, osteopathic medicine is
17 essential to any discussion about access, especially here
18 in Illinois.
19 Access to health care in Illinois is a growing
20 problem. Data from 2004 indicates that greater than
21 50 percent of the pregnant women in Rockford rely on
22 Medicaid for access to their prenatal care. This number has
23 been growing over the last several years.
24 This rising indicator has a number of contributing

1 factors, several of which have been alluded to by some of
2 the previous speakers. One of the primary issues is the
3 changing job market in the stateline area. The large
4 industrial base of employment has moved to a more
5 service-oriented market.
6 The service industry jobs are often nonunion and
7 lack the benefit packages of the more industrial type of
8 employment. Many of these small businesses are subject to
9 very high health insurance premiums because of existing
10 conditions and lack -- pre-existing conditions and lack of
11 buying power. A potential solution to this would be changes
12 in the current regulations to allow groups of small
13 businesses to band together to achieve cost savings in
14 insurance.
15 One of the other issues linked to access is
16 reimbursement. Many practices in the stateline area do
17 limit access based on payer, as has already been previously
18 mentioned. While this is not a pleasant topic, it is the
19 reality of running a small business.
20 Currently Medicaid in the state of Illinois
21 provides to me approximately $28.35 for compensation when
22 I see a patient for a routine Pap smear. This represents
23 about 18 percent of what I receive from commercial insurers.
24 The value that is gained from this preventive service is

1 far exceeded by the compensation.

2 To kind of skip ahead so we stay within this

3 three-minute window here . . . The secondary issue is

4 the delay in payment. The current days in my account

5 receivables as of this morning, based on my manager's

6 assessment, is 165 days. This represents 42 percent of

7 our practice's accounts receivables.

8 With this information, I think most people will

9 understand why physicians are literally forced by the State

10 of Illinois to limit the amount of Medicaid patients they

11 care for.

12 One of the other issues that I'm aware of is

13 the potential for audits and penalties. One of the

14 physicians -- one of the osteopathic physicians that

15 I'm aware of in this community had actually five years

16 worth of Medicaid charts reviewed which literally had

17 thousands of patient encounters. When the audit was

18 completed, which took the inspector nearly two weeks to

19 complete, there was found a mere thousand dollars worth

20 of overcharges. Remember the denominator we're talking

21 about here, five years worth of charges. And when you

22 looked at this, there was no assessment by the State of

23 potential undercharges, where the State owed him money.

24 I hope as you conclude your inquiries, you will

1 find a plan to address these issues. I know that
2 osteopathic physicians in Illinois stand ready to help you
3 and stand ready to help our patients in their care. Thank
4 you.
5 KENNETH ROBBINS: Thank you, Doctor. We are
6 actually providing about four minutes for everybody, so --
7 next I think we have Barbara Smith.
8 And let me ask the next group of five to come up.
9 That would be Mike Bacon, Mark Kellen, Gary Kaatz, Dick
10 Pouzar and Eric Henley.
11 BARBARA SMITH: Good afternoon. I'm Barbara Smith,
12 S-m-i-t-h, and I'm here to present the position of the
13 League of Women Voters of Greater Rockford and then some
14 local data on the needs for health care in our local area.
15 The League supports the goals of the Health Care
16 Justice Act because we believe all persons are entitled to
17 a basic level of quality health care, including for mental
18 health, dental care and prescription drug coverage, all at
19 an affordable cost.
20 We hope your plan that you develop will include the
21 following features:
22 One: It will attract a large pool of individuals,
23 the young and those nearing Medicare age so that the risk of
24 illness and medical expense is shared widely. The plan will

1 be inclusive; no groups of individuals will be left out,
2 including those with already existing medical conditions.
3 Two: The plan will be affordable to persons of
4 very low income through cost sharing with persons of higher
5 income.
6 Three: The plan will leverage the enrollment of
7 large numbers of people to contain costs. It will also
8 seek to minimize the costs of administration, the way
9 Medicare administration has been held to 3.2 percent of
10 total expenditures.
11 Just some of the local data here. The Illinois
12 Department of Public Health did a study in 2004, and here
13 are some of the findings:
14 26,300 individuals had no health care coverage.
15 74,600 persons had no dental insurance. More than 21,000
16 persons had forgone a doctor visit that they needed in
17 the previous 12 months. Nearly 26,800 failed to fill a
18 prescription in the prior year. Almost 39,800 people did
19 not pay a visit to the dentist in the prior 12 months.
20 And of those more than 31,000 were not -- have not seen a
21 dentist in more than two years or never.
22 Our League is concerned about how all of this
23 affects African-Americans and Hispanics. Our Rockford
24 Health Council did a study in which they had about 3,000

1 responses, which is a very high number, and they learned
2 more than a third of the Hispanics and one-sixth of the
3 blacks had no health insurance.
4 But within these groups, of the unemployed blacks,
5 more than a third, no insurance. More than 27 percent of
6 black males, no insurance. More than half the unemployed
7 Hispanics, no health care coverage. And of the Hispanics
8 without health insurance, 10 percent had never seen a
9 dentist. Finally, almost one-third of the Hispanics without
10 insurance said they were currently experiencing dental
11 problems.
12 The League urges you to consider the real human
13 faces behind these numbers. We also thank you for the time
14 you're devoting to this task force; and we eagerly await
15 your presentation of a plan for inclusive, comprehensive and
16 affordable health care. Thank you.
17 KENNETH ROBBINS: Mike Bacon.
18 MIKE BACON: Good afternoon. Thank you. I want to
19 commend you for the important work you're about. I'm here
20 on behalf of the Winnebago County Health Department --
21 KENNETH ROBBINS: Sir, could you give your name and
22 spell it so that the --
23 MIKE BACON: Mike Bacon, M-i-k-e B-a-c-o-n, health
24 director for the Winnebago County Health Department.

1 I'm here on behalf of the Department and the Board
2 of Health. We have submitted a policy statement on behalf
3 of the Board in conjunction with the Health Care Justice
4 Act.
5 We all know that health is a fragile commodity,
6 from personal experience or that of our family's. Tomorrow
7 any one of us could get a diagnosis of a life-threatening
8 illness.
9 Eventually in that scenario all of us would ask
10 ourselves have we had the benefit of a healthy lifestyle,
11 have we made healthy choices, have we had family and
12 community support for these actual healthy choices, have
13 we had access to a health care home that provides all of
14 the age-appropriate screenings, diagnosis and treatment
15 access, have we felt individually appreciated and encouraged
16 through ready access to culturally-sensitive services.
17 These are values that each of us would espouse for ourselves
18 and our families but collectively we have not been able to
19 achieve as a community, as a state and as a nation.
20 In Winnebago County -- others have cited figures --
21 the most recent figures we have available in our community
22 are greater than 35,000 residents are uninsured, and many
23 more are underinsured.
24 A disproportionate burden of those illnesses and

1 uninsureds are borne by Hispanics, 32 percent; 20 percent by
2 African-Americans; almost 30 percent by young adults; and
3 30 percent are in poverty; yet four out of five of these
4 individuals are employed.
5 Why is this important, to have health insurance?
6 Because those without insurance are less likely to have
7 the usual source of care, are most often to go without
8 screenings and preventive care, are more likely to receive
9 care in an emergency room, are more likely to forego needed
10 medical services, are more likely to lack trust in health
11 care providers and more often subject to avoidable hospital
12 stays. The human tragedy of this is enough, but these
13 are -- also wage a substantial toll on community health
14 status in our competitiveness as a community and as a state.
15 We recommend as a Board that no less than
16 50 percent of tobacco settlement dollars go to health care
17 and that those dollars first be focused on tobacco cessation
18 and tobacco initiation prevention initiatives.
19 We recommend further that primacy and prevention
20 lead the way in terms of implementing all recommended,
21 nationally recommended procedures for both community-based
22 and population-based and clinical preventive services.
23 We also recommend that the State provide support for the
24 Three-Share health benefit plan that is offered in this

1 community.

2 Our nation and our community are focused on making

3 progress in the Health Care Justice Act, and we appreciate

4 your being here and receiving testimony.

5 KENNETH ROBBINS: Thank you very much.

6 Mark Kellen.

7 MARK KELLEN: Good morning. My name is Mark

8 Kellen. That's spelled K-e-l-l-e-n. I am a Rockford

9 resident. I'm on the Board of Directors for the Association

10 of American Physicians and Surgeons.

11 Good afternoon. My message is quite clear; single

12 payer or socialized medicine systems such as Canada will

13 increase costs, retard innovation and end up denying care

14 to thousands of people. They have never succeeded anywhere.

15 We need a system based on health savings accounts and

16 personal responsibility.

17 I'm an anesthesiologist in practice here in

18 Rockford with 40 percent of my time being spent outside of

19 the OR in pain management. The flaws of our present

20 system are so painfully obvious, yet individuals like the

21 government live in some sort of dream world where history

22 and experience mean nothing.

23 My written comments, which are longer than

24 my verbal, show that Medicare actually has much higher

1 administrative costs than the private sector, that new ways
2 of providing health benefits will be greatly diminished by
3 any government-controlled plan.
4 I have given an example of LASIK surgery for vision
5 correction as the true indicator of what happens when
6 free markets are available, as the cost of the surgery is
7 30 percent less today than it was ten years ago and of far
8 superior quality. This does not apply to any other
9 procedure in medicine that I'm aware of because medicine is
10 already under excessive government control and regulation.
11 I have shown how people do not care about the cost
12 of their health care on a day-to-day basis with statements
13 such as "I don't care what it costs, I have insurance."
14 Most importantly, I have detailed a number of examples of
15 what happens in Canada with socialized medicine. Real
16 people suffer and die on a daily basis while endlessly
17 waiting in lines for needed health care. Costs are
18 controlled by preventing access.
19 This suffering mostly falls on those with fewer
20 resources or more disease as Canadians, who can spend close
21 to a billion dollars a year outside of Canada -- in fact,
22 the Canadian and British systems are both slowly imploding
23 with cash-based medicine increasing on a regular basis
24 despite being illegal in Canada.

1 Today's Rockford Register Star headlined a man who
2 was billed $673 for an ambulance ride across the street,
3 and his quote shows perfectly what is wrong with our have-
4 everything-you-want-and-make-someone-pay-for-it health care
5 system. "I probably could have walked it if I had known how
6 much that would cost."
7 KENNETH ROBBINS: Dr. Kellen . . .
8 RUTH ROTHSTEIN: Just wrap it up.
9 MARK KELLEN: Okay. To close, government control
10 of the health care system is socialism. The government will
11 dictate your health care and leave you with no choices about
12 what you want. Socialism has failed everywhere it has been
13 tried. I am stunned on a daily basis as to how intelligent
14 people can ignore the massive failures of other countries
15 and states and continue to make the same mistakes over and
16 over again. Thank you.
17 KENNETH ROBBINS: Thank you.
18 Gary.
19 GARY KAATZ: Gary Kaatz, K-a-a-t-z.
20 Good afternoon. I'm Gary Kaatz, president and CEO
21 of Rockford Health System, this region's largest health care
22 provider; and I'm very pleased to have been asked to be part
23 of this important session.
24 There are three excellent health systems

1 in Rockford. In a region hard hit by the decline of
2 manufacturing, health care has a significant impact on the
3 local economy. According to a recent study by the Chicago
4 Metropolitan Healthcare Council, health care in Rockford
5 represents nearly 15,000 jobs and just shy of a billion
6 dollars a year in personal income.
7 We have become the largest sources of employment in
8 this community. In that role, we have also become among the
9 community's strongest financial supporters when it comes to
10 nonprofit health care, economic development and quality of
11 life initiatives. Our region's economic challenges make us
12 extremely sensitive to the struggles of the uninsured and
13 underinsured.
14 Today Medicaid enrollment continues to rise.
15 In Winnebago County alone there was a 22 percent increase
16 between 2000 and 2003. Furthermore, Winnebago County has
17 led the state in 2004 for the number of personal bankruptcy
18 filings.
19 The problems of our region are definitely affecting
20 all of us in health care. At Rockford Health System we have
21 a long and strong tradition of caring for all residents in
22 the region. Our mission is simple; superior care every day
23 for all our patients. That superior care is provided 24/7
24 regardless of a person's ability to pay.

1 I'm extremely proud of our commitment to that
2 mission, which is reflected in the $70 million per year in
3 uncompensated services Rockford Health System provides to
4 our community. Our doors are open to all. Those doors lead
5 to the highest level of critical care in our community,
6 including a Level 1 trauma center, Level 3 neonatal
7 intensive care unit and pediatric intensive care unit.
8 One of the best examples that I can share with
9 you is our Ronald McDonald Care Mobile. In 2002 Rockford
10 Health System launched a Ronald McDonald Care Mobile in our
11 five-county region of Northern Illinois. We share the care
12 mobile with the University of Wisconsin.
13 In three years this clinic on wheels has treated
14 more than 2,000 children with both medical and dental.
15 We do dental in collaboration with Milestone here in town.
16 These are children who are uninsured or underinsured and
17 would have not been able to receive medical or dental
18 services otherwise.
19 We wish to express that the health systems intend
20 to play a key part in the solution. It is not the only
21 part. This is a community solution at best, and we will
22 fully accept our responsibility for working collaboratively
23 with people on imaginative and creative solutions to this
24 ever-growing problem. Thank you.

1 KENNETH ROBBINS: Thank you.
2 Let me introduce Dr. Quentin Young, who is also a
3 member of the task force and has just joined us.
4 DICK POUZAR: My name is Dick Pouzar, D-i-c-k
5 P-o-u-z-a-r. I represent the League of Women Voters of
6 Jo Daviess County and the northwest corner of the state.
7 The representative from the Greater Rockford Area for the
8 League presented the League's position on the health
9 care system already, so I'm not going to repeat that.
10 Let me just add to ask you to please consider the
11 needs of rural counties such as Jo Daviess County, where
12 emergency access takes more time due to distances involved
13 and is dependent upon volunteer EMS and where the elderly
14 may be more effectively and less expensively helped in their
15 own residences rather than in nursing homes or assisted
16 living facilities. So please include support for home
17 health care or assistance in your plan. Thanks for the
18 opportunity.
19 KENNETH ROBBINS: Thank you.
20 Eric Henley. And I'm not sure he's adding anything
21 to your time, but I just . . .
22 ERIC HENLEY: I'll take it. Eric Henley,
23 H-e-n-l-e-y.
24 Thank you for the opportunity to be here. My name

1 is Eric Henley. I'm a family physician. I have an M.D.
2 and an M.P.H., and I'm the chair of the Department of Family
3 and Community Medicine of the University of Illinois College
4 of Medicine campus here in Rockford. I'm also the medical
5 consultant to the Winnebago County Health Department.
6 Here are some thoughts I have about improving
7 access to people in the state of Illinois.
8 First, I think a redesign of the current system
9 should be organized around primary care, as there is
10 compelling evidence that a primary care driven system leads
11 to both lower costs and better outcomes.
12 Next, I think we should attempt to avoid for-profit
13 health care where possible because of the vast amounts of
14 money that go to marketing, administration and shareholder
15 and CEO profit. The medical cost or so-called medical loss
16 ratio in private companies in 2005 was Aetna 77 percent,
17 CIGNA 82, Humana 83, United 78, which basically means
18 20-plus percent of every dollar that's sent to the companies
19 doesn't go to health care.
20 Improving quality and pay-for performance plans
21 may be good for patient care, but they are unlikely to save
22 money, certainly not in the short run. Maintaining the
23 state's certificate of need process is important to prevent
24 inappropriate overbilling by hospitals and medical groups.

1 Since resources are limited, any plan should at
2 least provide a basic basket of services to all enrollees.
3 Increasing the use of technology in hospitals and
4 physicians' offices will take additional resources,
5 especially for small practices.
6 Carefully constructed drug formularies can lead to
7 more cost effective use of medicines and encourage greater
8 generic drug use and minimize brand name use where more
9 appropriate. Restricting the influence of pharmaceutical
10 companies and medical device makers on physicians, hospitals
11 and medical groups will help minimize use of inappropriate
12 and expensive medicines and devices.
13 Addressing chronic diseases such as diabetes,
14 cancer prevention, heart disease should involve the public
15 health systems. The evidence supports a multi-pronged
16 approach of prevention, including health education, changes
17 in policies such as cigarette taxes, changes in the
18 environment such as more playgrounds and bike paths.
19 And, finally, as an overriding principle, the
20 Institute of Medicine report on the uninsured listed some
21 principles for health insurance for all that I think
22 continue to be a sound and appropriate philosophical basis
23 for a new plan. Coverage should be universal, continuous,
24 affordable to individuals and families, affordable and

1 sustainable for society and should promote access to high
2 quality care that's effective, efficient, safe, timely,
3 patient centered and equitable. Thank you.
4 KENNETH ROBBINS: We ask the next group to come up,
5 Frank Ware, Brenda McGaw, Bridget Kiely, Mark Hunter, John
6 DeGuide and Ray Empereur. I'd ask Frank Ware if he would be
7 willing to lead off.
8 FRANK WARE: Good afternoon. My name is Frank,
9 F-r-a-n-k, Ware, W-a-r-e. I'm executive director of Janet
10 Wattles Center here in Rockford. We serve Winnebago and
11 Boone County.
12 A former surgeon general, Dr. David Satcher,
13 reminds us that there is no health without mental health,
14 and yet only one out of four individuals who need help
15 gets help.
16 The reasons for this are many. One is the stigma
17 associated with mental illnesses.
18 Another, lack of insurance parity with other health
19 care issues. An example would be a case here in Chicago
20 last year that was settled by HFS where they found that
21 lack -- or insufficient payments to physicians resulted in
22 lack of access to care to children. However, when HFS
23 designed a solution to that, they left out access to child
24 psychiatry, and I would suggest that that was an error.

1 Additionally, a bifurcation of behavioral health
2 care leaving the majority of poor people in Illinois to seek
3 safety net care.
4 There are other conditions, also, such as the
5 lack of integration, true integration of mental health and
6 physical health care. And we have really created in
7 Illinois a casualty-based system, seldom looking at early
8 intervention and prevention services to serve children with
9 serious emotional disturbances, which leaves us dealing with
10 them later in their illness.
11 We've also not done a very good job of integrating
12 informed educational responses to families who are dealing
13 with children's severe emotional disturbances, so they often
14 enter our system in a crisis without really informed consent
15 as to how to participate in treatment.
16 Most shocking, I think, is the recently report card
17 issued by the National Alliance of the Mentally Ill.
18 They graded all 50 states, and Illinois received an F.
19 We received an F for many, many issues which are detailed
20 in their report, and I will advise you to look at their
21 Web site in terms of their grading. I've also made more
22 specific recommendations in my written report.
23 I think life is particularly precarious for those
24 individuals who rely on Medicare and Medicaid. We have

1 going on in Illinois currently an issue where state
2 government is pushing radically to move from a (*grant and
3 aid) system to a fee-for-service system under Medicaid at
4 the very same time that the federal government is looking
5 for ways to reduce Medicaid expenditures, and I'm afraid
6 that our mental health system will be caught in between.
7 I'd like to finish up and keep on time here,
8 that we do have an opportunity, I think, in Illinois for
9 modernization of behavioral health services under a revised
10 Medicaid system that has not been touched very much or
11 improved in the last ten years, and I would refer you to
12 my written documents. Thank you.
13 KENNETH ROBBINS: Thank you very much.
14 Brenda McGaw.
15 I'm asked to remind all the speakers to be sure to
16 speak into the microphone. It is hard to hear in the back.
17 BRENDA McGAW: My name is Brenda McGaw. I'm a
18 registered nurse here in Rockford.
19 For the last 11 years I've worked in community
20 health in various agencies here in Rockford, and in
21 October -- last October I became part of Rockford City
22 Head Start as the health services manager.
23 Head Start is a federally-funded comprehensive
24 program with the mission of breaking the cycle of poverty

1 by preparing preschool age children to be effective learners
2 and citizens by assisting families to achieve greater
3 economic, social and personal self-sufficiency in support
4 of their children. This mission has not changed in the
5 40 years since Head Start came into existence as a part of
6 Lyndon Johnson's War on Poverty.
7 Head Start services have been provided to families
8 in Rockford and Winnebago County since 1965 at that time
9 through the local Community Action Agency. In 1975 the City
10 of Rockford became the grantee facilitated by the Rockford
11 Department of Human Services.
12 Since 1965 generations of children have been
13 touched by Head Start in our community. In order to become
14 a Head Start student, one must meet two requirements. He or
15 she must be at least three years of age, and they must meet
16 the poverty income guidelines. Head Start has been touted
17 as one of the most successful people programs ever created.
18 Of course there are many reasons for this success, both
19 visible and measurable and the more illusive and difficult
20 to measure.
21 Formal research tracking the lives of children
22 indicates that each dollar spent on comprehensive,
23 full-service early childhood programs returns $7 of every $1
24 of public money expended. One of the reasons for success is

1 our comprehensive health and nutrition focus for each and
2 every child who is enrolled. A hallmark of our program is
3 that every child has a Medical Home. The Medical Home goal
4 is consistent with the Healthcare Justice Act, Section 15,
5 Paragraph 1, that every citizen has access to a full range
6 of preventive, acute and long-term health care services.
7 Due to the economic requirement for acceptance into
8 Head Start, most of our kids have Medicaid as their health
9 insurance. Many area providers and health networks are not
10 accepting Medicaid patients into their practices. This
11 makes meeting our Medical Home goal more difficult.
12 By the sheer fact that our children are living
13 in poverty puts them at risk for many health conditions.
14 Accepting these risk factors mandates that our kids must
15 have certain health care screens as a part of the initial
16 health exam. For instance, our children live, attend
17 day care, visit relatives and play in ZIP codes in Rockford
18 that have been identified by the Illinois Department of
19 Public Health as areas with increased risk of lead
20 poisoning.
21 Due to this fact, our children must be screened
22 for lead poisoning before entering our program, yet some
23 area providers resist the fact that our kids need these
24 screenings. Ongoing information and education to providers

1 on the needs of kids living at this economic level is a must
2 if all citizens of Illinois can look forward to adequate
3 health care.
4 Quality protein, high iron and vitamin rich foods
5 are often more costly, putting kids in low economic brackets
6 at risk for anemia. This is the rationale behind requiring
7 an anemia screen as a part of the initial medical exam,
8 also. This testing is not always being included as a part
9 of the initial health exam. There is much evidence that
10 children --
11 KENNETH ROBBINS: Excuse me. I'm sorry, but
12 we're out of time. If you could just wrap it up, I would
13 appreciate it.
14 BRENDA McGAW: I really think -- I'm speaking on
15 behalf of children who do not have a voice -- that a couple
16 more minutes really is important.
17 KENNETH ROBBINS: Well, I think in fairness to
18 everybody, we're trying to be sure that everyone has an
19 opportunity. So if you could -- if you have written
20 comments, we'll be more than happy to take them.
21 BRENDA McGAW: Can I come to a conclusion of what
22 our kids need as well as our families?
23 KENNETH ROBBINS: You sure can as long as it's
24 wrapping it up.

1 BRENDA McGAW: Once again, I feel like children do
2 not get their voices heard.
3 And I appreciate the comments of Frank Ware because
4 that was something that I was not able to address in this,
5 the mental health issues that children in this area face.
6 What we need as far as the Head Start perspective
7 is to seek to be the voice for those who, for whatever
8 reason, lack the resources to make their health care needs
9 heard.
10 Head Start kids and families need more local
11 doctors in all areas of practice and dentists to see
12 patients with a medical card, routine screening for risk
13 factors for people living in poverty, easier appointing
14 policies with consideration for work and child care
15 constraints and updated medical coverage to provide for
16 kinder, more sensitive patient care.
17 KENNETH ROBBINS: Thank you.
18 Bridget Kiely.
19 BRIDGET KIELY: My name is Bridget Kiely,
20 K-i-e-l-y, and I'm the administrator for TASC. TASC is
21 a non-for-profit statewide organization that provides
22 treatment referral and clinical case management for
23 individuals involved in our public systems who display
24 problems with addiction.

1 For over 25 years we've worked hard to provide
2 disadvantaged, disenfranchised and underprivileged
3 individuals with the services they need to restore health,
4 stability and self-sufficiency.
5 Every year we work with close to 30,000 clients
6 who become involved with the criminal justice system,
7 juvenile justice system, TANF, child welfare system and
8 the Department of Children and Family Services system
9 because of drug use.
10 I'd like to talk about three issues today, expanded
11 access to substance abuse treatment, does treatment work and
12 how much will it cost.
13 The need for treatment. No one can doubt the
14 impact of drug use on public systems, particularly criminal
15 justice, where TASC has the most experience. The statistics
16 in the criminal justice system are appalling, and here are
17 just two: Up to 80 percent of people arrested in Chicago
18 for any crime test positive for the use of at least one
19 drug. At the beginning of the 1990's, 4,000 inmates were
20 put in the Illinois Department of Corrections for a drug
21 offense. Just last year over 11,000 were put in the
22 Department of Corrections.
23 So do the people who need treatment get it?
24 For the criminal justice population, the federal government

1 estimates that 20 percent who need treatment get it.
2 95 percent of TASC's clients have no health care whatsoever.
3 For those who can't get treatment, where do they
4 go? Well, they end up in our jails, in our prisons, in our
5 mental health facilities and back out on our streets in our
6 community.
7 Does treatment work? Is treatment the answer?
8 Will it alleviate the burden? Yes. It works to achieve not
9 only a reduction of drug use but also an overall improvement
10 to the functioning of individuals for production and
11 engagement.
12 In 2002 the Illinois Office of Alcoholism and
13 Substance Abuse released the results of the largest study of
14 treatment outcomes ever done in Illinois. The results were
15 dramatic, showing not only significant reduction in drug
16 use but also significant improvement in employment,
17 self-sufficiency, family relationships and overall health.
18 There can be no question about it, treatment does work.
19 And how much will it cost? Well, my question is,
20 how much does it cost when we're not paying for it? In
21 other words, how overcrowded is our jail? How many low-
22 level drug offenders were sentenced to prison at the cost of
23 25,000 per year? How many crimes were committed each year?
24 And how many children end up in DCFS?

1 People who are seeking treatment, people who would
2 benefit from treatment are people who for the most part
3 realize they've made some mistakes and need to change. And
4 for them to get to the point where they're ready to change
5 and discover that they can't access the services they need
6 and that they'll have to be on a "waiting list" until they
7 can get treatment is a true social tragedy.
8 Substance abuse is a public health issue, one of
9 the most serious. It's a public safety issue, again, one
10 of the most serious. Treatment holds the promise of making
11 real progress in restoring the damage caused by drug use
12 and addiction. Thank you so much for your time.
13 KENNETH ROBBINS: Thank you.
14 Mark Hunter.
15 MARK HUNTER: Good afternoon. My name is Mark
16 Hunter, H-u-n-t-e-r. Please excuse my voice. I am fighting
17 a cold.
18 I am here representing the Minority Health Advisory
19 Council. Here in Winnebago County, as has been referenced
20 before, there has been an unprecedented study done in 2005
21 which recorded over 3,000 individuals, African-American and
22 Hispanic individuals, regarding their health status and
23 their feelings regarding health care.
24 I have a -- you're certainly welcome to this entire

1 document. I do have just some things that I am going to
2 highlight.
3 There have been discussions here regarding the
4 increased access, increased physical, tangible assets.
5 I want to leave with the committee that there are more
6 things other than the tangible, physical facilities that
7 will facilitate true access to care and true justice.
8 There are issues that are seldom talked about when
9 talking about access to health care. In our survey there
10 were issues regarding the lack of transportation to get to
11 medical services. There also were issues, particularly in
12 the Hispanic community, that spoke of the language barrier.
13 There's also an issue that I feel is the elephant in the
14 room, and that is the issue of trust, trust in the health
15 care system.
16 We asked these individuals if they had reasons
17 for -- if they had reasons for avoiding care, and the issues
18 center around the issue of how they perceived that they were
19 being treated when they actually did receive care.
20 African-Americans scored the highest on all of the
21 indicators regarding the reasons for avoiding medical care,
22 prior mistreatment, lack of trust in the doctor, lack of
23 trust in the health care system.
24 Parenthetically, of African-American males who

1 responded to the study, 42 percent of African-American males
2 reported lack of trust in the health care system. Nearly a
3 third of the individuals when asked about this whole issue
4 of avoiding medical care, if they perceive any kind of
5 discrimination based on race, gender or economic status,
6 and the data will indicate that people do have an issue with
7 that.
8 So in closing, we just want to say that as we are
9 looking to try to create all -- as much tangible assets as
10 possible to please consider the intangible, please consider
11 the elephant in the room, and that is trust.
12 We need to have monies in our community that will
13 allow us to help to facilitate the broken bridges that exist
14 in our community, people who cannot get -- people who are
15 having trouble for whatever reason accessing the services
16 that are already here. Thank you.
17 KENNETH ROBBINS: Thank you. And if you have a
18 copy that you could leave with us of that report, we'd
19 appreciate it.
20 MARK HUNTER: The entire one?
21 KENNETH ROBBINS: If you have it.
22 MARK HUNTER: Absolutely. Thanks.
23 KENNETH ROBBINS: Thank you.
24 John DeGuide.

1 JOHN DeGUIDE: My name is John DeGuide, last name
2 spelled D-e-G-u-i-d-e. I'm the current president of the
3 Winnebago County Medical Society. I'm a gastroenterologist
4 here in town with Rockford Gastroenterology. I just want to
5 share my thoughts with regard to need to improve access in
6 this community.
7 If the thought of this is to go to a single payer
8 system, I would be strongly against that because I think
9 a single payer system increases costs, discourages new
10 innovations and ends up denying health care. I think health
11 care should be financed by a combination of public and
12 private mechanisms.
13 I've had experiences, including my own family,
14 including my wife, who's the medical director of Milestone,
15 medical director of P.A. Peterson, a private practice
16 internist here in town, that has had to close her private
17 practice to Medicare and Medicaid just because she can't
18 make ends meet with that. And I think Dr. Pescatore and
19 Dr. Kellen expressed similar comments earlier because the
20 reimbursement is low, the payment billing cycles are
21 markedly delayed. It's not unusual to not get paid for
22 these patients for over six months. And it was a very
23 difficult decision for her because she strongly feels these
24 people need care, too. But if her business becomes

1 insolvent, 12 of her employees will be out of work, as well.
2 And then I think we need some innovative thinking,
3 which a single payer system doesn't always provide. In my
4 practice I prescribe a lot of acid-reducing medications, and
5 I have patients not wanting the generic Omeprazole, which
6 is about $24 per month; they'd rather have the prescription
7 drug that's $116 a month for a 30-day supply because "If
8 it costs more, it is probably better." And then you get
9 problems with copays that are less than -- or more than what
10 the person would be able to buy generic for, so . . .
11 These are some of the problems I encounter every
12 day. Other things I encounter are people that have
13 lifestyle factors like tobacco and alcohol that lead to
14 markedly increased health care costs. So one of the things
15 I strongly believe is we should have medical savings
16 accounts that at least with these extra costs people can
17 have -- in some way have to pay more for their health care.
18 I couldn't leave here without talking about lawsuit
19 abuse, which we're still battling in this state. 80 percent
20 of Illinois lawsuits result in no payment, yet millions are
21 spent defending these; and these are -- this is money that
22 could be used to increase access for other patients.
23 In closing, I don't think we can implement a new
24 program without getting the current programs we have that

1 are smaller working. Thank you.
2 KENNETH ROBBINS: Thank you, Dr. DeGuide.
3 Ray Empereur. And coming up we have Kim Montgomery
4 and Leon -- and I'm not sure I can make out the name here.
5 LEON SINGLETON: Singleton.
6 KENNETH ROBBINS: Okay. Come up, please. Is that
7 Singleton?
8 LEON SINGLETON: Yes.
9 RAY EMPEREUR: Good afternoon. It's Ray Empereur,
10 E-m-p-e-r-e-u-r. I serve as the executive director of the
11 Rockford Regional Health Council.
12 In looking over the audience, I'm not surprised
13 to see many of the organizations that are members of the
14 Rockford Health Council here today, and so I'm pleased to
15 represent that body.
16 We are a non-for-profit, community-based
17 organization with a mission in the northwest area of the
18 state to improve the health of people in the four-county
19 region which includes the counties of Boone, Ogle,
20 Stephenson and Winnebago.
21 In 1999 and again in 2003, comprehensive Healthy
22 Community Studies completed in our region underscored
23 the ongoing problems associated with being uninsured or
24 underinsured. We've heard statistics today. I won't

1 repeat them.
2 Recently the prestigious Institute of Medicine
3 issued a report calling on America to solve the problem of
4 underinsurance and uninsurance in our society. We agree
5 that the time has come.
6 The Rockford Regional Health Council favors public
7 policy that encourages and promotes local, state and
8 national efforts combined to improve access to health
9 insurance. Four years ago we participated in the Illinois
10 Assembly Project that addressed how to expand access on a
11 statewide level here in Illinois. FamilyCare is now a
12 reality in Illinois. KidCare has been improved and
13 expanded, and the Governor's All Kids plan is under
14 development for implementation later this year.
15 The All Kids program, while a worthy concept in our
16 view, as it's now designed has two major flaws that really
17 must be addressed before the plan can be fully implemented
18 to meet its intended purpose. First, the plan is based upon
19 Medicaid provider rates, which may seriously limit provider
20 availability. Medicaid rates are too low to entice many
21 providers to render care to those who will be covered by
22 All Kids.
23 Secondly, the PCCM model, as it's referred to, upon
24 which All Kids will operate and through which savings are to

1 be generated to help cover the cost of the plan, is untried
2 on a large scale. Thus, there is as yet no assurance that
3 the PCCM model will generate sufficient state savings to
4 cover the cost of insuring over 250,000 additional Illinois
5 children.
6 In the private market we favor innovation and small
7 employer-based health insurance. In 2003, in fact, Health
8 Access Plan was launched in Winnebago County, offering
9 for the first time in Illinois an affordable entry-level
10 employer-based insurance plan coupled with a Three-Share
11 premium subsidiary.
12 Health Access Plan was developed by the Rockford
13 Regional Health Council with funding from HRSA and the
14 U.S. Small Business Administration. HAP is now managed by
15 a local separate entity, Health Access Plan; and it really
16 deserves the support which was recently obtained through
17 the Illinois Department of Healthcare and Family Services.
18 In closing, we want to suggest and urge this group,
19 the Adequate Health Care Task Force, to develop a sound
20 financial -- and favor development of a sound financial and
21 programmatic basis for the All Kids program and to ensure
22 that this plan can be successful in extending coverage to
23 all needy children in Illinois.
24 We also urge that you find ways to extend coverage

1 to everyone, including uninsured working adults, through
2 innovative employer-based approaches such as Health Access
3 Plan. Thank you very much.
4 KENNETH ROBBINS: Your timing's perfect.
5 Kim Montgomery.
6 KIM MONTGOMERY: My name is Kim Montgomery. I am
7 the education --
8 KENNETH ROBBINS: Please spell your name.
9 KIM MONTGOMERY: Oh. M-o-n-t-g-o-m-e-r-y.
10 I work for RAMP. We are a center for independent
11 living. We provide services and advocacy for people with
12 disabilities. I am also a person who has experienced a
13 catastrophic medical event in my life. My son four years
14 ago experienced a spinal cord injury, which is sort of
15 what also brought me to RAMP.
16 Recently RAMP has been experiencing -- we refer
17 people to services. We don't provide services necessarily.
18 We refer people to services. Our mission is to promote
19 an accessible society that allows and expects full
20 participation by people with disabilities, so we work with
21 people where they are to try and help them meet their goals.
22 Many people who have disabilities have trouble
23 accessing adequate health care, as you know. Many people
24 with disabilities, including my son, are recipients of

1 Medicaid services. And unfortunately, because our system in
2 Illinois is somewhat broken, we are not able to access the
3 services that we need in order to stay healthy.
4 We also have private pay insurance that covers my
5 son, and Medicaid is a secondary. We both work. He's a
6 college student. I'm very worried about what's going to
7 happen to him when he graduates from college and needs to go
8 out and find a job. People with disabilities experience
9 discrimination already in employment situations, and I think
10 our current health care system really kind of almost drives
11 employers to discriminate. People who have chronic health
12 situations are expensive to cover.
13 So to point out in the Rockford area, one of the
14 things that we have experienced recently is the loss of a
15 durable medical equipment provider that provided services
16 who has gone out of business, actually sold their business.
17 It was taken over, moved over to Belvidere.
18 They provided services that nobody else in this
19 whole Northern Illinois area provides, and that is services
20 that allow people with disabilities to have mobility with
21 their vehicles. And if you have a lift in a vehicle
22 around here, you're going to have a hard time getting it
23 worked on, being able to find transportation to get to work,
24 to get to the doctor, to get anywhere.

1 In DeKalb, which is kind of on the fringe of this
2 congressional district, there are no providers that take
3 Medicaid payments. There's a requirement for kids to have
4 dental checkups, but there are no dentists that will accept
5 Medicaid. The problems are numerous. I'll be happy to
6 answer any questions, or you can use me for a referral
7 source. Thank you for your time.
8 KENNETH ROBBINS: Thank you.
9 Mr. Singleton.
10 LEON SINGLETON: My name is Leon Singleton,
11 S-i-n-g-l-e-t-o-n. I didn't prepare no script because
12 everything that I have to say comes from the heart and comes
13 from the experience that I endure since my situation arised;
14 and I still have problems with it.
15 After serving 25 years in the Illinois Department
16 of Corrections -- at the age of 17 I was sent to prison.
17 I was released when I was 42. After a year and a half of
18 being out, I learned that I needed quadruple coronary bypass
19 surgery.
20 I couldn't get none of the hospitals to take care
21 of me. They wanted to send me from one hospital to another.
22 Eventually I got the operation. But then it came time
23 30 days after the quadruple coronary bypass that I needed
24 rehabilitative services. I couldn't get nobody to pay for

1 that. The hospital told me no, you can't have that.
2 90 days after the initial quadruple coronary bypass
3 surgery I had to go back in the hospital to have stints
4 placed in for some unforeseen reason. I had all kinds of
5 complications. I still have complications.
6 I've got over $300,000 in medical bills right now,
7 and they're sweatin' me. They're beating my door down for
8 their money. Public Aid covered me for six months. After
9 that six months I was left out here on my own.
10 Have I been to the doctor? No, I haven't been
11 to the doctor. They've stripped me of all their trust,
12 everything that I endured, everything that I went through.
13 And this just isn't something that's off the top of my head.
14 I've got witnesses. City officials witnessed the treatment
15 that I received as a result of going to this hospital and
16 not having this insurance coverage. That became an issue.
17 I'm thinking that because I didn't have that
18 rehabilitative services or to have anybody pay for those
19 services, that's what caused me to have to go back in the
20 hospital in less than 90 days after the initial surgery to
21 have stints put in. I still have complications now. The
22 last time I went to the doctor was November 8th of last
23 year, and that was with a cardiologist.
24 I haven't been back to a doctor since. And guess

1 what? I've got health care. But where is that trust after
2 what I've went through? Although I went to prison, I spent
3 all that time, I took advantage of that time. And I came
4 out here, and this is my cause because I don't feel that I
5 should have had to go through all those changes in order to
6 get health care.
7 And I'm asking you guys to go back to your bosses,
8 whoever they are -- and if they want to ask me any kind of
9 questions or anything, they can get ahold of me. They
10 can get ahold of me through the City of Rockford Human
11 Resources Department, which aided me in much of my plight
12 with the hospitals in getting health care. And that's all
13 I have to say.
14 KENNETH ROBBINS: Thank you, Mr. Singleton.
15 Ted Haley.
16 TED HALEY: My name is Ted Haley, and I work for
17 the university here in Rockford at the medical school. I'm
18 an associate professor --
19 KENNETH ROBBINS: Sir, if you could spell your name
20 for the reporter, please.
21 TED HALEY: H-a-l-e-y.
22 KENNETH ROBBINS: Thank you. And speak into the
23 microphone. I'm sorry.
24 TED HALEY: Now, I'm associated with the Physicians

1 for National Health Program, and I'm very interested in a
2 single payer program being developed in this country. And I
3 think it's a terrible shame -- I think we should be ashamed
4 of ourselves. We're the only one of the major
5 industrialized nations in the world that does not have
6 single payer kind of health care provided for our citizens.
7 And there are at least 46 or maybe 47 million Americans who
8 don't have any health care, and at least 18- to 20,000
9 people die every year because they don't have any coverage
10 for health care, and so they neglect their own health on
11 that.
12 Now, why we should have a single payer is that the
13 health care industry, privately speaking, wastes so much
14 money on the administrative costs. The average person in
15 this country, $1,389 has been figured out of budgetary
16 paperwork is wasted; whereas in Canada only $497 per person
17 is used up in that way.
18 So I think it's a terrible shame and it's a crisis
19 that we should need to face. And most Americans agree that
20 health care costs should be shared, and the great many of
21 them feels that the U.S. government instead of spending so
22 much money on other ill-advised things should be getting
23 into the business of providing health care for its
24 population.

1 Now, I myself know something about having no
2 health care and no insurance to pay for something. My
3 son, who's an avid skier, got caught in an avalanche, and he
4 couldn't see where he was going and he smashed into a tree
5 and broke his arm. $15,000 later his arm was fixed and back
6 in pretty good shape again. So I think we should be
7 terribly ashamed of ourselves. And the way to go is single
8 payer because that saves an awful lot of money. Thank you
9 for listening.
10 KENNETH ROBBINS: Thank you very much.
11 I think we have . . . Matt Hunsaker, if I'm
12 pronouncing that correctly.
13 MATT HUNSAKER: Matt Hunsaker, H-u-n-s-a-k-e-r.
14 Good afternoon. I had not planned on speaking
15 today but, rather, being here as a concerned citizen to
16 learn.
17 I'm a physician by training, a family physician,
18 and I've spent most of my career working with underserved
19 populations and at-risk populations.
20 The early portion of my career I was in Southern
21 Illinois and worked in the migrant health center as the
22 medical director there. There the at-risk patients
23 were indigent and underdocumented, if not completely
24 undocumented. Lack of access was the rule, not the

1 exception. The medical office there in the camp was
2 located in a workers camp among migrant people providing
3 appropriate care in a setting that makes sense.
4 Much of our model in the United States focus
5 on medical center medicine and drawing the at-risk and
6 underserved to our medical centers. Primary care family
7 doctors have provided the vast majority of initial services
8 to the most at-risk populations in Illinois and across the
9 nation. Adequately funding this is key to any successful
10 program.
11 Early intervention, prevention and chronic disease
12 management intersect in a primary care physician's
13 office. Attempting to meet capacity demands for the
14 under-reimbursed and delayed payments forces physicians to
15 make fiscal decisions regarding the feasibility of providing
16 care to at-risk populations.
17 The poor, the underdocumented and at-risk
18 populations have often been disenfranchised in our country.
19 They have been with us, and they likely will always be
20 with us, this segment of our community. Identifying and
21 implementing an appropriate system does not, as one speaker
22 suggested, represent socialism.
23 Thoughtful consideration of system design, primary
24 care orientation and disease prevention is key to cost

1 control and society's ability to afford the system. Scare
2 tactics to ignore the challenges facing us and equating them
3 to the spector of socialism ignores the provider capacity
4 shortage and marketplace elevation of cost driven by profit
5 motivation that is currently occurring.
6 Rural and urban communities face huge manpower
7 shortages, and delayed payment challenges force physicians
8 to limit access to at-risk populations. Correcting the
9 shortcomings would be an adequate step in fixing the system
10 until a more effective system can be implemented for at-risk
11 patients.
12 Prompt payment, mental health preventive and
13 chronic disease services must be addressed. Our goal should
14 be excellent care, but I suppose adequate would be a target
15 for now given our current health care status in many
16 communities. Thank you.
17 KENNETH ROBBINS: Thank you very much.
18 We do not have anyone else signed up to speak,
19 but we have advertised that we will be here from 4 until
20 6 p.m., so the task force members will stay in the event
21 someone should arrive and expect to be able to speak.
22 Ms. McGaw, if there are other things that you
23 wished to say but we didn't afford you time to, I'll be more
24 than happy to give you that opportunity.

1 BRENDA McGAW: Thank you very much.
2 What I was thinking after I ran out of time to talk
3 to you was that I wished I had really gotten to tell you,
4 the most important part of my statement, was that as dealing
5 with children every day that most all of them fit into the
6 poverty level.
7 We've had at least three children this year that
8 have needed the services of a specialist in the form of an
9 ear, nose and throat specialist. These children have been
10 denied access to an ear, nose and throat specialist here in
11 Rockford just simply because they have a medical card.
12 They were referred and they will be seen, but they
13 have to travel all the way to Chicago to the University of
14 Illinois-Chicago campus, and this is going to take an
15 all-day process for these children. First of all, one of
16 the families has no adequate transportation, so we've
17 arranged for them a caravan to pick them up.
18 Their appointment's at 2:15 in the afternoon.
19 They will be picked up about 10:00 in the morning, and it's
20 estimated that they won't be back in town until probably 6
21 or 7 that night.
22 This is going to require a four-year-old to be in
23 the car most of the day to see a doctor. And then if any
24 treatment is going to be required -- this, of course, will

1 be a consult visit. If any treatment will be required, that
2 will be another trip to Chicago, probably an overnight stay
3 for the family. We're going to work out those details as
4 needed. But if surgery or further treatment's going to be
5 necessary, it could be another trip to Chicago.
6 Also, we have this year identified over 300 of our
7 591 children that are enrolled that need dental treatment.
8 Last year our statistic proved to be about 255 of our
9 children needed dental treatment, and of those children
10 only 80 completed treatment.
11 In our area we have a contract with Crusader Clinic
12 for dental care for our children. We take them in buses to
13 the clinic for exams; and there they're diagnosed if they
14 need treatment or not, of course. When treatment comes
15 about, then the parents must call for an appointment.
16 First of all, Crusader's telephone system is very
17 congested; it's antiquated. There are not enough people to
18 handle phone calls there, to take calls from our families,
19 and it's very difficult to get an appointment.
20 Also, Crusader has no Saturday or evening hours for
21 dental appointments. I find this is very difficult for our
22 families. They are trying to work, they're trying to manage
23 their children; and they have no flexibility in scheduling
24 there.

1 Our other concerns that I feel our children -- just
2 a minute. Let me look at my notes here.
3 A couple of our children need a dental care that
4 they're going to need some anesthesia for. And if you've
5 ever been three or four years old and you saw a dentist come
6 at you with a needle to deaden your mouth, it's a pretty
7 frightening ordeal. The medical card will not pay for
8 conscious sedation for children to have their dental care
9 done, so consequently those children go without dental care.
10 Thank you.
11 KENNETH ROBBINS: Thank you very much. We will
12 take a 15-minute recess. And if others wish to speak, you
13 may do so after that. Thank you.
14 (Recess taken.)
15 KENNETH ROBBINS: Let me ask Jim Knutson to come
16 up, please.
17 JIM KNUTSON: Hi. My name is Jim Knutson,
18 K-n-u-t-s-o-n, and I'm the benefits manager at Rockford
19 Acromatic Products, a local manufacturing --
20 KENNETH ROBBINS: Jim, just one second.
21 (Off the record.)
22 JIM KNUTSON: I would like to say just a couple of
23 things on behalf of the business community. In addition to
24 the benefits manager at Rockford Acromatic, I am a member

1 of the Illinois State Chamber Health Care Task Force and
2 attended the last task force meeting in Chicago.
3 This afternoon I'd like to really talk about three
4 things. One, I'd like to speak to the issue of information
5 and ask that the task force consider reinstalling or
6 consider something along the lines of the old Illinois
7 Health Care Cost Containment Council, which provided
8 information, I think primarily hospital discharge
9 information, but it talked about cost and quality and to
10 maybe consider something along the lines of what the State
11 of Pennsylvania is doing, where they are issuing something
12 along the lines of report cards that speak to quality and
13 costs at least in the hospital inpatient setting.
14 The second thing I'd like to just mention is what
15 I think is a fairly successful local program. The Rockford
16 community has formed the -- it's called the Employers
17 Coalition on Health. And it is a -- really is a public-
18 private sector partnership of to date primarily self-funded
19 employers who have gotten together for the purpose of
20 purchasing health care.
21 The reasons that I think it's successful are it's
22 an employer-sponsored coalition. There has been some talk
23 about administrative waste, inefficiency and profit chewing
24 up a big part of the health care dollar. And in the Echo,

1 or Echo-Echo plan as some people say, those middle costs
2 are minimized and there is an opportunity for direct
3 dialogue between purchasers and providers which I think
4 has been successful.
5 And, finally, I'd just like to mention some
6 examples of what I think are successful public-private
7 partnerships that I've seen and participated in over the
8 years. I've been a member and a board member of the Midwest
9 Business Group on Health, and we worked with the Institute
10 for Health Care Improvement and put together what I think
11 was a successful diabetes collaborative that Cook County
12 took over and I think used and benefited from and improved
13 the health status of the community some.
14 In the area of chronic care, there's the Rand
15 report and the New England Journal of Medicine report, which
16 I think was mentioned earlier, which said that people are
17 only getting chronic -- care for chronic conditions, about
18 half of the recommended care. And we realize that that's an
19 important area of -- that's underserved right now. And I
20 think through public-private partnerships we can enhance the
21 value of health care delivery and health status. And so I
22 think that's about it.
23 KENNETH ROBBINS: Thank you.
24 One other person has asked to speak, Dorothy

1 Reddic.
2 DOROTHY REDDIC: My name is Dorothy Reddic,
3 R-e-d-d-i-c.
4 I represent Black Health Care Initiative Coalition.
5 And the concern that I see is access to health care,
6 adequate health care and quality treatment.
7 A lot of times people will contact us here lately
8 with complaints about being treated unfairly in our current
9 health care system. A couple of times I've witnessed
10 mistreatment, inappropriate discharges, and I believe that
11 in some cases it's even illegal.
12 We've lodged complaints. We've complained to
13 the Illinois Public Health Department, to JCAHO, to the
14 hospitals; but unfortunately in our community people still
15 think that it's okay to treat people of color unfairly in
16 access to health care.
17 I think that the doctor that got up and spoke
18 about the approaches and making the services available
19 where they're needed and culturally-sensitive services is
20 something that our state needs to look at in the health care
21 system. It's inadequate now; it's not accessible. And
22 I'm just here to represent those individuals that have
23 experienced that and make a request of the State that we
24 implement some changes. Thank you.

1 KENNETH ROBBINS: Thank you.
2 (Recess taken.)
3 KENNETH ROBBINS: Let me try to sort of describe
4 the context of our operation. We have about three or four
5 more public hearings to engage in around the state. There
6 will be one -- by the time we finish, we will have had at
7 least one in each congressional district. There will be a
8 couple of others that have been added, as well.
9 We are hiring -- and, Ashley, we have not yet
10 hired a consultant --
11 ASHLEY WALTERS: No.
12 KENNETH ROBBINS: We're in the process of hiring
13 a consultant who will then evaluate various proposals that
14 will be submitted to the task force. Organizations or
15 individuals may submit such proposals.
16 The consultant will do actuarial work, cost
17 analysis work, data mining in terms of how many are
18 likely to be affected and how with each of these proposals,
19 sometime this summer will bring those evaluations back to
20 the entire task force.
21 The task force will then spend a significant period
22 of time evaluating each of those with an eye toward being
23 able to come forward with a consensus recommendation
24 sometime in the October time frame that will be presented

1 to the General Assembly and to the Governor.
2 Does that help?
3 AUDIENCE MEMBER: Yes, sir. Thank you.
4 (The meeting was concluded
5 at 6:00 p.m.)
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1 C E R T I F I C A T E

2

3 I, AMY R. CAMPOS, Certified Shorthand Reporter and

4 Registered Professional Reporter, in and for the County of

5 Winnebago and the State of Illinois, do hereby certify the

6 foregoing is a true and correct transcript of my shorthand

7 notes so taken as aforesaid.

8 I FURTHER CERTIFY that I am not counsel for nor

9 related to any of the parties herein nor am I interested,

10 financially or otherwise, in the outcome hereof.

11 I FURTHER CERTIFY that my certificate annexed

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15 Dated and affixed with my seal of office at

16 Rockford, Illinois, on March 28, 2006.

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