ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ADEQUATE HEALTH CARE TASK FORCE
WEDNESDAY, MARCH 15, 2006
4:00 p.m. - 6:00 p.m.

IN RE THE MATTER OF:)
) TRANSCRIPT OF
) PROCEEDINGS
ADEQUATE HEALTH CARE)
TASK FORCE MEETING)
)

The above-entitled matter commenced before the Adequate Health Care Task Force, at Augustana College, Wallenberg Hall, 3520 7th Avenue, Rock Island, Illinois.

PRESENT:

MS. JAN DAKER
MR. JIM JORDAN
MR. GREG SMITH
MR. JIM MOORE
MS. MARGARET DAVIS
MS. ASHLEY WALTER - Policy Analyst
MR. RAEL SLAVENSKY
MR. WILLIAM LEAVER
MR. CHUCK BRUHN
MR. SAM VASQUEZ
MR. RANDY MULLIN
MR. FRANK SAMUELSON
MS. MARGARET TWEET
MS. KAREN METCALF
MS. LAURINE ARMETTA
MR. STEPHEN TEETER
MS. STELLA SCHNEEKLOTH
MS. SHANNON PETERSEN
MS. CATHY STARLING

MS. DAKER: Good afternoon, and welcome to the 17th Congressional public hearing for the Adequate Health Care Task Force 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, as well as their functional status.

Access to health care is most affected by the act of those seeking care to afford the services that they need. Therefore, the uninsured, working poor, racial and ethnic minorities, and undocumented immigrants in Illinois are least likely to be able to afford to pay out-of-pocket for many health care services.

Many Illinoisans lack access to the health care system because they lack health insurance. On any given day, an estimated 1.8 million Illinois citizens are without health insurance. Additionally, a growing number of Illinois residents are underinsured, and the consumers share of the cost of health insurance is growing.

While Illinois has many safety-net providers, including public and private clinics, public hospitals, and charity care administered by public hospitals that attempt to narrow the gap between the insured and uninsured, many uninsured Illinoisans lack access to a usual source of preventative, comprehensive, and continuous care.

The Health Care Justice Act signed into law by the Governor in August of 2004 encouraged 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 maintains and improves the quality of health care services offered to Illinois residents.

The act created the Adequate Health Care Task Force, which has undertaken the task of developing this access plan. The 29 members of the Task Force were appointed by the Governor, the President of the Senate, the Minority Leader of the Senate, the Speaker of the House, and the Minority Leader of the House.

As part of this work, the Task

Force will be holding at least one public hearing in each congressional district to seek

input from the public regarding the access plan, which is why we are all here this afternoon.

On behalf of the Adequate Health Care Task Force and the Illinois Department of Public Health, I would like to thank each of you for coming out this afternoon to take part in this important process. I would also like to thank Augustana College for sharing their space with us this afternoon.

Before we get started there's a couple of housekeeping items that must be addressed. First, if you have not already done so, please sign in at the table located just inside this room. This will help the Task Force and the department track the number of people who attend this hearing. There are also two handouts available at the table that provide more information about the Health Care Justice Act and the Adequate Health Care Task Force and this public hearing.

Second, should you wish to testify, please be sure to sign up at the table

near the entrance to this room on the gold-colored sheets. Individuals will be called to testify in the order in which they

sign up. If you brought written testimony to submit you may also do that at this table.

We will begin the hearing by calling up the first five speakers. And when we call you up, if you could just sit right up here in the front row in the order in which you are called (indicating). But before you testify I'd like to remind you to say and spell your first and last names for the court reporter, and she would also like you to speak nice and slow. And please be reminded that the testimony will be limited to three minutes. We're not terribly strict on this. This is our official time keeper (indicating).

And before we start I should introduce myself. I'm Jan Daker, I'm from Belleville, and I'm representing the United Congregations of Metro East on this Task Force.

MR. JORDAN: My name is Jim Jordan. I represent the Director of Insurance who's an ex officio member of the Task Force.

MR. SMITH: I'm Greg Smith with

Group Marking Services in Lincoln, Illinois.

MS. DAKER: And there was no requirement to be on the Task Force to be able to pronounce names well, so remember that, all right?

We're going to start with the first one, Rael Slavensky, the second person is Bill Leaver, third person is Chuck Bruhn, and Sam Vasquez.

MR. SLAVENSKY: My name is Rael Slavensky. First name is R-A-E-L, last name is S-L-A-V-E-N-S-K-Y. I'm the Director of Planning and Prevention for the Rock Island County Health Department.

As one of the safety-net providers in Rock Island County, we are acutely aware of the disparities among populations in our county between people who have coverage for their health care and people who don't. We don't provide the broad spectrum of safety-net services, we only provide some safety-net services, but we are aware of what the situation is in Rock Island County.

I have some facts and figures for you. I'll try to make them brief. In 2002

there was a community survey done by the Quad Cities Health Initiative. Among their findings were that 11 percent of the people in Rock Island County reported having no health care coverage. Seven-and-a-half percent of children in Rock Island County did not have insurance or

health care covered. That compares to Scott County, across the river, at almost twice as much. Scott County was 3.4 percent.

Again from this 2002 survey, 13.6 percent of adults avoided getting a prescription because of costs, 5.2 percent of children. 10.6 percent of adults reported avoiding an M.D. visit because of costs. That's up from 8.14 percent in 2001, from a different survey. 6.5 percent of children also reported not being able to have doctor's visits because of costs.

Another interesting part of this, because it's not just about paying for the doctor, 4.8 percent of adults reported not being able to get transportation to the doctor, and 3.7 percent of children.

Of course, we know that in minority communities and among low-income

people these disparities are even greater. What we found was that in Rock Island County almost 10 percent of African Americans had trouble finding a doctor in 2002. 8.8 percent of Hispanics, as opposed to 4.7 percent of whites. For people who were under 200 percent of poverty, over 12 percent of them had difficulty finding a doctor.

Now, the solution to these things are going to be complex, but one of the things that we do know is that we have to fix things. We practice prevention as our primary work in the health department. We know that prevention is cost-effective, we know that by providing preventative services, from mammography to blood pressure screening, we can lower health care costs, and I would ask you, in conclusion, to consider those things when you consider what we're going to do in this situation.

Thank you for the opportunity to testify.

MR. SMITH: If you'd like, you could give the statistics to us so that we could put it in the record, to Ashley.

MR. SLAVENSKY: Okay. Sure

MS. DAKER: Next is Bill.

MR. LEAVER: Thank you. I'm William Leaver. That's W-I-L-L-I-A-M, Leaver, L-E-A-V, as in Victor, E-R, President and CEO of Trinity Regional Health Systems.

Trinity is a three-hospital system located in Rock Island. We have campuses in Moline, Illinois, as well as across

the river in Bettendorf, Iowa. Roughly 500 beds. We also have 25 other locations in the Quad Cities -- broader Quad City area. We treat roughly 21,000 admissions -- inpatient admissions every year. Roughly 90,000 in emergency department urgent care clinics, and thousands more in an outpatient and in our physician offices.

Trinity is very concerned about the growing crisis of the uninsured and the underinsured, and we believe that this is not only a state-wide but it's a national issue, and we believe it will require a comprehensive, all-inclusive solution.

The problem will only get worse. We have seen, in the last couple years, a

growing number of uninsured, a growing number of people who just simply cannot pay the bill. We know that this is not a problem -- not just a problem that affects the poor and the unemployed. We know from statistics that 50 percent of the uninsured have jobs, they just don't have benefits to pay for their health care.

As a not-for-profit, tax-exempt hospital, we believe our mission is to serve anyone at any time. We do that, and do that

proudly. Last year we provided $9.5 million of free care, care to individuals who had no insurance or the inability to pay. We also, in addition to that, subsidized by another $8.8 million, a state-run Medicaid program where we're getting roughly 62 percent -- or $0.60 on every dollar of cost. Not charges, cost to provide this care. The charity number I gave you of $9.5 million is cost, not charges.

In addition to roughly these $18 million of free care and subsidy, we also provide over $2.5 million of services to the community, supporting the Quad City Health

Initiative, which the gentleman from the Rock Island Health Department just talked about, as well as many other services.

We also have a very aggressive charity policy. We work very hard to make sure that people know that we have a charity policy. We are actually much more progressive in terms of what we will discount based on financial need.

In conclusion, hospitals are -- I think are doing a lot to help the uninsured, but we cannot do it alone. We need a lot of

help doing this. We also have limited resources to respond to this problem.

Universal health care is really a goal I think we all should endorse and embrace and support. We recognize that Illinois and the nation face a daunting problem that cannot be solved easily or quickly, but placing a greater burden on hospitals will not solve the uninsured crisis. It will only damage, we believe, the health care system that our patients and communities rely on. To me the solution must involve government, employers, individuals, as well as hospitals

and physicians to solve.

Thank you for hosting this hearing in our 17th Congressional District here in Rock Island. We appreciate your support. Thank you.

MS. DAKER: I have a question for you.

MR. LEAVER: Sure.

MS. DAKER: You mentioned universal health care. Do you feel that Illinois, by itself, can provide that?

MR. LEAVER: Well, I think there are examples where other states have done that, but I think we have to be very careful about

the model that we use. Maine has done this. I don't know that they've had great success. We think that the solution has to be -- it would be better if it were national. I'm not sure that that will happen quickly enough. As you said earlier within your opening remarks, there are 14.8 million Illinois citizens that don't have insurance. So I think we have to at least attempt some type of universal solution here in Illinois.

MS. DAKER: Thank you.

MR. BRUHN: Good afternoon. My name is Chuck Bruhn, and I serve as the Chief Executive Officer for the Genesis Medical Center.

MS. DAKER: Spell your name.

MR. BRUHN: B-R-U-H-N, as in no.

As I said, I serve as the Chief Executive Officer at the Genesis Medical Center Illini campus in Silvis, Illinois, and I want to thank you for the opportunity to speak before you today.

Genesis Illini has long been concerned about this crisis of the uninsured and underinsured, as demonstrated by our mission statement, which reads, "Genesis Health

System exists to provide compassionate, quality health care services to all those in need."

Currently our charity care policy provides a formula based on income, number of dependants, and resources that allows us to determine a sliding fee schedule for the individual who receives any hospital services based on the federal income policy guidelines. And in many cases that means that the individuals receive the care totally free.

Information regarding the financial assistance program is provided at the time of service, in our patient handbook, by financial counselors, and through a customer service phone number.

Last year we referred approximately 160 patients with billed charges of $1.3 million to our charity care program. The actual costs of these services are reflected in our charity and bad debt accounts -- Again, as Bill mentioned, it's cost as opposed to charges -- amounted to $3.4 million in uncompensated expenses during this same time period. In addition to the annual $3.4 million in uncompensated costs, charity care expenses, Genesis Illini provides approximately another $330,000 in costs associated with activities and civic

involvement, community funding, sponsorships, health education and promotion and subsidies to other community health providers.

But the benefits that Genesis Illini provides to our communities go well beyond charity care or helping patients obtain financial assistance. A vital community program we provide is our level-two trauma

center and designated pediatric emergency service. This is done at an annual loss to the hospital of nearly $1.9 million.

Financial pressures of being squeezed between uncontrollable soaring costs and declining reimbursements have challenged many hospitals in their effort to continue vital programs or retain positions in their communities. Historically, many of our reimbursement sources pay less than the cost of providing care. Medicaid, for example, only pays $.21 for every dollar of the actual cost of providing those services to those individuals, while Medicare only provides $.39 for every dollar spent on actual cost and service to that group of individuals.

In conclusion, hospitals alone cannot solve this crisis of the growing

uninsured and underinsured population, and yet continue to provide the highest levels of programs, technology, and quality that our nation has rightfully come to expect and demand. This challenge and standard of care would require that all in the state holders, hospitals, health care workers, unions,

businesses, and governments must collaborate and develop workable solutions.

Again, I want to thank you for the opportunity of speaking before you today, and I've made copies of my remarks which I'll drop off at the door. Thank you.

MR. VASQUEZ: I'm Sam Vasquez, S-A-M, V-A-S-Q-U-E-Z. And I don't want to get much into the specifics about the different things that's going on, but in generalities, I'm concerned -- And I got this Reader's Digest for this month, April, "I can't afford to get sick," so I'm taking some of the things out of there from a different alert.

Now, UAW has always been concerned about people who work in the shop and also when they go back home in the community, so that's why we're involved. That's why we've become involved in the community for different specific interests of ours, and one of them is

health care.

And one of the gentlemen mentioned a national health care system. I don't think the states can do it alone. First, they put in legislation, but there's no

funding. You've got to have the funding to implement any program, and it's false when you bring some people's ideas up to the fact that there's some kind of a health care system going to be implemented and there's no funding for it. They say that comes later. So anyway, I just thought I'd bring that up.

The Congress has stricken $11 million from Medicare and Medicaid in this last session. I think the priorities should be changed. We're providing health care for the people in Iraq, hospitals and whatever that we're building, but we can't afford to take care of our own people.

They're worried about those who are more wealthy than the poor. And the reason I say that is because the President has put in some kind of a proposal about health insurance savings accounts so that the individual -- The average person hasn't got that kind of money to start one, but the wealthy person can put one

in there, I don't know what the limits are, 20,000, 30,000, 50,000, tax free. No interest will be taxed.

The people that's going to have

to fill in the gap are those that are poor that can't afford to buy one of these. And then when it goes into the insurance and when they're in the insurance program, those are the ones more apt to get sick or the older ones. And so the wealthy, rich people -- and I have nothing against wealthy and rich, but this Congress seems like they're putting together some kind of a plan for their benefit, and the ones that have to suffer are the poor.

Like I said, they've cut off from Medicare and Medicaid, and I just -- On this prescription drug program, kind of reminds me of the Catastrophic Health Care Bill. Politics as usual. That program, everybody but -- The President and some of the other ones say it's good, but most people have difficulty with it. It's so confusing. I thought, and everybody else thought when they proposed this idea, that it would be one -- a one-payor system, but they divided it among all the different insurance corporations that have different plans. And some people -- The second

day I went down to Walgreen's, and this happened to be an individual thing, and he was

trying to get his prescription drug filled, and the pharmacy -- the guy from the pharmacy -- the pharmacist, he just told him, he said, "You don't have this one covered. They don't -- under that program you have there's no coverage for it."

So that's a -- I just don't agree with that. Too many people are confused with it, except the president and Senator Grassley over there.

What's bothering me most of all, this is not a third-world country. I've been to different countries, and I was in Mexico one time. A little child got sick or something, I said, "Why don't you take him to the doctor or the hospital?"

"We can't afford to."

Can't afford to. This country shouldn't have to use that phrase, "We can't afford it." Shame that this country is rich, is intellectual, is educated, and all the other things that go with it that can put a man on the moon, can't afford to keep its citizens healthy by providing some type of medical

coverage.

You know, I was born in the depression time. I grew up in the depression. I went in the Army Second World War. Lieutenant come down the line -- And this is why I say again -- he said, "You haven't been working on your teeth. What's the matter with you?"

Because we had no money, not until I got in the Army. They took care of it.

But, you see, this is not a third-world country, and I say if you're going to propose some type of legislation, funding should be adequate enough to cover the legislation.

That's all I've got to say, and I want to thank you for being able to say that. Thank you.

MS. DAKER: Thank you.

Our next speaker, Randy.

MR. MULLIN: I'm Dr. Randy, R-A-N-D-Y, Mullin, M-U-L-L-I-N. I'm -- I practice, and have now for 30 years, out in Geneseo, and I am a family physician. I'm actually third-generation, small-town general physician.

I wish to address two points of access and the liability questions in this state, and I think the two dovetail a great deal. Access to care has become a problem.

I delivered 1,200 babies in Geneseo, but I, along with a number of other doctors, have gotten out of the business, can't afford to stay in the business of delivering babies because of the professional liability focus, because of the cost of insurance type of thing. We're down to two people in Geneseo who deliver babies. I guess we shouldn't cry when there's so many economies in the southern part of the state who have none.

The access also shows up because I work in the emergency room, and in the emergency room I run into the case where I have a potential head injury problem on my hands and I'm going ship it out to a neurosurgeon, and sometimes there are none. A neurosurgeon -- There isn't one available. I'm talking about trying to get someone to Iowa City or Peoria because the Quad Cities didn't have the coverage. And they're -- the professional liability vulnerability problems of this state

compared to our neighbors plays directly into that.

I also would like to speak to the care that I would hope we would take when we talk about health care services. This not speaking of it is monolith. By that I mean there's a difference between the societal value of prenatal care, immunizations for children, which has a great benefit for all of society. And then you get into -- run into the case of, for instance, a liver transplant, which has only one person it'll benefit and can run into thousands and thousands of dollars. And I say that as the father of somebody who was at the head of Mayo's transplant list a few years back. Thank God the technology is such that Wendy is doing well, but I knew that I was going -- I would be spending everything that I've ever accumulated for my retirement to get her those services. But I also know that kind of expense is probably not going to be covered by a system that -- because being in the business of health in this state, I know that the Medicaid paradigm is always woefully under-funded. It's always behind in its

payments. It has now turned the corner where it's making a difference in people who will take Medicaid.

Particularly I find that trying to find my pediatric patients an ENT or a neurologist or mental health services, I can't find anybody that will take somebody on public assistance. And if we expand services without funding, then the people who were in the business of health care are going to be able to tell -- they're going to look at that and they're going to choose not to join. And so it's not directly, but very, very much related, and in an indirect function would be to the fact that -- that we won't have people to send our primary care patients to.

The Oregon (phonetic) experience of a decade ago was interesting, where they drew a line from societal value from prenatal care on one end to -- to transplants, cosmetic surgery on another, and the definition across the board for health care services and comprehensive care was what you could pay for, the way the actuaries do it. And I think to promise people services and not be assured of

the funding is -- is going to be a disservice to our populous. And I do thank you for the opportunity to speak to you today.

MS. DAKER: Thank you very much. We don't have any other speakers.

MS. WALTER: Do you want to take a break and see if anyone else wants to sign up?

(Whereupon, Jim Moore entered the room.)

MS. DAKER: Sounds good. We really encourage you to sign up and speak. It doesn't have to be all that formal. You do need to sign up.

MR. MOORE: I'm Jim Moore, I'm with the OSF Healthcare System.

(Whereupon, a recess was taken.)

MR. VASQUEZ: Now, what do you do when you get this hearing concluded? Do you go back and give a report to somebody and the legislature or what? And do they -- do they go through trying to implement some type of a legislation that would be covering people with health care of some kind or other?

MS. DAKER: Actually, that's a

good question. Would you like to take that one?

MR. SMITH: I can do part of it. The law was -- or the Task Force's responsibility is to get input not only through public hearings and testimony such as yours, but also we have regular meetings to listen to experts from, you know, academia and all sorts of areas, and then we -- we have some discussion.

There's also a research entity that has been hired by the state to review -- come up with various options and look at up to six different possible solutions. And once that research entity comes back to the committee, then we discuss the various options, and it's our charge to try to come up with a recommendation to solve, you know, all the various issues that were discussed.

So, yeah, there's -- we're not going to make the legislation, but the idea is that we come back with a recommendation or recommendations for the legislature to take a look at, and then they're the ones that actually --

MR. VASQUEZ: I'm talking about health care providers committee or something that's going to work on this legislation. Is

that what it is?

MR. SMITH: Well, the --

MR. VASQUEZ: Not to the general legislature.

MR. SMITH: No, it would go to the general legislature and it would be introduced in the form of a bill, and then that bill would have to be researched and then voted on, et cetera.

MS. DAKER: That's to the state legislature.

MR. SMITH: Yeah, this is just a state thing, it's not national.

MR. VASQUEZ: The only problem that I've seen, a lot of this going on is funding. We can all put ideas in there and we can bring up some type of legislation and enact a law to say all children should be provided some kind of health care in the state of Illinois, but they don't provide the funding.

MR. SMITH: Right.

MS. DAKER: That's part of --

MR. VASQUEZ: And that's why I say politics play a big part. Like the Cash Cow Health Care Bill. I don't know if you know about that way back. And it was put in there for just the election, and after it was over

they found out it wasn't no good and they repealed it.

MR. SMITH: That was the national one on the --

MR. VASQUEZ: It was politics, and that's why I'm wondering are they making some type of a place for where they can fund this thing or just throw it out there in the air.

Prescription drug program, when President Bush put this program out before the election and all that everybody thought they were going to have a 25 percent change. They threw out all the different ones and you got anywhere from 1.87 to $34, $48 coverage, and none of it's any good.

MR. SMITH: Well, we would have to look at what it would -- The research entity is supposed to give us some idea of what it would cost so we can present that, but the

legislative process has to address all those things. So yes, it is going to be political.

MR. VASQUEZ: Well, that's what I was wondering.

MS. DAKER: And we need to be finished by October of this year.

(Whereupon, Margaret Davis entered the room.)

MR. JORDAN: It's also important to emphasize that it's a bipartisan Task Force, and if you sit -- you know, I just joined the Division of Insurance, but it's quite an impressive group. CEOs of hospitals, consumer groups are represented, so we really do have some of the best minds in Illinois working together in a bipartisan basis, and that's really the start of any kind of comprehensive solution. So while it might not be an ideal solution like from your perspective today in this hearing, it certainly is the necessary first step, so it's important to just remember that. Because if you start out with a bipartisan group it certainly helps get things done.

MS. DAKER: Margret, did you

want to introduce yourself?

MS. DAVIS: Hi, I'm Margaret Davis from the Healthcare Consortium of Illinois. Sorry I'm late. I drove down from Chicago, couldn't find my way, but I got here.

MS. DAKER: Margaret has also not missed a single hearing, correct? She's been to every congressional hearing. We can't

all say that.

MR. SLAVENSKY: If I could, I've got a question for you. Rael Slavensky from Rock Island County Health Department. One of the issues that we know is a problem is people who work trying to get their children to the doctor during working hours. And I have to comment that the time that you had for this hearing also is relatively inaccessible to people who are working, people who have children in daycare, and I was wondering if you have had other hearings on weekends, later in the evenings, those kinds of things.

MS. DAVIS: No, we haven't. That has been a concern, but in some congressional districts this has been better than others. So we'll take -- Actually, our

staff person will take that in consideration. We try to get some time where we thought that some people would get off at 5, they could come between 5 and 6, you know.

MS. WALTER: I would just like to clarify quickly that that's not my arena, you can take that back to the Task Force and that's your decision to make.

MS. DAKER: We understand what

you're saying, and it's been very, very difficult for all of us to come up with times that we are available, also. It's just been really tough, and if we've had larger crowds we've stayed later to take care of it, so --

MR. SLAVENSKY: Okay, thank you.

MS. DAVIS: And we had, also, a written process too, so that anyone who may be missed can submit their recommendations online.

MR. SLAVENSKY: I'll just comment that, you know, I usually consider myself pretty aware of these things, and I was aware of the hearing. I didn't know there was a written process. In the announcements that I got it wasn't mentioned.

MS. DAVIS: And on that -- Where

you signed in you got a piece of paper. The website is on there, and so it -- and every testimony that has happened -- We've been in many congressional districts, and the court reporter transcribes everything verbatim, and you can just read.

And I just want to let you know there's so much pain and suffering in this state that I -- I've been a nurse for 32 years, and I just thought it was unique to inner-city Chicago, but going south of Springfield, boy,

there is a story to tell there.

MR. SLAVENSKY: Thank you.

MS. DAKER: Thank you, we appreciate it.

Next two speakers, Frank Samuelson and Margaret Tweet, will you come up?

MR. SAMUELSON: Hello. My name is Frank Samuelson, S-A-M-U-E-L-S-O-N. I live in Moline, Illinois, and for the past year or so I've been a member of a local group that's concerned about a number of social issues. It's called Progressive Action for the Common Good, and I've been a member of the health care forum in that group, and have become more

educated about the health care situation in our country.

I personally have health insurance, Medicare, I'm of that age, and also additional coverage through my own plan with my previous employer. However, I'm more and more aware of people and concerned about people who do not have health insurance. I have been -- I have learned, through the study of the Institute of Medicine, national study, which probably you are familiar with, or people in your Task Force, that they have created some

statistics, including the fact that 45 million Americans have no health insurance. And an even more startling statistic, perhaps, is that 18,000 Americans will die this year as a direct or indirect result of not having health insurance. Treatment is delayed, they don't see the doctor, maybe inadequate treatment when they finally get it. So it's a matter of life and death, it's not just some political or general issue. It's a matter of life and death for some people. I don't know how many of those 18,000 will be Illinoisans, but certainly some of them will be.

I participated in a discussion on this issue in my local church last Sunday, and one woman in the group said that she was one of the people who has no health insurance and has serious health issues. And, thanking her for sharing that with the group, she said, "I feel helpless and hopeless in trying to deal with the health care system that we have when I have no insurance and I have serious problems."

So that's just one person, but I think many people would express that same feeling.

That's all I have to say.

MS. DAKER: Margaret?

MS. TWEET: My name is Margaret Tweet, T-W-E-E-T. I have been a member of Church Women United for decades. And Church Women United -- Probably 15 years ago Church Women United, nationally, decided that we would get to the root causes of poverty, and we were going to take on that task and eradicate the root causes of poverty. Needless to say, we didn't accomplish that fact, but we did discover, through that, that the real -- the thing that drove most people into poverty was

health care, the cost of health care. That would range from a family with children who had serious health problems to divorced women who found that they were no longer covered under their previous husband's health care and had problems, ended up in the hospital, and became impoverished because of that.

As an aside, my nephew ended up in bankruptcy because his health insurance, although first saying they were going to cover something, then decided no, after the fact, they did not cover it, so he ended up in bankruptcy over that medical bill. And my brother, who was a bank president, said that most of the bankruptcies that he had any

experience with were caused by the cost of health care.

So my big concern -- I mean, all these concerns are always in this, but one of my real concerns with health care is cost containment. And most of us are not truly aware of how much things cost, because our insurance -- health insurance covers them. We might get this bill back -- I too am covered now by Medicare, and we get it back and it says

how much it cost and how much Medicare will pay, but we don't really pay a lot of attention to that because it's paid, right? And if it's going to be paid -- If this universal health care, which I'm very much in favor of, if that's ever going to happen the cost of health care has got to be contained.

I am on, not your most expensive medication, but a medication that, if I bought it in this country at the price in the pharmacy, it would cost me $140 a day. I got that through Canada for about 3.50 a day. And now that I am on the drug -- you know, the one for seniors, and we have one of those -- we're under Humana. Can anybody remember the name of those things they're called where they take the money from Medicare and -- Does anybody know

the name of that?

MR. MOORE: Medicare Advantage.

MS. TWEET: Yes. Yes. And under that it now costs me $2 a day. Now, that medicine, is it still -- is it only costing $2 a day? You know, who's paying that extra money if that money is really that -- is it really that expensive? That is really a big concern

of mine, is cost containment.

And then as an aside, I just heard -- I was listening to a program on the radio, and this man who was in health care said he felt that everybody who pays taxes, when they submit their tax -- their tax form, they would have to have proof of health insurance. That would mean then everybody that is working would have health insurance. But he said the key to that is that that health insurance would have to be affordable. That's another thought.

Thank you very much.

MS. DAKER: Karen Metcalf.

MS. METCALF: Good afternoon. I came here resolved not to speak, but I feel as though --

MR. JORDAN: Can you identify yourself?

MS. METCALF: Yes, my name is Karen Metcalf, K-A-R-E-N, M-E-T-C-A-L-F. I'm not a resident of Illinois. My husband is a pediatrician who practices in this district in Illinois. I live in Iowa.

My husband and I lived in Canada for over 20 years. We have many points of

comparison with the system there, and we've been calling upon that experience to try to organize people here in the Quad Cities through the progressive action group that Frank Samuelson spoke of for universal health insurance, because we know, from firsthand experience, that when people have insurance it takes a tremendous strain off them. It's something that we must provide for every person in this country. If people haven't lived without that burden, they can't imagine what it feels like. But I've lived -- I grew up in this country, went to Canada, came back here, and I've seen the contrasts and I know what's possible.

I know that I'm despairing to some degree of our political process. I know this is a political process. I know that we have to engaged politics, but I also think it's time for people to start voicing their concerns

directly, that we have been silent for too long. We have been told this is too complicated an issue, and therefore we have been disempowered, and it's time for us to speak up as individuals and as groups to make

our voices heard. That's what we're doing here in the Quad Cities, both sides of the river.

Just as an aside, I have been involved with some of the people in the Iowa legislative process, including someone who's running for governor of Iowa. We are pushing for a universal health insurance plan in Iowa. You have to get the dialectic, but, you know, that's -- it's time for us to take action.

I think the context of the Institute of Medicine report, which sets a timeline of 2010 for universal health insurance in this country, is something that should be put into every public discussion about health care, including what you're about. Because it's too easy to say it's Never Never Land, it's off in the distance. We have to incrementalize it, we have to start doing -- we have to start doing it now.

Thank you.

MS. DAKER: Thank you.

Any other speakers?

MS. ARMETTA: I'm Laurine Armetta, L-A-U-R-I-N-E. No one would spell it right. She wondered what organization, well, I

represent them all, and everything's been said. UAW, the president of our union, Church Women United, Margaret, Steve -- Oh, he left.

I just came from the AARP meeting yesterday. Project Now. Margaret's husband is not here. But I also belong to the Safe Citizen Action for the State of Illinois, who is Vince Thomas.

And everything -- Like I say, all these people have pretty much said what they -- I'm not one of long words, but I haven't heard anything with No Child Left Behind. I just came from the fitness center, as you can tell this afternoon, and I hear many teachers down there that say there's lots of kids left behind down in the West End. That is a bad, bad comment of No Child Left Behind. They can't afford it, they can't -- I don't know what happens.

MS. DAKER: Are you referring to health care?

MS. ARMETTA: Well, yes, No Child Left Behind is health -- Oh, is that

education?

MS. DAVIS: That's education.

MR. JORDAN: Principles still apply.

MS. ARMETTA: Well, would be.

Anyway, as far as health, yeah, I don't take prescriptions. Those are drugs, right?

MS. DAKER: Yes.

MS. ARMETTA: Right.

I sat up in Chicago with Hillary Clinton probably five -- I don't know how many years ago, probably five. If we had some natural health care in this country you wouldn't have to build all those hospitals and hospitals and hospitals and care centers and all those things. People would be healthy.

I know doctors that have gone to Australia and Japan that wonder why they live 120 years. I'm only going to be 100. I just -- at the AARP meeting yesterday I just planted my 100-year, and then it goes from there.

But anyway, yeah, I take natural health. And that's what Hillary said, if they were on natural health it would be a lot less

25 expensive because you don't have to build all

1 the hospitals and all the high-rises and so
2 forth. Okay. That's the end of my story.
3 MS. DAKER: Thank you.
4 MS. DAVIS: Do you have many
5 natural practitioners here in the Quad Cities?
6 MS. ARMETTA: Well, my own
7 doctor's wife is in Mannatech, if you want to
8 hear the name. I can't tell you how,
9 M-A-N-N -- Oh, I left my bag in the car. But
10 if you want to look at a website look at
11 Glycoscience.
12 MS. DAVIS: Glycoscience?
13 THE WITNESS: Glycoscience.org,
14 then type in "Ambertose."
15 And it's cell-to-cell
16 communication. It helps your eyes, your ears.
17 My own son, when he -- he takes it regularly --
18 went back to the eye doctor he had his glasses
19 changed. He had to get less prescriptions.
20 I have a priest right here that
21 was taking the Ambertose and went to the
22 doctor. "What are you doing?" He says,
23 "You've got to quit taking that Ambertose, your
24 blood is too good."
25 He'd have to stop some of his

drugs or decrease them and you wouldn't have to -- I know somebody that got on it, had nine drugs. She's a diabetic. She was on Coumadin, that was good too. Well, she went to her doctor and says, "I'm not going to tell you -- or ask you if I can take it, I'm going to tell you I'm going to take it."

And he wondered what it was, and she told him the Ambertose, and he said, "Keep taking it. I give to it my wife."

But he wouldn't give it to his patients because they wouldn't have to come -- I haven't been to a doctor for two and a half years.

MS. DAKER: Well, we have another speaker, Stephen Teeter.

MR. TEETER: My name is Stephen, spelled S-T-E-P-H-E-N, Teeter, T-E-E-T-E-R, I live in Rock Island. I've been a resident of Rock Island since 1957. I'm 55 years old, and when I was about two months -- or two -- I'm sorry, two weeks from being 49 I was let go from my place of employment, which was a hospital. So I went about five years without any kind of insurance, until about two months

ago, and during that -- during that time it was really -- This was individually, okay? My wife was under Medicare Part A and B. And as was suggested before, you know, the -- most of the stuff is paid for as far as Part A and Part B, but -- but not going to a family physician until a couple of weeks ago for about three or four years, the -- you know, it's a little difficult for some people to get around, I think, to -- to -- and not know what you're -- some of your ailments and stuff are.

This -- I don't -- I know the state doesn't have any kind of thing with Medicare Part D, but this kind of don't know at all kind of thing kind of scares me a little bit.

My wife, so far, has taken medication that the actual cost was about $1,200. So she's about halfway -- We're not even three months through the time period. She's about halfway through the time where I'm going to have to pay full price for some of her medication. And some of that medication is about -- is over $200 per pill, you know, for medication. It's Lamictal. And so I'm trying

to navigate through the time to where I have the shortest amount of time to pay for, you know, the loan thing, okay?

This $5 a thing is really nice. I like this, all right. And it's -- you know, it's five or 28 or 56, whatever. It's a lot better than paying full price, all right. But then when you get to the point where -- maybe in June or July, and you get to that $2,350 limit and you have to go for the next 11 or 12 or $1,300, whatever the thing is, and you have to pay full price where you're paying $233 for a -- and at the same time trying to navigate, say, your -- I live -- you know, your house thing, for your -- the Rock Island County -- You know, they come up with where the payments are like in June and then August and then September and November.

MS. ARMETTA: Taxes.

MR. TEETER: Yeah. So you're trying to pay both your Medicare -- I mean not your Medicare, but you're trying to pay that plus that plus that, and then you end up -- you have to go to the bank and take out a loan, puts you behind on payments. I'm -- You know,

so then I'm at the point now, you know, where I get to certain times of the month or whatever and I take money -- I'm taking money -- I'm taking about 800 -- between 700 and $800 a month out of what I was going to retire on from my -- from when I was working at the hospital and I'm using that as my living expenses.

MS. DAVIS: Steve, did you know that in Illinois we have the Illinois RX? And I would just like for you to contact three organizations. All of them are coordinating entities for that doughnut hole you spoke of.

MR. TEETER: Okay.

MS. DAVIS: Pacificare, AARP, and WellCare.

MR. TEETER: Yes.

MS. DAVIS: And they may be able to give you some relief.

MR. TEETER: We're under her -- She was under that program, okay, and she was assigned the AARP, all right. But I'm thinking for the next time -- this is for next year, all right, that if I could get to Pacificare, but not like where it's a $60 a month payment.

MS. DAVIS: Right. You may want

to try WellCare.

MR. TEETER: WellCare?

MS. DAVIS: Uh-huh.

MR. TEETER: Is that Blue Cross?

MS. DAVIS: No, it's an HMO plan. But it's -- There's three plans in the State of Illinois that are working to try to do Illinois RX. Our state -- I'm not sure about Iowa -- is trying to address this doughnut hole which is very, very large for seniors and disabled people. They have contracted with three entities, Pacificare, AARP, and WellCare. And I just want you to try to, you know, investigate all three of those plans, because I think that they can help you.

MR. TEETER: I've been looking into Pacificare, and they have one plan that's like $63 a month.

MS. DAVIS: Try the other two and see what you come up with.

MR. TEETER: Okay. Thank you very much.

MS. DAVIS: Thank you.

MS. SCHNEEKLOTH: I'd like to make a comment. My name is Stella Schneekloth.

MS. DAKER: Spell your name, please.

MS. SCHNEEKLOTH: ST-E-L-L-A,

Schneekloth is S-C-H-N-E-E-K-L-O-T-H, and I'm with Project Now. It's a community action agency. And I -- I've been working for Project Now for the past 25 years, and I've seen where one of the biggest problems that I have with the people that we serve is a lack of health care. Now, we see individuals who go to work sick, who aren't able to take care of their children in the right way because they're so ill; that they let things go for so long that they've gotten to the point where there is no cure. And so I would like to be able to see that we could have some kind of health care coverage. It's not a question of people not working, it's that they cannot afford to go to the doctor. They go to the emergency room. The emergency room doctors get frustrated because they don't see them again for the after-care, then they give them prescriptions. They don't have the money for the prescriptions, so what is the point? I mean, the reason that they go there is because

they're so sick, and -- but if you can't afford the prescriptions you're going to continue to be sick unless they give you a shot or do some alternatives.

So we are very fortunate here to

have Community Health Care, but that is not the solution. The solution is for everybody to be able to access health care in the way that they should so that it would be a preventative instead of just going when there's an emergency.

And the other thing is, when you talk about health care we need to talk about dental. There's no one that covers any type of dental. It's unfortunate that people lose their teeth not because they're not trying to maintain them, but because they don't get the preventative care, and you see a lot of children suffer with their teeth as a result. Yes, there are programs available, but they're very limited. It's not like they can take care of everybody.

Thank you very much.

MR. JORDAN: What kind of population do you work with?

MS. SCHNEEKLOTH: The low-income population, and I also work with the immigrant population. And, as I said, it's not a problem that's going to go away, that I see it day-in and day-out.

We -- I'll tell you a very quick

story: We had a gentleman that was at work. He was working for a cleaning company and was cleaning and all of the sudden he doubled over. They took him to the hospital, they did emergency surgery, he had a colostomy. They left it -- And I don't know the terminology, but they left it exposed, and when he went back they said, "We won't reverse it. We won't do anything, because you don't have any health care coverage."

Luckily we had a worker at the organization where I work, and she spent countless hours talking to health care providers, talking to the hospital, and was able to make some arrangements, finally, after this went on for weeks and weeks.

He didn't even have the money to buy the --

MS. DAVIS: Bandages?

MS. SCHNEEKLOTH: Yes. And the cleaning supplies that he needed to keep himself from getting a bad infection. And so, you know, the man was willing to work, he was working, but how can you work in that condition? And then how can you allow people to suffer in that manner?

MS. DAVIS: Was that corrected?

MS. SCHNEEKLOTH: Yes, it was, but it was only after a lot of communications went between the worker and the doctor. The doctor then agreed, and he's been making payments. Not that he'll ever finish, but he's been making payments on his surgery.

MS. DAVIS: Was the worker a social worker?

MS. SCHNEEKLOTH: Actually, she's a volunteer with Counsel One of Iowa (phonetic). That's an organization here and --

MS. DAVIS: And the immigrants you speak of, are they Hispanic origin?

MS. SCHNEEKLOTH: Yes, but we deal with immigrants, period. We -- I mean, generally our organization deals with Latinos, but we feel that people are people, and if you

feel that you don't have an avenue, then you're welcome in.

MS. DAVIS: What other populations are you dealing with?

MS. SCHNEEKLOTH: We've had Russians, we've had people from Africa, so, I mean --

MS. DAVIS: We're trying to get a feel for, you know, emerging populations in

sectors in the state. So are you having a situation with language also?

MS. SCHNEEKLOTH: Well, we were able to communicate, that was not a problem. But, you know, we do -- we're very fortunate here that we do have a lot of talented people and a lot of people who are able to translate.

But I'm also talking about that other organization that just got their funding cut and that's World Relief.

Thank you.

MS. DAKER: Thank you.

No other speakers?

MR. SLAVENSKY: We deal with immigrants a lot at the health -- Rael Slavensky.

THE COURT REPORTER: Thank you.

MR. SLAVENSKY: One of the emergent populations here is West African, who are French-speaking, and we have one doctor in Rock Island County who speaks French. We otherwise have immigrants from at least 65 different nations. The last estimate I heard was that there are about -- I think it was 78 different languages spoken in Rock Island County.

MS. DAVIS: 78?

MR. SLAVENSKY: Yeah.
MS. DAVIS: That's very --
MR. SLAVENSKY: So we're a port of entry. We get people from everywhere. And because we do see them at the health department, you know, I'm aware of that.
MS. DAVIS: I was wondering --
MR. SLAVENSKY: And we have worked with World Relief in the past and they're in big trouble.
MS. DAVIS: I was wondering, since it's the Quad Cities, do you see a lot of transferring across state lines?
MR. SLAVENSKY: It depends on

the services availability. I particularly am involved in things like HIV and sexually transmitted diseases. Our services on this side are mostly grant-driven. The services in Iowa are mostly funded by the county, so they have a much broader spectrum of availability of, for instance, sexually transmitted disease services.
Also, because of differences in style. We do anonymous testing. Iowa does only confidential testing for HIV. We tend to get people from Iowa. We also get people from

a lot of other Illinois counties, simply because in very small counties people are worried about confidentiality. So there's a fairly significant amount of crossover, one reason also being that a lot of our specialist physicians are in Iowa.

MS. DAVIS: Okay, so the specialists services, they can --

MR. SLAVENSKY: For instance, the virology center who treats HIV patients, the major diabetic center is in Iowa. There are other -- We do have heart surgery and things like that on both sides of river, but

there are specialists who have gone to Iowa because of liability issues.

MS. DAVIS: Who is Community Health Care?

MR. SLAVENSKY: It's a federally-qualified health center that has offices on both sides of the river. Many of us call the river the Berlin Wall for various reasons.

But Community Health Care does span the river. They have -- Because they have to deal with two different states and two different funding sources in terms of things like Medicaid, they have their problems. They

try to do a fair amount of community outreach. We cooperate with them in certain kinds of areas.

MS. DAVIS: Does the health department relieve on the dental care?

MR. SLAVENSKY: No. We have, through our school health link program, people have gotten referred for dental care. There's a couple of programs -- Let's see, Healthy Smile. I can't remember them. It's sort of not my area of expertise, but there are

volunteer dentists who provide care.

MS. DAKER: On this side of the river?

MR. SLAVENSKY: On this side of the river, and they overlap, too. I couldn't tell you. I know it's a fairly small number. There have been a lot of initiatives around dental care. And actually, you know, in terms of the relative need, it's not adequate, but there's been a lot of volunteers and a lot of people who are working at these programs. I can't really give you the details. I'll e-mail you.

MS. DAKER: That would be great.

MR. SLAVENSKY: Because, as I

said, there's other stuff, so I'll tell her about that stuff.

MS. DAKER: Thank you. Much appreciated.

Petersen is the last name.

MS. PETERSEN: Hello, my name is Shannon Petersen. It's S-H-A-N-N-O-N. I came today solely as -- to be an observer. But I am originally from here in Moline. I currently live in Peoria, I work for a community health

clinic similar to what's here in the Quad Cities. My organization is called Heartland Community Health Clinic. We are what is called a federally-qualified health clinic. What that means is I --

MS. DAVIS: Where is Heartland?

MS. PETERSEN: It is in Peoria, Illinois.

What it means to be a federally-qualified health clinic is I get a higher payment rate from Medicare and Medicaid. Okay, and the reason I get this higher payment rate from these organizations is to support your uninsured and underinsured in Illinois, okay?

About 20 percent to 30 percent of my clinic is uninsured individuals. We work

on a sliding fee scale basis. Unfortunately, without funding from the State of Illinois, I cannot continue to provide these services, so that's where these services need to come from. I need funding from the State of Illinois to help continue to support my uninsured and underinsured.

Caterpillar is one of our

largest employers in the Peoria area, okay? Many of our union workers at Caterpillar have no coverage for primary health care services. They'll pay for emergency room, they pay for lab services, but they don't pay for doctor's visits, they don't pay for immunizations. Many of my children are going without.

The health department provides -- And I know the same thing happens here in Moline, because I used to work here in Moline at these offices, at these hospitals, the same thing happens. We need to get the word out that there are federally-qualified health clinics out there to help the uninsured and underinsured.

But again, we're running into -- I run into, so many times, people that are the working poor. We've got Mom and Dad both

working, they've got three children, they're making a decent living to where they can pay their rent, they can put food on their table, but they make too much to qualify for Medicare and they make too much to qualify for my sliding fee scale.

MS. DAKER: A question on

Caterpillar, if you know, they don't pay for preventative care or else is there --

MS. PETERSEN: They don't pay for office visits.

MS. DAKER: Is that across the board, or is that only if you don't pay a certain amount?

MS. PETERSEN: That's for their union workers. Management workers they pay 80 percent. The union workers are my working employed. They're my moms and dads with children, they're my retirees with Medicare that still have that 20 percent co-insurance.

MS. DAKER: How many people are insured by Caterpillar?

MS. PETERSEN: Jim would probably be a good one. You're from Peoria.

MR. MOORE: Well, the UAW is down to 7 or 6,000, significantly. Used to be 29,000.

MS. PETERSEN: Right.

You know, I mean, and you've got your elderly who are retired and living on a pension. You know, one major thing you guys really need to push with this Task Force is

education. I can't tell you how many of my elderly patients I have come in asking questions about this Medicare Part D. I have been to so many conferences on this trying to understand this myself to try and explain it to my elderly. And it's a difficult thing for me to understand, let alone my elderly patients, and I can't explain it to them. Get them affordable health coverage, get them the drugs that they need, get them the drugs -- I -- It's impossible for me to try and explain it to them without me spending at least an hour on the phone with their chart in my hand going over each and every medication they're on with that insurance company to see if it's covered and at which tier level it's covered. When I've got 7,000 patients in my clinic, and that's just one patient, I don't have, in an eight-hour day, that much time to spend on the phone with an insurance company, okay? The education needs to be there and it's not. It is not at

an education level that is understood by these patients.

So whenever you put out literature you guys have to remember to put it

as 5th or 6th grade education level, because that's the majority of what my elderly patients -- that's what education level they're going to understand. And unfortunately the coverage that I have seen come out -- the literature I have seen come out on Medicare on this Medicare Part D, I have a hard time understanding it. My patients are not understanding it.

MS. DAVIS: I was going to ask you, is your clinic at Heartland getting any of the community expansion dollars from IEPH?

MS. PETERSEN: We are getting some, but it's still not enough to substantiate, you know, my uninsured and underinsured. We are pushing, you know, to -- our goal is to support the uninsured and underinsured of the Peoria area, and we are accomplishing that goal, but it is a very hard goal to accomplish. It's getting the word out that not only are the clinics here in the Quad City area as well as the Peoria area as well as the Bloomington area, that type of thing.

MS. DAVIS: Are you running a deficit?

MS. PETERSEN: At this point we're running pretty level. But the problem is the word is not out there. You know, we need to let these people know that there are the clinics out there, there is access to health care.

Another barrier a lot of my patients run into is transportation. We try and help with that barrier, but we can't help all the time. You know, our -- You know, our costs to cover transportation are just as great as any other organization. You know, again, the money has to be there. It has to come from the state for us to provide these services to my patients.

MS. DAKER: You say you get a higher rate from Medicaid and Medicare. Is there -- Does it match dollar-for-dollar?

MS. PETERSEN: Sometimes. I'm not a fee for service clinic, I'm an encounter-rate clinic, meaning I don't get paid for every procedure I perform, I get paid one set fee.

MS. DAKER: And what is that

called again?

MS. PETERSEN: I'm a federally-qualified health clinic. I get an encounter rate.

MS. DAKER: Thank you.

MS. PETERSEN: Thank you.

MS. DAKER: We'll get you all up here.

MR. SMITH: Can't leave until everybody talks, right?

MS. DAKER: There's a couple people in the back row.

MS. DAVIS: Do you want to say something?

MS. STARLING: I'm concerned there's no --

MS. DAKER: You need to come up and say your name,

MS. STARLING: I'm not a very good speaker.

MS. DAKER: That's all right.

MS. DAVIS: State your name.

MS. STARLING: Cathy Starling, S-T-A-R-L-I-N-G.

I'm concerned about there's no -- no programs for people who are single.

MR. SMITH: So you're saying you're under the federal poverty level -- or single person that is --

MS. STARLING: No children --

MR. DAVIS: No children.

MS. STARLING: -- and you can't get a Medicaid card. There's some programs in there, but they're limited. There are programs where people have children, but for single people there are no programs available.

MS. DAVIS: I was wondering, have you availed yourself of the Community Health Care?

MS. STARLING: Yes, but -- They run a good program, but it's limited, especially for people who are disabled, and to get a medical card their criteria is very, very strict. It takes a very long time, and meanwhile there's people -- their medical condition gets worse because they can't afford to get to the doctor or medication, and it's just -- it's just hard.

MS. DAVIS: What about using the health department? Does the health department have chronic illness care?

hereby certify that I was called in the capacity of a Certified Shorthand Reporter to report the foregoing proceedings in the above-captioned matter and that same was taken down by me in stenotype and later reduced to Computer-Aided Transcription under my supervision and direction, and that the foregoing Transcript of Proceedings is a true and accurate record thereof.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which these proceedings were had, and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

Dated at Davenport, Iowa, this 29th day of March, 2006.

CERTIFIED SHORTHAND REPORTER.

(Inaudible, unidentified person speaking from the back of the room.)

MS. DAVIS: Enough said. He said no care.

Okay, thank you.

MS. STARLING: You're welcome.

MS. DAKER: Appreciate it.

MS. DAVIS: Jan, we usually take a little break and we go out and talk with the people, and then you have a cutoff date -- time.

MS. DAKER: Sounds good to me.

(Whereupon, a recess was taken.)

MS. METCALF: Karen, K-A-R-E-N, Metcalf, M-E-T-C-A-L-F.

Our group, Progressive Action for the Common Good, is collecting 18,000 handprints here in the Quad Cities to represent the 18,000 people who die unnecessarily every year because they lack health insurance. And the 18,000 number is out of the Institute of Medicine report. I don't -- Not quite sure what she wants me to include, you know. But we're enlisting churches, we have civic organizations, we have -- We haven't yet

mounted a major publicity campaign because we want to get a little bit further along, but we've been doing it -- We started last April, so we're into our 11th month of it. We would like to get them collected within the next few months. We will be doing a major push to uncover the uninsured the first week in May. We will take those handprints, when we've collected them, to Springfield, to Des Moines, and then on to Washington. The purpose of doing it is to empower the people in the Quad Cities to believe that they can be involved in this process for change, and then to give publicity to the Institute of Medicine report, which calls for universal health insurance by 2010.

(Whereupon, a recess was taken.)

MS. DAKER: As there are no more speakers, we are officially adjourned.

(Whereupon, the hearing concluded at 6:00 p.m.)

THE REPORTER: The hearing is now complete. When transcribed, the original of the hearing shall be delivered to Ashley Walter.

(UNLESS OTHERWISE DIRECTED BY COUNSEL OR THE PARTIES HERETO, THE STENOGRAPHIC NOTES FOR THE FOREGOING HEARING SHALL BE DESTROYED AFTER A PERIOD OF 3 YEARS FROM THE DATE OF TAKING OF SAID HEARING.)

C E R T I F I C A T E

I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do