ORIGINAL

18TH CONGRESSIONAL DISTRICT PUBLIC HEARING OF THE ADEQUATE HEALTH CARE TASK FORCE UNDER THE HEALTH CARE JUSTICE ACT

REPORT OF PROCEEDINGS of the meeting of the Adequate Health Care Task Force for the Illinois Department of Public Health, heard on the 1st day of February, 2006, at the Peoria Civic Center, Room 220-222, Peoria, Illinois, 61602.

A P P E A R A N C E S

MEMBERS OF THE ADEQUATE
HEALTH CARE TASK FORCE:

DAVID KOEHLER, Chair
KENNETH SMITHMIER
JAMES A. DUFFETT
CRAIG BACKS
RALPH SCHUBERT

SPEAKERS:

MR. KOEHLER: Good afternoon. We have 4:00 so we'll begin. First of all, let me introduce the panel here. We are the members of the Adequate Health Care Task Force.

To my immediate right is Ken Smithmier, a member of the Task Force. I'm David Koehler. I'll be your Chair this afternoon.

To my immediate left is Jim Duffett, and Dr. Craig Backs next to him. And then we have as well Ralph Schubert who is from the Department of Human Services from Springfield, and also our stenographer this afternoon is Kathy Johnson.

I'm going to read to you just a brief statement that we read at each hearing just to be consistent with what we do to start out the hearing.

I've already welcomed you. This is the 18th Congressional District public hearing for the Adequate Health Care Task Force, which is under the Health Care Justice Act.

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

Access to health care is most affected by the ability of those seeking care to afford the services that they need.

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

Many in Illinois lack access to health care systems because they lack health insurance. And on any given day an estimated 1.8 million of our citizens are without health insurance.

Additionally, a growing number of people are under-insured and the consumers also pay a share of the cost of health care, which is growing.

While Illinois has many safety

net providers that attempt to narrow the gap between the insured and under-insured, including public and private clinics, public hospitals, and chair to chair administered by private hospitals.

Many of the under-insured lack adequate access to preventative and comprehensive care.

The Health Care Justice Act signed into law by the Governor in August of 2004 encourages the State of Illinois to implement a health care plan that provides access to a full range of preventative and acute and long term health care services and that maintains and improves the quality of health care services offered to Illinois residents.

The Health Care Justice Act creates the Adequate Health Care Task Force which has undertaken the task of developing this access plan.

The 25 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 our work the Task Force will be holding at least one public hearing in each congressional district to seek input from the public as we work to develop this plan, and that's why we're here this afternoon.

So 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 and for taking part in this important process. I'd also like to thank the Peoria Civic Center for providing this space to us.

Before we get started there are a couple of housekeeping issues that must be addressed, but before I do that let me introduce as well David Carvalho who is from the Department of Public Health and who is one of our staff people that is guiding and directing the work of the Adequate Health Care

Task Force.

If you have not done so already please sign in at the table when you came in so we know that, who you are in terms of your attendance.

This will help us track the number of people that have been attending our hearings.

It's also important to get some of the handouts that are available. It provides more information about what the Health Care Justice Act is and about the work of the Adequate Health Care Task Force and this public hearing.

Secondly, if you wish to testify be sure to sign up also at that same table. Individuals will be called to testify in the order in which they sign up.

You have these yellow sign-up sheets here. We're just going to read them in order as I get them. Then I'm going to actually have you, I'll call your names in numbers of five. If you would come up in the front row so we can have, you have easy access to the microphone.

If you have written testimony you may either leave it up here on the table with me or you may leave it with Ashley at the sign-in table as you go out the door.

You don't have to testify, or if you have written testimony you can just leave us your written testimony as well.

If you are going to give us oral testimony then we would ask for the benefit of the reporter, who's going to take all this verbatim, we keep all these hearing minutes and you can access them on the internet as well, but please spell your first name if it's somewhat difficult.

Spell your last name. Pronounce it very clearly so that we can have that as part of the record.

You get three minutes and, Dave is going to do that. This is always the prize job of being the time keeper.

But we'll give you a notice when

it's one minute remaining, and then what else? 30 seconds? No. No. Out of time. One minute and then out of time and then we cut you off.

Anything else I've forgotten? With that, let's call the first five people up here. Roy Ricketts, Mike Everett, Harry Wolin, James Polk and Joyce Harant.

And we'll start with Mr. Ricketts.

MR. RICKETTS: Thank you, Dave. Thanks for the opportunity to share a few thoughts regarding our health care system today.

My name is Roy Ricketts, R-O-Y, R-I-C-K-E-T-T-S, and I am president and CEO of the Peoria Association for Retarded Citizens as well as Board Chair of the Arthritis Foundation, a greater Illinois Chapter.

I'm an advocate for persons with disabilities as well as an employer providing services to individuals with developmental disabilities.

Healthcare is a major issue in

each of my roles. From these perspectives there's two major holes in the current system that I would like to address.

The first is that people with disabilities and/or their families are often denied insurance because of their pre-existing conditions.

From a workforce standpoint they're often unable to even explore new employment opportunities if they have insurance with the existing employer that are excluded by a potential employer. They become a virtual prisoner of their disability.

The second role parallels the first and has to do with the working poor. These are people trying to provide for themselves and their families, often working two jobs but can not afford premiums or payment deductibles and co-pays even if they have coverage.

For those in this situation with major health issues it often leads to abandonment of jobs in order to access Medicaid coverage.

Certainly there are no easy answers to the healthcare dilemma. I suggest that as government, businesses, health care providers and the insurance industries study this problem that they look beyond currently available data and statistics and try to project the cost of not fixing the flaws in the system.

Government can't afford today's cost of Medicare and Medicaid, and demands for these programs will rise exponentially.

So I think collaboration is essential. We are the wealthiest nation in the world. Access to health care by all citizens must be the top priority. Thank you.

MR. KOEHLER: Thank you very much. Mike Everett.

MR. EVERETT: Good afternoon. Mike Everett, E-V-E-R-E-T-T. I'm the current president of the Labor Council of West Central Illinois representing approximately 120 affiliated unions and over 20,000 union members of central Illinois.

Health care, or more correctly the cost of health care, is the single most troubling issue on the bargaining tables everywhere in central Illinois, and probably the United States.

The rising cost of health care overshadows all other issues on bargaining, on collective bargaining.

It is continuing to erode our standard of living as it devours any potential wage increases at a rate that makes rising gas costs look good.

The clock is ticking. Something needs to be done. My daytime job is acting business manager of the International Brotherhood of Electrical Workers, Local 34.

As business manager I serve as a trustee on a labor management health and welfare fund.

Our health and welfare fund is fairly large. We have 27 participating local unions and hundreds of participating contractors across eight states.

Our plan covers over 27,000 members, spouses, and dependents. We have nationwide preferred provider arrangements with Blue Cross/Blue Shield.

We have arrangements with Guardian Dental and MetroHealth on drugs. We are large enough, we're a large enough group to be able to negotiate some of the best discounts for health care that can be found in this country.

With that said, I'm here to tell you that we're going out of business. Chasing health care costs in this country is putting us out of business. Health and health care cost shifting is putting us out of business.

As a private payer paying for the uninsured and picking up their cost shift from inadequate Medicare and Medicaid programs is putting us out of business.

The Federal minimum wage is $5.15 an hour. It's a little higher in Illinois, but in most states it's still $5.15.

That just happens to be our hourly contribution rate for each hour an electrician works.

A month's coverage requires 140 hours or $721.00 a month. When my members are unemployed they can continue their coverage with their COBRA rights by self paying $610.00 per month.

This is next to impossible to sustain if you're drawing unemployment for an extended period of time.

So one of the points that I do want to make is well paid, hard working construction workers are periodically going without insurance several times in a year.

Unfortunately, most of my members, or a lot of my members are playing Russian roulette with health insurance coverage.

Many of them and their families are going without insurance for extended periods of time in order to make ends meet.

They're rolling the dice hoping

no one gets sick so they can pay their mortgages, utility bills and put gas in their car.

My membership experienced a 71 and a half percent increase in their contribution rate over the last four years. As their reward they also have higher deductibles, more out-of-pocket expenses, and less all around coverage.

Something has to be done. Private payers like us are an endangered species in this country.

We will soon be joining the ever growing ranks of the uninsured. And when that happens the health care industry in the United States will collapse, unless of course you believe the Federal government is going to do something about this mess.

I personally wouldn't bank on that. They seem to have a little conflict of interest out there in D.C.

There's a little conflict between where most of the campaign contributions come from and the interests of the people they're supposed to be representing.

In conclusion, this health care, this country's health care system has already failed more than 45 million Americans.

It's going to take, how many more is it going to take for this country to wake up? My electricians are going out of business chasing health care costs.

We are going out of business competing with uninsured and pensionless electricians locally because we pay our own way and we pays theirs too when they go to the emergency room.

And, finally, my opinion, all American workers are in the same sinking boat when it comes to competing globally.

Our failed health care system has tremendous cost to the dwindling number of products we still produce in this country.

A universal health care system for all Americans would improve our competitive position.

It appears, however, that we intend to level the playing field globally with an unhealthy and uninsured American work force.

We can do better than that, and we need to start right here in Illinois. We cannot afford to wait on Washington D.C. They think everything is fine out there. Thank you.

MR. KOEHLER: Harry Wolin.

MR. WOLIN: Thank you. Good morning, or afternoon. My name is Harry, H-A-R-R-Y, W-O-L-I-N.

I am the administrator chief executive officer of Mason District Hospital in Havana, Illinois.

I first want to thank you all for holding these Task Force hearings. We think they're important. They address a very serious concern that is really facing all of us.

I would echo the comments that have already been made and add that as a provider we share those same concerns.

Mason District Hospital, we've been designated as a critical access hospital. We serve the residents of Mason and southern Fulton County. It's a huge geographic area but it represents only about 25,000 people.

We've been concerned with this crisis because we are the only provider of health care in that area.

We supported the Health Care Justice Act and we work hard with you to find a solution to this problem.

While it is truly a national problem that's going to require support from Washington to answer the concerns of ERISA and the issues that are addressed through that law and its impact on working companies that are self insured, the efforts to start in Illinois are important and must be continued.

Mason District Hospital and hospitals all across the State are committed to serving the needs of the residents in our community.

As the only provider meeting

those rural isolated communities we treat every patient who shows up at our door 365 days a year, seven days a week, 24 hours every day.

Our patients in the communities depend on this. They turn to us in times of crisis. When they don't have coverage, when they can't get in to see the doctor, they show up at our doorstep.

We truly are the health care safety net for the uninsured and the underinsured.

Last year Mason District Hospital provided uncompensated care, almost nine percent of our revenues, over 11 percent in our operating expenses.

This is a cost that is making it very difficult for us to sustain operations. And yes, we shift cost but it's not enough.

The problems of unemployment, underemployment, in rural communities has been well documented. And the area that hasn't been documented is the issue of the uninsured in rural communities.

I can tell you some anecdotal evidence and data that it rivals those of the inner cities in terms of the percentage if not the numbers.

But our contribution as a rural provider goes beyond just meeting the financial needs of the people we serve.

But we, through the underwriting of the Central Services, we operate two rural health clinics; we provide an emergency room with a staffed physician 24 hours a day.

And to those who live in an urban area that may not seem like a big deal, but in a rural community to not have an emergency room physician available when you hit the door means the difference between life and death.

And let me tell you, it is expensive but a cost we gladly bear because that is our mission.

We also operate two ambulance services. Actually, it's one ambulance service, two ambulance bases covering the geographic area that we serve.

Another area of critical need to the rural communities, and one that is grossly inadequately reimbursed not only by insurance companies but by the third party payers, Medicaid and Medicare as well.

In addition to this we face the typical cost of any health care system; pharmaceutical costs, forced costs, the medical liability crisis that was addressed last year, but has yet to result in financial savings to any of the providers.

And, quite frankly, we are the first responders in terms of crisis. While we were all geared up for bioterrorism, luckily we have not had to deal with that, but we deal with tornadoes every year.

This is the first year that we have not had any loss of life from a tornado in our area or any loss from damage, but it is something that we're always responding to.

In spite of these challenges we continue to provide quality life-saving services. We provide a vital economic link to the communities we provide.

We are the largest employer in the county, and the fact that our 200 jobs represents a tremendous boost to the economic engine of our rural development, it is something that is crucial.

With our farmers, with our small employers, it is something that is very important to maintain the basis of communities.

I can't do this in three minutes. I'm going to cut through a lot and it will be in the written testimony that I submit, but I would mention to you that hospitals cannot solve this alone.

It's going to take a broad base of support both from industry, from employers, and from government. And we thank you for your consideration.

MR. KOEHLER: Thank you. James Polk.

MR. POLK: I'm James Polk, J-A-M-E-S, P-O-L-K. I'm delighted to be here today. I have one thing to say before I start is that I think that the time of the day is the wrong time.

I am, because from 4:00 to 6:00 a lot of working poor is getting off of work who do not have insurance, and so they don't have the opportunity to come here at these meetings, so I would hope that you would take that back to have them a little bit later in the evening instead of 4:00 in the afternoon.

I'm James Polk and I'm representing an organization called Family Involvement in Education, and we are developing local neighborhood school councils in all of the schools, and health care is very, very important for everyone, and especially a lot of people in District 150.

There's 62 percent of the kids that go to District 150 is in poverty somehow or involved with the lunch program; so therefore, their parents and families are working and do not have insurance.

So I'm very delighted for you being here, and that we need as a community, and as you said here today, I am a, I had polio when I was a kid and I have had childhood rheumatoid arthritis all my life, so without health care I would have been dead by now.

So I want to say that the importance of health care to all of us, in order for young people to achieve in school they have to be healthy.

And so health care, and their families, in order to work two or three jobs, health care is so very important.

So as a political process, move forward. I hope that it's not just talk because in 1981 when Quinn Young was talking about, and he's on your, you guys was talking about universal health care, and nothing has happened as of yet.

So I just plead with you to move the political process along, and you need to start staging these meetings at a later time in the day. Thank you.

MR. KOEHLER: Thank you. Joyce Harant.

MS. HARANT: Thank you for this opportunity. My name is Joyce Harant, J-O-Y-C-E, H-A-R-A-N-T.

I'm the president and CEO of Planned Parenthood, Heart of Illinois, and I've been in that position since 1979.

I believe that we need a health care system that puts an emphasis on preventative health care.

We need to devise ways to provide financial incentives so that we can move from a sickness oriented view of the health care system to one that promotes wellness.

And this requires, I believe, change in how we reimburse what is reimbursible, moving away from that office visit is reimbursed to looking at something more wholistic.

And of course reproductive health care services we believe are primary health care for most women and men.

Universal access is needed that is nonjudgmental, confidential, client-focused and comprehensive.

Young people in Illinois also need to maintain their access to confidential reproductive health care services. Planned Parenthood is also a small business.

Every year we're going out and trying to bid out health insurance, and when people have to change health insurance plans, provider, physician-patient relationships change, I believe it has a negative impact on health outcomes and on malpractice.

Planned Parenthood's also a health care service provider, and we're a really uncomplicated provider.

Yet, it is so astonishingly difficult to bill for just a preventative health care service to private insurance or the government through Medicaid or Medicare.

Every time a target niche group has provided some really important health care, mammograms, cervical pap smears, whatever, the government is spending millions of dollars to figure out how we're going to enroll people, how we're going to make them eligible, what forms we're going to use, what codes, and then providers have to figure out how they're going to bill for that, adding tremendous administrative burden.

We are contractors with different health insurance plans. We have to contract each individual plan. Each of those plans says now we have to credential every provider. And the burden just keeps growing and duplicating.

And this insanity is going to strangle, well, it is strangling the whole system, and it's going to collapse.

I think we must get administrative uniformity to remove the costly duplicative processes that are removing millions of dollars, billions of dollars out of direct health care and increasing the administrative cost of doing business.

It seems to me that one can only get this kind of uniformity if all people are covered for health care services, everybody has services and access, and one entity is responsible for the payment of services, so everybody has access and one entity is responsible for payment. Thank you.

MR. KOEHLER: Thank you. Before I call the next group let me just introduce that we have somebody representing Senator George Shadd's office, Peggy Messinger. Peggy, are you here? Thank you for joining us.

Also, let me mention that we will, we're prepared to stay here until 7:00 if there is testimony.

The reason we changed the hearing official time from 4:00 to 6:00 is that in many places we were waiting that last hour with no one there.

So we'll go to 4:00 to 6:00, but if there's more people to testify and people are here and want to do that we'll stay until 7:00.

We'll stay, I'll stay later than that. But we can, they'll stay with me. Let me call the next group up. Anna Saxon.

There's going to be Carol Ladwig

speaking for Glen Barton; Gil Nolde; and Nelvie Anderson. So Anna, you're first.

REVEREND ANNA SAXON: I am Reverend Anna Saxon, A-N-N-A, S-A-X-O-N, and I rise to testify before this body today as a clergy person serving a local congregation as an on-call chaplain in a local hospital as well as just simply a concerned citizen of the State of Illinois.

For many citizens of the State of Illinois the need for assistance in obtaining the basics has increased in recent years, and more and more people are turning to churches in an attempt to meet these very basic needs.

As a clergy person serving a local congregation I witness the need firsthand. Most pertinent to this hearing is a phenomenon that has recently become increasingly and very prevalent.

I've personally fielded as many as six requests in a one week period for assistance to fill prescriptions for much needed mental health, and acute and long term disease medication.

A week does not go by in our office that I do not receive at least one request for medications. And those requesting this help fall into every age range across the spectrum.

For some the request is made at the end of the month when they suddenly find themselves out of money and yet suddenly ill enough to require prescription medications.

Others make too much for State and Federal programs but not enough to cover the cost of regularly needed medications for chronic illnesses.

Let me assure you that our congregation does its very best to assist people in need. And indeed, we give out thousands of dollars a year for just such situations.

However, we are not a pharmacy; we do not have the means by which we can purchase medications for people without physically going to a pharmacy ourselves.

Lastly, we do not have limitless funds to utilize in assisting people in securing very necessary medications for themselves or their children.

It certainly breaks this pastor's heart to hear the desperation in a parent's voice as they try to secure much needed asthma medication for a child just released from the emergency room after an acute attack.

It deeply hurts me when I hear a concerned voice of a wife who is trying to obtain critical medication to keep her husband who suffers from bi-polar disorder mentally healthy and not be able to meet these needs.

These calls also leave me wondering if these are the people reaching out to the church for aid how many more are out there who don't call our church for assistance.

Now, as an on-call chaplain at a local hospital I see the unnecessary tragic and expensive flipside of these situations.

I am in the intensive care unit to support a family where someone who has not had the financial means to remain on their mental health medications is now being treated for an attempted suicide.

I am in the emergency room to comfort the elderly spouse who is sitting beside his wife's bed.

They did not have the financial means to obtain their medications to prevent another exacerbation of congestive heart failure and now she's critically ill.

The cost of medications for these kinds of events can not be as much as the cost of having a family be forced by medical necessity to become fully dependent on Medicaid and other forms of State Aid.

The cost of medications cannot be as much as the cost of housing an elderly person in a nursing home for the rest of their life because they become too ill to be independent.

The cost of mental health drugs cannot be as much as repeated stays in State funded or mental health institutions.

I'm a Presbyterian clergy person and our Presbyterian system covers all people, regardless of pre-existing conditions.

Premiums are paid by the employer based on a percentage of employees' salary and the deductibles and out-of-pockets are a percentage of the employees' income.

There is obviously ways to make programs where all-in work. Other organizations in other states have designed all-in programs that work as well.

It is time for health care to be treated as a basic service for all people that all people deserve and not as a luxury that the wealthy can afford.

I believe this is a matter of justice. It's a matter of fiscal responsibility, and it is a matter of improving the overall health and well-being of the citizens of the State of Illinois.

Thank you for seeking public input across the State, and especially today. Thank you.

MR. KOEHLER: Thank you. And then Carol Ladwig reading a statement that Glen Barton wishes to enter into the testimony.

MS. LADWIG: My name is Carol Ladwig. It's C-A-R-O-L, L-A-D-W-I-G, and this is Glen Barton's statement. It's G-L-E-N, B-A-R-T-O-N.

I am sorry I can not be in Peoria today to personally deliver my message. My name is Glen Barton and I'm a retired chairman and CEO of Caterpillar, Inc., a fortune 100 company.

During my latter two years of leadership at Caterpillar I was also the chairman of the Health and Retirement Task Force of the business round table.

This organization represents approximately 150 other countries' largest employers, with employment exceeding 10 million in annual revenue is more than four trillion.

During my leadership role the HRT became major advocates of Medicare and Medicaid reform and were directly involved in the passage of Medicare, of part D of Medicare, which provides prescription drug benefits to Medicare and Medicaid recipients.

While far from perfect, this plan at least starts to address one of the major Medicare deficiencies.

I should add at this point that these comments are my personal thoughts and in no way should they be construed to represent the position of Caterpillar, Inc., or the business round table.

Since retiring from Caterpillar I've become a student of the health care situation in our country.

I am discouraged by what I am seeing; 45 million Americans are without health care; our businesses are becoming non competitive with other countries' products because of the health care costs.

And he has a number of other reasons that I, in the interest of time. In summary, I submit our health care system is badly broken and in need of dire changes.

So where do we go from here? Let's look at first at the positives. We have very good health care facilities and excellent health care providers.

The largest things hindering their performance are (1) administrative costs associated with receiving compensation for services provided; (2) malpractice insurance.

And (3) the continual need to invest to stay competitive, so rather to require legislative changes; medical liability caps; and elimination of anti-trust considerations preventing hospitals from cooperating on specialized services provided.

The quickest and simplest solution to receiving compensation for services provided is to go to a single payer system. Oh, well.

We have such a system today for the elderly. Medicare. It works amazingly well in my opinion.

We pay for this part A through the Medicare tax on wages and income. We have the option to purchase B.

My first proposal extends Medicare to not only the elderly but also the uninsured. People with income less than two times the poverty level should receive this coverage free, just as children from lower income families receive free or reduced school lunches.

Payments by others would be on the basis of annual income with everyone required to have coverage.

This eliminates the huge liabilities health care providers have, and lets them do what they're supposed to do, provide medical services to the ill and the injured.

My second proposal is health care premiums should be treated as tax deductible expenses just as school taxes are.

And furthermore, employer paid premiums should be treated as wages and benefits and not treated as tax deductible expenses by companies.

These premiums set by Medicare would be paid directly to Medicare. This will make the employees more cognizant of their health cost and cause them to be better health care consumers while getting companies out of the health care business.

And our nation must become more involved with lifestyle issues; smoking, obesity, poor diets, lack of exercise, etc.

If we are to reduce our health care cost rate of increase to any significant degree ideally premiums should be risk rated, but this may make health care even more unaffordable for many of the low income groups.

Our best minds are needed to be challenged to address how this issue can best be managed.

MR. KOEHLER: Thank you very much. That was a lot to read. And all of these are going to be available on our web site, all of the proceedings, even the oral testimony. Gil Nolde.

MR. NOLDE: My name is Gil Nolde.

That's G-I-L, N-O-L-D-E. I'm a volunteer director on the Central Illinois Agency of Aging.

We are a not-for-profit social service agency aimed at improving the health and the quality of life of older adults in the six county area of Marshall, Stark, Woodford, Peoria, Tazewell and Fulton counties.

I speak on behalf of the advocacy of the agency. I want to speak first to the idea of accessibility and quality of health care.

Quality training and education are necessary for providing Illinois' future health care work force with the tools and experiences needed to equip them in delivering quality services.

State and Federal policy and resources at both levels are needed to continue to support new and existing primary physician and other health care professional training programs to reduce the cost of health care, to increase quality, increase patient satisfaction, and decrease both morbidity and mortality.

Advocating for appropriate inter-disciplinary education among health and social service professionals, shared curriculum educators, et cetera, could bring more of a harmonization of a health care system delivery system and less of a fragmented approach in addition to being more cost effective.

Many times older or disabled individuals are unable to access services in a timely manner due to a limited number of providers who accept Medicare and/or Medicaid.

The problem is exacerbated when the individual lives in a rural area. Advocated for an expanded definition of primary care to include service delivery by multi-disciplinary health care teams would allow for an additional qualified pool of health care service providers.

When a situation demands involvement by, or consultation with a specialized physician who is not available in that location alternative forms of service delivery such as electronic forms, telemedicine, telemonitoring, teletherapy, et cetera, should be available, accepted and have comparable insurance coverage.

The rebalancing of long term care services is already underway in Illinois, so we'll skip that paragraph and go to the next point real quick.

Prevention. Obviously, prevention is a critical aspect especially for older adults.

And if regular physical activity has been shown to be benificial to good health, as it has, then the value of that physical activity needs to be validated by more consistent coverage of structured physical exercise programs.

And, in addition, we need education for older adults and their caregivers on what kind of and how and how to get access to more physical activity.

Finally, and perhaps most

importantly, the whole area of mental health among older adults. Mental illness has been shown to aggravate and worsen a wide range of medical conditions.

Mental health then becomes a critical element in reducing hospital stays and preserving health care dollars.

There's a need for awareness by mental health and physical health care practitioners of the interconnectedness of body and mind, and they need to be encouraged to work together to best serve the consumer in a wholistic manner.

And to sum up the very last point, they both need the same kind of insurance coverage without discriminating against the mental health practitioner providers. Thank you.

MR. KOEHLER: Thank you. Nelvie Anderson.

MS. ANDERSON: I'm Nelvie Anderson. That's N, like in Nancy, E-L-V, like in Vickie, I-E, Anderson, A-N-D-E-R-S-O-N.

I'm with Church Women United and with the Interfaith Alliance. The large reductive middle class of this country has made it the great country it is.

With its capacity for considerable buying power it has given us a strong economy. At present, this group is shrinking as it is being squeezed with lowered income and increased expenses.

This cost, the cost of health care is a major factor in this decline. How will this affect our country in the future?

A woman told me of a couple that went into the hospital; she did not survive but he did. Without insurance all of his savings and retirement were gone.

He only had his home left and he could not sell that as the money would go for medical expenses.

Thinking he had a comfortable retirement he was left with nothing. Many people cannot afford to pay the high cost of health insurance.

From 2000 to '04 premiums rose 36 percent, while earnings rose only 12.4 percent. In Illinois two million people are uninsured with most of them working.

One thousand dollars is added to the cost of the family health insurance premium each year to cover the cost of the uninsured.

Some companies large and small can no longer afford to provide the health insurance they once did and are passing the cost to their employees.

Retirees are not always provided with health care at a time when their income is lower and health needs increase.

50 percent of the bankruptcies are due to health care. We are all only one health care crisis away from bankruptcy. We are in a health care crisis.

We need to simplify our health care system. It is a patchwork with programs put in place to cover loopholes, most having their own administration.

In the U.S. we pay three times as

much as Canada for health care related paperwork and administration. We spend twice as much as other industrialized countries for our health care.

The issue is we need more health care for our dollars, not more dollars for health care.

Needed is quality health care that is accessible, contains cost and is affordable for all, fair for the people, business, industry, and taxpayers.

Health care should be fair and available to all income and age levels, have portability, have no restrictions or previous conditions, emphasize prevention.

Health care needs to include wellness, dental and mental care, plus prescription drugs. It needs to cover braces, hearing aids, dentures, items necessary for prevention but too expensive for many people.

The National Coalition on health care states that universal health care will save more money and cost less than our present system.

With everyone in one system, the healthy and wealthy, the poor and the less healthy, no one will be left out. We all need to be in one system to make it work.

Containment of cost will serve as an economic incentive for attracting new businesses in Illinois. Health care does not need to be a part of contract bargaining.

American companies will be more competitive as the cost of health care will not be added to products.

Currently, the auto industry adds over one thousand dollars to the price of a car to cover the cost of health care, while foreign companies do not need to add this cost.

The cost with change to a new health care system must be done in increments and will take time, but change is an economic necessity and a wellness issue.

Our concern needs to be for the good of the whole. We are in a health care crisis. With the eyes of the country on us we have the opportunity to be a pacesetter. Will Illinois have the courage to change?

MR. KOEHLER: Thank you. Before we call the next group up let me just check with the Task Force here.

Generally we take a short break at 5:00 just for about two or three minutes. So Joan Krupa, Betty Jones, Sherry Sherman, Michael Brown and Michael Vidus.

Go ahead, Joan. You're up there first.

MS. KRUPA: My name is Joan Krupa, J-O-A-N, K-R-U-P-A, and I'm the CEO of Heartland Community Health Clinic in Peoria, Illinois.

The mission of Heartland Community Health Clinic is to provide accessible, high quality, comprehensive primary health care services for the medically underserved, and this is important regardless of ability to pay through collaborative community partnerships.

Today we are celebrating our

second year as a, having a birthday party down here as a Federally qualified community health center.

And in that time we've grown from 849 patients to over 7,000. Now, if that isn't an indication of health care crisis in our community and in our area, I don't know what is.

I have a bunch of services that we offer as a community health center but I also am suggesting that the community health center model, the FQHC model, is one of the answers to our growing crisis in this state.

Today over 800,000 patients are served in community health centers in Illinois. In 2005 Illinois FQHC's served over 325,000 uninsured patients, and those patients had 78 percent having income at one hundred percent or below Federal poverty guidelines.

FQHC's saved the State of Illinois 81 million dollars annually, and that's according to an IDPH study of literature review on the impact of health centers on State

Medicaid spending.

Increased usage of health centers resulted in reduced ER care that's been mentioned before, and could save the State annually 343 million dollars according to a published study by the National Association of Community Health Centers.

Also, we do this in a way that provides quality. For example, in our first year of operation we were JCAHO accredited, so we serve populations by fostering provision of high quality, comprehensive care that is culturally sensitive, linguistically appropriate and community directed.

These efforts should be applauded enthusiastically, but more importantly funded appropriately.

I have three suggestions for providing access; fund additional Federally qualified health centers within the State of Illinois through the CHC expansion grant program.

Right now we spend about 3.5

million dollars in getting expansion of care. We need more than that. If we do that we can leverage additional Federal dollars.

Second suggestion; affordable medications through FQHC's 340B program; increase patient compliance and reduce health care costs overall.

The FQHC model allows for a 25 to 75 percent discount off of retail drugs for patients that are enrolled in FQHC's. Another reason to grow the model.

And the final is, legislators must resist the temptation to reduce Medicaid funding for the State's most vulnerable populations.

We're in a budget crisis but let's not, the model only works, FQHC, works only when Medicaid reimbursements are timely and fair.

It may be tempting in the short term to massage State Medicaid reimbursement, but then FQHC's serving close to a million Illinois residents will go out of business.

Only 20 percent of Heartland's operations are funded with Federal grants. We must make up the difference through private donations, other grants, and most importantly Medicaid revenues.

Help us stay in business. We like what we're doing. Thank you.

MR. KOEHLER: Betty Jones is next.

MS. JONES: My name is Betty Jones, B-E-T-T-Y, J-O-N-E-S, and I am a resident of a nursing home, of a local nursing home here, and also a member of the Peoria Task Force.

We need a health care system that is run of, for and by patients themselves. We the people need to be allowed to make our own choices on how the system is run.

We need freedom for the medical professionals to treat us in the best possible way.

Government need only help us combine all existing systems into one complete very effective outlet for medical care.

This new system could be called Medcare, M-E-D-C-A-R-E. A toll free telephone number spelling out, spelling out this name could be at the core of the communication central linking method of unity.

Each person who is physically able could be required to help manage their part of the system by volunteering time equal to half their cost of care.

Those unable to contribute could be covered by the efforts of those who can. Payment for cost of care could come in various forms.

Support could be accepted through individual contributions to help from foundations, grants from Federal and State, and to any kind of outlet forms.

Other examples would be from school children's class projects to higher institutions of learning and their class programs' projects.

The bottom line here is for all

of us to all work together on providing the money needed for health care.

In conclusion, I would like to read a statement from State representative Aaron Shock's office.

Aaron Shock is supportive of efforts to increase efficiency and access to a health care delivery system.

Also, I would be willing to seek the necessary data toward this end. Thank you.

MR. KOEHLER: Sherry Sherman is next.

MS. SHERMAN: Hi. My name is Sherry Sherman. It's S-H-E-R-R-Y, and Sherman, S-H-E-R-M-A-N. And I'm not with any organization, I just wanted to give a personal narrative.

I found myself unemployed and uninsured about four years ago and at the time I couldn't afford it. I had been laid off of my job and wasn't able to pay my COBRA payments, and I was in a car accident while in that position and I broke my neck at the C2 level and was unable to breathe on my own. That's the aftermath.

In the first 24 hours of my care it was approaching $4,000, so I filed for bankruptcy and then became a Medicaid patient. And my frustration with the current system with Medicaid and also disabilities, which is another matter, led me to pursue my masters degree in public policy, and my focus was in health policies and service policies.

And while there I did a cost comparison of what was covered under Medicaid and what would have been covered under my employer's health insurance and I found that I was way better off in terms of care, as I was in rehab for about two years, under Medicaid.

My care would have been cut off by my insurance well before I was recovered and I certainly wouldn't be standing before you in this condition able to go back to work if I hadn't been on Medicaid.

But now I've finished my degree

and I'm unemployed and now I find myself uninsurable because spinal cord injuries aren't something insurance companies want to cover, underwrite.

So I want you to keep that in mind. And also that one percent of our population accounts for 30 percent of our health care spending and 10 percent of the population accounts for 70 percent of our health care spending.

And although HSA's might be great for people who already have insurance and can afford insurance, they don't help people who can't.

And most people who have chronic problems and serious illnesses aren't going to want to shop around for a cheaper doctor or cheaper care.

And people in my situation where you're in a tragic accident certainly aren't going to call around and say who has the cheapest lifeflight. So I want you to keep that in mind.

And also, that the current Medicaid program is disincentive to work because if you work full-time and your employer doesn't provide insurance then you're going to lose your Medicaid benefits and you can't afford to pay for the premiums.

I know your hands are tied with ERISA regulations for employers that are self insured, but I just wanted you to keep that in mind. Thank you.

MR. KOEHLER: Thank you very much. Michael Brown.

MR. BROWN: Good afternoon. My name is Reverend Michael Brown, B-R-O-W-N. I'm a local pastor and I'm the vice president of the Central Illinois Chapter of the Interfaith Alliance which is an active interfaith group in the Peoria area that includes members from a wide variety of religious traditions.

Our mission is to promote the positive role of religion as a healing and constructive force in public life.

If there's one thing that

virtually all religious traditions agree on, it is the moral law known in our culture as the golden rule.

In virtually all of these traditions we are called upon to treat others as we wish to be treated.

Is there any one among us that wishes to lose our insurance because of changing jobs or being laid off?

Is there anyone among us that wants to be turned down for coverage because of a pre-existing condition or to go bankrupt because of overwhelming medical bills we incurred without access to insurance?

If none of us wants to suffer those conditions ourselves, then the great moral law says that we must not cause our neighbor to suffer those fates either.

Therefore, from an interfaith religious perspective we must arrange our lives together in society so that everyone has access to health care.

Everyone has worth and dignity

and deserves access to this necessity of life. Therefore, universal coverage is a moral imperative.

Once we agree that universal coverage is a moral necessity then the question becomes how to accomplish that goal.

An obvious first step would be to look at other people who have accomplished this goal and see how they did it.

Virtually every other industrialized country in the world has created a health care system with universal coverage except the United States.

They have almost all done it by moving to a single payer system. If there are exceptions to this rule then of course they should be investigated, but the single payer systems are way out in front in terms of a track record of success.

Not only do other countries with a single payer system achieve universal coverage, but they do it at about half the per capita cost of our system, or in other cases even less.

And many of these countries have better health statistics than we do. To learn from their experience is an obvious course of action. There is of course resistance to this idea in our culture.

We are a culture of extreme individualism which is often one of our virtues, but in this case our ultra individualism is not helping us solve the problem. We will need a more cooperative response to be successful.

If we insist on staying the course of splicing together more and more individual profit-making entities and more and more government programs into an ever more unwieldy, overhead burdened, Rube Goldberg non-system, we will find ourselves increasingly weighed down by the ever escalating cost of that misjudgment.

The symptoms of this unhealthy approach are seen everywhere today, including in this room. Most obviously in spiraling costs for both individuals and businesses and the huge and expanding numbers of our fellow citizens who are uninsured.

The time has come to do something different, and Illinois can be a leader in that new direction. There is no excuse for non action.

Based on everything we know so far universal health care provided through a single payer system appears to be the most effective, least costly, and most moral path to a healthy system of health care for all our citizens. Thanks for listening.

MR. KOEHLER: Thank you. Michael Vidas, and then we're going to take about a three or four minute break.

MR. VIDAS: Thank you for allowing me to speak. My name is Dr. Michael C. Vidas; V, as in victory, I-D, as in David, A-S, as in Sam.

I'm a physician in the Peoria area. I'm a member of the Illinois State Medical Society as well as the Peoria Medical

Society. I speak for myself though today.

I think that part of our problem, and usually is, is money. What are we going to do Monday, how do we fund these systems. Everybody's talked about different ways. It's going to be our main problem.

And I think funding is always difficult, and especially when we talk about any payer system. Are we going to send money to the government in Washington?

I've heard that frequently we send dollars to get back cents. And I do worry about that. I worry about that with all funding.

I think that Heartland is a very good way to start. It's a local system. The money stays here. The money goes here. How do we perpetuate, how do we expand on that system? That is for you to help us decide.

Existing programs need to be funded but they need to also be fiscally responsible. There's duplication within existing programs, and this needs to be addressed.

People also must participate in their care. If they don't participate in their care they're not willing to save the money to go the extra mile.

And that also means that they have to take care of themselves and they have to be adequately schooled.

They have to be educated, and they also need to do healthy things. And we've talked about that a little bit, and I think that's very important.

There are costs to the providers as well. Remember that we have health, we have a malpractice difficulty in this State, and it has been addressed with the non-economic caps. Will they be sustained?

Will our Supreme Court indeed rule this time? They've ruled twice against caps, and it costs us money. That costs everybody in the State money.

It costs every company in the State money, not only through medical malpractice but in difficulties with product liability, et cetera.

I support access to care and for everybody. But, while you have to pay the providers of the care, and that is the guy that moves people in the hospital; he needs adequate payment just as the physicians do.

Will a single payer system work for us? I'm not sure. You remember that when we send away money to different places, if we send away money to Washington, do we get dollars back for dollars? I'm not sure that we do.

The present system needs to change, but if you change it too drastically it's like a speeding train. If you move it along, if you slowly change it, we can change the direction.

If we change it too drastically I'm afraid we'll derail it. All citizens must have access to a basic system. How do we accomplish this? This I'm not sure of, but indeed we do need to accomplish that.

Medicare needs to change, Medicaid needs to change, and we need financing for these systems. We need to figure out what to do and how to finance them.

Ancillary costs such as insurance for even the health care providers and for malpractice, of course, as I mentioned.

I emphasize again preventative, preventative, preventative. Let's be healthy, and indeed maybe we have to even think about our environment and how we're going to clean it up. Thank you very much for allowing me to speak. I appreciate it.

MR. KOEHLER: Thank you. I want to take about, I'll take about a four minute break and in that time, the bathrooms are down the hall to your left as you go out the door.

Those of you who have not signed up to speak but all of a sudden had a desire to speak, go back and see Ashley and fill out one of the yellow sheets here. So we'll see you back in four minutes.

(Break taken at this time.)

MR. KOEHLER: I call up Greg Chance, Steve Ridley, Andy Chiou, Blair Gambill, Cheryl Budzinski.

Again, Greg Chance, Steve Ridley, Andy Chiou, Blair Gambill, and Cheryl Budzinski. If you would come and sit in the front row, please.

MR. CHANCE: Good afternoon and thank you. My name is Greg Chance, G-R-E-G, C-H-A-N-C-E.

I have the pleasure of serving as a public health administrator for the Knox County Health Department located in Galesburg, Illinois.

As you know, Galesburg has been extremely affected by the current downswing in our economy, and so I'm pleased today that the Adequate Health Care Task Force is coming down to rural Illinois to allow us to give our perspective.

As you know, living in rural Illinois increases the risk for being uninsured. This is primarily due because of the rural economy tends to be dominated by smaller employees and the self-employed and because rural residents are more likely to work for low wage employers.

Obviously, both small and low wage employers are less likely to offer health insurance.

Additionally, when rural residents enter the private insurance market they are likely to pay higher administrative fees, find fewer health insurance choices, and be underinsured.

Subsequently, rural residents pay a higher proportion of their income for health insurance because premium rates in rural Illinois are comparable to or even higher than those in urban areas, especially when you average in the issue of income.

As we all know and as you heard previously, rural populations tend to be older and poorer. Subsequently, we rely heavily on public sources of coverage for health insurance.

For this reason rural residents and health care providers are more heavily impacted by coverage changes and inadequate provider payment rates in our Medicare and Medicaid and SCHIP programs.

Due to these issues rural Illinois residents are less likely to seek primary preventive care and subsequently are likely to be in poor health.

A strong and reliable source of health care financing are critical to address these issues and to seek better positive health outcomes.

As I mentioned Knox County, we've had extreme issues as it relates to unemployment. We currently did a household survey in Knox County where we saw that almost one in eight household members are not covered by health insurance in Knox County.

As expected, subsequently low income individuals in Knox County often forego routine preventive medical care and end up in our hospitals and emergency rooms where there obviously the costs escalate.

Additionally, Knox County has identified that the inability to access dental and behavioral health services is a significant community health concern for our residents and has been identified in our strategic plan as issues that need to be addressed.

One issue with the dental services is, not only in Knox County but probably in Western Illinois representing at least six to eight counties, we do not have one dentist that's willing to accept Medicaid.

Obviously, when we have extreme dental care issues those individuals end up in the emergency room which are not equipped to handle that type of issue.

Furthermore, psychosis was the ninth leading hospitalization reason for Knox County residents in 2004.

Also, psychosis was a leading reason for Knox County children age five to 17 to be hospitalized in that year.

A significant barrier to

receiving mental health services is the inability for care in Knox County.

Furthermore, the local area's insufficient mental health service capacity, including a complete absence of inpatient psychiatric facilities and no private pay psychiatrists, further aggravates this access to health care issues.

When we seek services outside of town, especially here in Peoria or in the Quad Cities, we look at waiting lists of at least 30 days to three months.

So some recommendations; we really, and it's obvious that's why the Task Force was put together, we need to look at several public policy issues.

One significant issue we need to look at is to retool public policies and programs in Illinois that are aimed at assisting students entering a health care profession.

We especially need to look at how do we encourage students to come back to rural

Illinois to practice. And that's not just in primary health care, that is in the allied health professions as well, dentistry and behavioral health.

We need to look at the opportunity to create tax incentives for health care professionals to establish their practice in rural, underserved areas.

Perhaps a reduction in sales tax, property tax, similar to TIF districts, et cetera.

We need to establish financial incentives such as enhanced reimbursement or, again, taxes for health care providers whose practices provide a certain percentage of care to the uninsured or underinsured, especially in primary health care.

Two quick items; we need to talk about public health. Drastically underfunded in Illinois, we're looking at core public health services funded only about $1.25 cents per capita across the entire state.

We're talking about needing a

healthier community, healthier population. We need to invest in public health. Thank you very much.

MR. KOEHLER: Thank you. Steve Ridley.

MR. RIDLEY: Good afternoon. My name is Steve Ridley, S-T-E-V-E, R-I-D-L-E-Y. I represent 500 members of Unite Here Local 16 who work in Peoria hotels and food services.

Our members average under $9.00 an hour and can't afford to pay towards their health care.

Most qualify for public assistance with their health care, but would jump at the chance to have employer provided health care.

As an example, our members who work for U.S. Dining Services at Bradley University just voted down their contract due to the employer demanding they contribute to their health care premium.

Workers who average under $9.00 per hour just can't do this. They're already just barely getting by. The health care premiums for our members have doubled over the last five years with no end in sight.

Health care costs are bringing down our members' real wages and forcing them to drop coverage and go on public health care assistance which further jumps the cost to all of us.

A one payer system with universal health care for everyone would help all of us lead a better life.

And in the little booklet that was handed out to us, it's right here in the front in the need, from 2000 to 2004 health insurance premiums rose by 34.9 percent, and during the same period average wages rose by only 13 percent.

And I think in our sector the costs were up a little bit higher on the health insurance and a little less on the wages.

So we're looking at more labor disputes as time rolls, moves along here. Over this, this cost of health care that's really out of control on both sides of the party, and just trying to figure out what, how we're going to do this.

We hope to avoid a labor dispute at Bradley but we'll just have to see how that works out. Thank you.

MR. KOEHLER: Thank you. Andy Chiou.

MR. CHIOU: Good afternoon. My name is Andy Chiou, C-H-I-O-U. I'm a native Peorian and a proud graduate of District 150.

I'm also a vascular surgeon with the Peoria Surgical Group and the University of Illinois College of Medicine here in Peoria.

I also serve on the Board of Directors of the Peoria Medical Society, and I'm speaking for myself this evening.

I also hold degrees in economics and a masters degree in public health and health services delivery. In my Department 15 surgeons provide the backbone for level one trauma in downstate Illinois.

We care for a vast region

extending from Rockford to just north of Springfield. We care for everybody, regardless. Anybody that's brought in lifeflight. Anybody that comes in through the ER doors.

We provide as one small group over 2.5 to three million dollars of uncompensated care to this community every year.

We've gone six to nine months or longer without reimbursement from the State of Illinois for Public Aid patients. We continue to see all these patients.

We provide surgical support regardless of insurance and insurance status. I myself have over 60 percent of my patients that are covered by Medicare, Medicaid, Public Aid, or simply have no insurance.

Last year some of us paid over $27,000 per policy for our families for health care coverage. In other words, we're very much in tune and in the system, including all of its problems.

I was a student in the State of Massachusetts in the 1980's when universal health care was enacted. My student health care policy went from $600.00 immediately to three thousand dollars.

Several of my classmates dropped out of college that year because they couldn't afford health care because it was mandated for all.

I also served 16 years in the United States Air Force. I served in the universal health care system. We covered all active duty military, retired military and all of their dependants.

Let me give you an example of both the good and the bad of a system like that where it is one payer, one entity, and one budget.

In general, in any given year we are on a relatively shoestring budget. When 9-11 occurred we massively shifted all of our assets. We shifted them to disaster response, we shifted them to wartime coverage.

The flagship hospital in San Antonio for which I served as chief of vascular surgery was decimated. Retirees, dependents and spouses waited exceedingly long times for care, for services, for surgery. That's one example.

Another example, and again, this is not to take down a system that may have benefits, but certainly the Medicare Part D is not perfect, as most people will probably agree.

This is another example of a one payer system that was then subletted out to multiple, multiple, multiple, multiple payers.

There are some issues and things that certainly we can bring up and some reform items, some suggestions, and we have to start somewhere. Prevent direct public advertising.

Do we need direct advertising to a public in order to create markets where the demand is for the highest, the best, the latest, the greatest, when oftentimes the bread and butter and the tried and true, which is pennies on the dollar in comparison, is just as good.

Secondly, prevention. And I agree, and that's been talked about a lot here. We need to pay for preventive services.

Thirdly, you have to reform liability. My liability insurance is on the order of multiple salaries of primary care physicians. And that is one individual.

Reduce administrative costs and burdens, perhaps universal medical records that you take with you and you don't have to keep filling out the same form every time you go to an office or a hospital.

Every time you do that somebody has to take that paperwork and regenerate that and retype it and reproduce that. Those are all administrative costs. That's 15 percent savings right there off health care.

Either regulate the health insurance agencies and companies or don't regulate them, but right now what's going on is last year, a few months ago I should say, I read an article that the CEO of United Health Care, which covers a lot of lives here, was compensated over 120 million dollars.

Where do you think those dollars come from? Policy holders. Companies. Unions. Health plans. We have three hospitals here in Peoria. They advertise a lot.

They advertise to a community that maybe doesn't really know why they're advertising against each other or for each other.

Many of us don't have a choice in what hospital we go to, so why are they advertising? That's a lot of dollars wasted in my mind.

There's likely no one size fits all with one huge mandate from a State or Federal entity work.

We need to all work together to converge toward the goal of accessing coverage for all without breaking the bank.

With a single payer system we

would have the advances, would we have the advances that we have today? The vast majority of advances in health care in this world come from this country. And I will certainly stop at that.

But lastly, I'd like to say that individually we may think we don't have the ability to make a difference, but these are the examples.

Everybody here today, one by one, we can make the difference. We just need to start asking questions and boldening ourselves, educate ourselves, and take it in our own hands as a start.

So my head spins when I think about the reforms of this vast and complicated system, but we have to start somewhere and we have to start by looking in the mirror and making our own choices and acting ourselves. Thanks.

MR. KOEHLER: Thank you, Dr. Chiou. Blair Gambill.

MR. GAMBILL: Yes. My name is

Blair Gambill. I'm the CEO and president of Secure First Health Plans. I'm also the Senatorial Republican candidate for the 46th District this coming year.

I'm here today because there's a couple of things --

MR. KOEHLER: Can you spell your name for her?

MR. GAMBILL: The last name's G-A-M-B-I-L-L. The first name is Blair, B-L-A-I-R without an E. Some people sometimes put an E on it.

So, anyway, I'm here today because a couple issues I'm concerned with that I just wanted to share with you; I've heard a lot about doing a single payer system today.

And even though on one side that seems like a wonderful thing, my concern is on the other side that a lot of people don't realize what the price is being paid on health care now on a single payer system.

For instance, if we look at Medicare and its payments and if we look at

Medicaid and its payments, and I've already heard here today, many doctors and a few hospitals have said, hey, we can't live on that type of payment. That's not enough for us to get by.

So one would wonder where does the money come from to make it affordable for those hospitals and those doctors to get by.

Well, right now it seems to be coming from the health insurance industry. And I see certain cases where certain providers pay what we would call 140 or 170 percent of the Medicare rate, and then we get calls from doctors saying hey, we can't work for that.

That's under, you know, that's what you're considering reasonable and customary but it's also more than Medicare would pay. It's also more than Medicaid would pay.

And the concern I have in that system is, if we were all on a single payer system who's going to pick up the difference?

What a lot of people don't

realize is 80 percent of the people in the hospital are over the age of 65 by many statistical analyses.

My problem with that is we've got 20 percent paying to make up the difference for the affordability for the other 80 percent.

Now, on a personal level I want to share something that I think needs to be changed and it's needed to be changed for over 20 years in the business.

I see people every day that call our office and so forth and are extremely upset because they go to a particular hospital and when they go to that hospital they're under the idea that their PPO is going to cover that particular hospital and all the services in that hospital.

When they get there they come to find out that the anesthesiologists, that the X-rays, that the emergency room physicians, the particular surgeons and so forth as far as groups don't happen to be under the PPO that was in that hospital.

My concern is, if I go to a particular hospital I would think, and I think it's pretty reasonable to think, that the people that work on me, that I have no choice in choosing, maybe an anesthesiologist for something, I guess I'm not going to wake up on the table while I'm being operated on and say gee, no, I don't want you, I want the other person in my PPO. I'm not going to do that.

My concern is that we need to do something and we need to work together to make sure that all these people when we enter those doors into any facility that claims to be in our PPO, that anybody that does the work in that facility is taken care of by the same networks that they claim are going to be able to take care of me on my insurance program, whether that be on a fully insured plan, whether that be on a self-funded plan or whatever.

And I would just hope that we all together can work over the next year and so forth and maybe add that too, because my heart goes out to all of you because this is such a complicated system. It is very difficult to make these changes and so forth.

There are so many variables that come into it, you know. You know, the minute you think you've got it fixed over here then the dike starts bleeding over here. Okay.

And we keep hearing about hey, well, you know, Medicaid is not being funded correctly. Well, it's a single payer system. Where is the money coming from?

And we have to worry about how we would take care of that fully. All right. So I guess I ask over the next year that we really work on some type of way to make sure that these hospitals and these physicians are all on the same page so that the poor client doesn't get caught in the middle and end up with 10 or 15,000 or 5,000 dollars in unreasonable expenses because they weren't under their PPO. Thank you.

MR. KOEHLER: Thank you. Cheryl Budzinski. I thought I saw Cheryl here. All right.

We are going to go to Rudy, I can't read your writing. Rudy Habben. Is that right?

MR. HABBEN: Right.

MR. KOEHLER: Rudy, just a second. William Albers, Steve Smart, Rodney Osborn, and Pearl Taylor, you're next if you'd come up toward the front. Rudy, go ahead.

MR. HABBEN: Rudy Habben, R-U-D-Y, Habben, H-A-B-B, like in BB gun, E-N. I'm a resident of Peoria, retired, not in the medical profession, although I did spend 17 years working for the Division of Health in the State of Wisconsin.

And I'm going to be somewhat focused on the information I received from listening to At Issue on PBS and then reading the Journal Star, and under those programs they said we have to start somewhere and we, in terms of recommendations and so forth.

And so I've been reading about the Governor's proposal on kid's care, and from what I could find out about it through the press and so forth that it's financially do-able and it would reach 250,000 kids.

When I worked for the State of Wisconsin we had the Federal program, the WIC, which was Infants -- Women, Infants and Children Program which is a food stamp program out of the Department of Agriculture that focuses on pregnant women and then lactating, pregnant and lactating women, and it had a health education program that went with it.

And it seems to me that, well, we were, it was one of the most cost effective programs we had in the State of Wisconsin because it helped in terms of reducing fetal alcohol symptoms, low birth babies and so forth.

And so in terms of your recommendations, if the Kids Care program does go through maybe the Department of Public Health can find other public programs that could be added to that so that you'd have a pretty comprehensive program for kid care.

The second one is with health education. And a couple days ago we had a public hearing here on Senate Bill 2267 which is a responsible sex education program which provides funding to communities that request that, school districts that requested to have a comprehensive sex education program.

And I don't know what the scope is of health education in the public schools, but it seems to me you would start with Kindergarten kids on the importance of washing their hands and so forth and then through junior high on the importance of diet in terms of obesity and anorexia and steroids and so forth, and then sex education and so forth.

So I noticed in your list here that the Department of Public Education isn't listed. This program on sex education would go to the Department of Health and Human Services.

So the Department, probably one of your recommendations might be a survey of health education in schools and some sort of program to develop a comprehensive health education program. Thank you.

MR. KOEHLER: Thank you very much. William Albers.

MR. ALBERS: Thank you for the opportunity of speaking this afternoon. My name is Bill Albers, A-L-B-E-R-S. I'm a pediatric cardiologist in Peoria, Illinois and I've practiced here since 1967.

I was previously chairman of the Department of Pediatrics at OSF St. Francis and the College of Medicine in Peoria, and I'm practicing part-time still here in the City of Peoria.

I've long been frustrated by the system of health care in this country. As a pediatric specialist I've had the opportunity to see many of my infant patients successfully treated with life-saving procedures and excellent nursing care, only to find that as they reach adulthood they are often ineligible for health insurance coverage and unable to obtain employment because of their previous history.

When I read of spaghetti suppers which are held by well-meaning people to help a family pay medical expenses for a loved one I'm convinced that our system has failed.

And in recent years I've tried to study this problem and I am convinced that the current system can no longer be defended and must be radically changed.

Essentially, I believe we have two problems, which if we don't solve them will bring our economy down.

Although we have excellent hospitals and excellent physicians and other providers our system has 46 million uninsured nationally, two million in the State of Illinois, and we have many more under-insured.

And, secondly, the system is just too expensive. Health care is twice as expensive in this country than in any other industrialized country. And the two problems, the excessive cost and the uninsured, are related.

The uninsured gets substandard

care and have substandard outcomes, it's been very well demonstrated. They present late for treatment; they don't follow up well on chronic diseases; and they obtain a lot of their primary care in emergency rooms, which is one of the most expensive sites.

And of course I think there's a lot of waste and administrative excesses in the current system which adds to the cost.

I'm going to give you two brief anecdotes which I believe will illustrate how the problems of the uninsured impact first, major family decisions; and secondly, the quality of care and outcomes, and then I will stop.

The first is a six year old little girl whom I have seen several times with a very mild abnormality of one of her heart valves.

This is a birth defect but it's very mild. The child is doing very well and has an excellent long term prognosis, and just needs occasional visits and tests to be sure that there's no progression.

This family, whose child was born in North Carolina, her father is an unemployed mechanic, self-employed mechanic I should say, and they were unable to buy insurance for this child because of her very minor heart condition.

The best quote they could get was a thousand dollars per month which they couldn't afford, so they had to move back to Illinois so that the mother could obtain work with benefits, and the child could be taken care of by their babysitter.

They did not want to move but they had to because of the inability to obtain affordable health insurance.

The second case is a young man I took care of as a young child who had a more severe involvement of his valve and needed to have an artificial valve placed. Because of that he was on blood thinners.

He was assisted by DSCC, Division of Services for Crippled Children, during childhood but when he became an adult he was no longer able to obtain coverage.

He was a very proud man, and even though we offered to donate our services he did not want to have big medical bills, so he often failed his appointments, forgot to get his lab work, and wasn't very well controlled on his anti-coagulation.

He developed a hemorrhage into his spinal cord and became paralyzed as a result of that. And about 15 years later he presented and, in fact, several months ago in an extremely late stage of congenital heart failure, and died.

And I'm convinced that this young man would be alive today if he had had access to adequate health insurance when he turned to be an adult.

I don't pretend to know all the solutions to this problem, but I'm sure that this cannot be solved by bandaids.

And I would just, if I may, list six important principles of any solution that is eventually put into place.

First of all, it must offer universal coverage. Everyone must be considered.

Secondly, it should be no more costly than the current system. And this can be done if administrative costs and inefficiencies are eliminated.

Thirdly, it must be easily accessible and user-friendly. Fourthly, the plan must include measurements of quality and quality control.

Fifthly, the prices must be regulated but negotiated fairly between payers and providers.

And, finally, the cost of research, infrastructure, improvement for hospitals and providers and the cost of medical education must be considered and included. Thank you.

MR. KOEHLER: Thank you very much. Steve Smart.

MR. SMART: Thank you. Steve

Smart, S-M-A-R-T. I'm Dr. Steve Smart. I'm an allergist/immunologist as a specialist here in Peoria.

I've been here for 10 years after moving here from the same Air Force Hospital as Dr. Chiou, and what I'd like to do is just replay Dr. Chiou's comments and sit down.

I'm also active in the Medical Society including the delegate to the State Medical Society speaking for myself. There's no easy answer.

And let me also add that this might be a little disjointed. I didn't think I was going to be able to make it here by 4:00 so I just scribbled notes in the back.

We all know what we want. We want everything and we want it cheap. The woman earlier had a laundry list of things including braces.

And if we want that then we may need to spend 20 to 25 percent of the GDP to pay for it. And we have to ask ourselves whether we're willing to pay for that type of cadillac coverage for everything.

We need to be practical. We heard about a thousand dollars added to the cost of a car for health care, but what about the one to two thousand dollars per baby delivery that's added for the cost of malpractice premiums? Let's think about that.

The uninsured, the under-insured, the indigent need help, and there are successful options locally such as Joan Krupa mentioned, the community health centers.

They could use increased government funding for affordable free clinics and faith based programs.

But Governor Blagojevich is all kids, and in the absence of realistic plans for funding is you're responsible because the State can't even meet their Medicaid obligations at this time.

We have to be practical here. They're not just low pay, they're no pay. More and more doctors are not seeing these patients. Then what?

Fewer and fewer doctors are like myself and Dr. Chiou who right now can and will continue to see these patients, but it's not going to stay that way.

And the best students are going to stop going into medicine if they see our health care system crumble.

You know what, last year small pharmacists all across the State had to take out personal loans to keep their doors open because the State wasn't paying them for the medications.

So let's not expand things until we find the money and the funding to do what we're already obligated to do.

There have been many references to single payer systems, and this is seen as a panacea and it's understandable.

But it's a fairy tale to believe that the government is going to be more efficient at just about anything.

The government will not be more efficient, and single payers will mean decisions by beaurocrats, waiting lists, waiting lists for waiting lists, and rationing.

More socialistic countries than ours have already tried and failed, and they come here for their health care, those who can afford it, from those countries.

We do need to learn from their experience. We have the best health care in the world. There are serious problems but we do have the best health care. And no matter what, we can't ruin it by tearing it down and making it one big government entitlement program.

We do need to build on the current system. The kind of care America has come to expect is expensive. There are real problems we need to address. These include affordability.

These things have already been mentioned. Drug costs. Restrictions due to pre-existing conditions. These are important things. They're obstacles and they do need to be addressed.

Liability reform; personal responsibility, and patient participation. HSIs are a great model because when patients become real consumers and the liability issue gets pulled out health care costs will go down.

Those unnecessary MRI's won't be done. But not until there's an incentive for that to occur. Thank you.

MR. DUFFETT: I just wanted to make a couple comments, and I don't want to show any of my biases at all here.

When you talk about rationing of health care, what's interesting, what's interesting right now is it's not the government that is rationing my health care.

It's an MPA person that's that one eight hundred number away that's rationing my health care.

So when you want to use the issue of government rationing the health care, in fact, the private sector right now is rationing people's health care and we as a society all have to figure out about what is going to be, you know, we have rationing right now, and I think it's wrong to, if we want to point fingers at government or point fingers at the private sector.

MR. KOEHLER: That's fine. Let's get some of this as a wrap-up, okay?

MR. DUFFETT: Okay.

MR. KOEHLER: All right.

MR. SMART: Yeah.

MR. KOEHLER: We're going to go through the --

(Several people talking at the same time.)

MR. SMART: We're going to do this at the end.

MR. KOEHLER: We're going to have Rodney Osborn, please.

MR. OSBORN: My name's Rodney Osborn. It's Dr. Rodney Osborn, and I have the privilege of practicing as a private practice physician with a specialty in anesthesiology here in Peoria.

Mr. Duffett, you're very

fortunate to have an MPA to make decisions for you. The majority of physicians --

MR. DUFFETT: I can not --

MR. OSBORN: -- have less than high school educated people making decisions with regard to who gets care.

I'm very fortunate to practice here in Peoria with Dr. Chiou and Dr. Albers and Dr. Smart. I've taken care of the same patients that they've taken care of.

For Dr. Chiou I currently take care of his Public Aid or no-pay patients. In the past I did the open heart anesthetics for Dr. Albers' patients.

It's been a privilege for me to practice in this community as part of a large group that makes no distinction as to the type of insurance or the ability to pay that our patients bring to the hospital.

And I'm thankful for that. I need to tell you that it's the altruism of the physicians, physicians like Dr. Albers and Dr. Chiou and Dr. Smart, that have carried this health care system for many, many years.

But I need to tell you that that altruism is no longer going to carry this system.

And I need to tell you what others won't admit, that the system is crumbling, and that the best students are not going into medicine.

The lack of sufficient financial support limits access to care for some individuals and it limits access to certain kinds of care for all individuals, even those with insurance.

Low reimbursements, lengthy payment cycles are considerable problems with the current Illinois Medicaid program. And to tier too many physicians, not Peoria physicians in large part, but too many physicians in health care, professionals, from participating in the program.

We in Peoria have the same problem that the western part of this 4th and 14th District that I was a trustee for for many years found with dental care and dental emergency care.

I will tell you I'm a trustee and a past president of the Peoria Medical Society. I'm vice president of the State Medical Society, but I stand before you as a personal testimony to the medical care that we receive here in Peoria and the physicians that provide it.

All patients need to be more conscious and cognizant of the costs of health care. Patient cost containment and participation in health care decisions are crucial.

This includes some sliding scale payments for deductibles, co-payments, co-insurance. They all must be included in any access plan.

The individuals have to be made accountable for the way they use the health plan available to them. Many of our uninsured are uninsured by choice.

Dr. Chiou and others perhaps

haven't been as blunt as they could be. When Dr. Chiou served in the Detroit area and others have been in the Detroit area the cars in front of the homes of the uninsured cost more than the homes. I think that's a serious flaw in our society.

Many medical problems arise outside of the health care delivery system as a result of lifestyle and environmental factors. Good factors like diet and exercise, bad factors like smoking, alcohol consumption, whether or not you use your seat belt.

An expensive, ongoing public education program must be included in any proposal.

Are we fortunate here in Peoria to have one of the largest gastric bypass morbid obesity surgical programs anywhere in the country? Thank you.

MR. KOEHLER: Thank you. Pearl Taylor.

MS. TAYLOR: Good afternoon. I'm Pearl Taylor, P-E-A-R-L, T-A-Y-L-O-R. This last gentleman took my thoughts.

I'm associated with many organizations in this State, not only the city, the State.

I'm a volunteer. I was an employee, but I'm a volunteer for the Agency on Aging. And that's what we do, we take care of the seniors and the disabled.

Yesterday we had this big meeting, and this big changeover to Medicare D, so many of our seniors is not going to be able to get their medicine.

And with the big changeover so many pharmacists are not taking the patient anymore because they say they're having a backlog of not being paid.

I'm a retired nurse. I worked in the emergency room for many years. I never saw anyone come in there that wasn't taken care of.

Today I was at a nutrition meeting and they asked me what are you all doing to educate the people on what they eat.

They said you are what you eat.

However, most of our bad health problems come from overeating, not eating, not exercising, not taking your medicine, and smoking.

So I am saying while we are putting all this together in a package maybe we can encourage some people to have some education for the school, the churches, seniors everywhere, to encourage people to let them know that their body is what they eat.

If you don't eat right you're not going to sleep right. And if you eat up all your money you can't pay your bills. Half of the people in America is overweight.

75 of the people like me and others are overweight because we don't eat right, we don't exercise.

So while we're getting all this together let's talk about, you know, somebody that can put this together, that we can work on diets.

This is a great country. I know

the doctors and all of these legislators and all these smart people, you're not going to let America go down the drain. You guys are going to take care of it. And I'm through. Take care of it.

MR. KOEHLER: Thank you, Pearl. We're going to take care of it.

MS. TAYLOR: Take care of it. That's your job. We depend on you. We put you there.

MR. KOEHLER: We've got five more speakers here. I'll call all of you up; Linda Foreman, Teresa Valerio, Jeanette Luschen, Bob Tudor, and Nathan German. Nate German. Yeah.

So if you'd come up here in the front row, and we'll take Linda Foreman first.

MS. FOREMAN: Hello. Oh, this is going to be emotional. Linda Foreman, F-O-R-E-M-A-N. I've walked through hell. To put it in a nutshell, it's going to be difficult.

In 1996 my husband needed, and I needed, health insurance. We took out an individual private policy for about $350.00 a month for him alone.

In '97 he had a heart attack, so we were locked into that policy and he could not be insured any other way.

By June of 2005 that policy's premium was $886.00 a month. He, because of health problems, was not able to be employed.

We, any place we went for assistance, and maybe I didn't go to the right places, to the right doctors, right hospitals, I don't know the system, I made too much money.

And I assure you, $30,000 is not enough to compensate for his medical bills, his drugs and a major medical insurance policy that's $886.00 a month and still try and live.

He had multiple system atrophy. No one could help. There was just this black hole. Everywhere we went there was nothing.

A State agency I contacted told me oh, dear, if you had divorced him two years ago he could get assistance. Because you're still married we can't do anything for you.

And then we hear the politicians touting family values. I'm a minister in this town. Ethically, even if I knew two years before that that I could have beat the system and survived financially, I still couldn't have divorced him for that. It wasn't ethical. I couldn't have done it.

Our church, our friends, when we were at the brink of bankruptcy with bills due all over, had a major fund raiser for us.

I may not live long enough to pay the balance that we put on credit cards because we felt we were responsible to pay it. And the system wouldn't help us in any way that we could find. So that's my story.

Jack's passing was in April of '05, and I'm still carrying a lot of credit card debt to pay for his medical bills, his drugs, office visits, emergency rooms, et cetera.

And I hope something can be done so no one else has to do this journey because the stress level for me knowing that's hanging over me and has been hanging over for many years is not going to help my health any either. Thank you.

MR. KOEHLER: Teresa Valerio.

MS. VALERIO: My name's Teresa Valerio. Close enough.

MR. KOEHLER: I'm sorry.

MS. VALERIO: T-E-R-E-S-A, no H. V, as in Victor, A-L-E-R-I-O. And thank you for hearing us today.

I'm speaking on behalf of the Illinois Society for Advanced Practice Nursing. I'm a nurse practitioner myself practicing here in Peoria, and having practiced as a nurse in this area for 28 years.

I'm, as a representative of the Advanced Practice Nurse Group I would like to talk just one minute about what advanced practice nurses are because many people are not familiar with that.

I hope that you become more familiar. And then a couple of our thoughts about how we can improve access, quality and affordability.

Advanced practice nurses include nurse practitioners, nurse midwives, nurse anesthetists and clinical nurse specialists. There are over five thousand in the State of Illinois currently licensed.

These professionals have education and training, are board certified in their specialty and licensed by the State of Illinois, well educated people with a masters degree or higher in nursing, and we provide preventative, acute, long-term care to Illinois residents of all ages in all areas.

We diagnose conditions, provide treatments, prescribe treatments and refer to specialists as needed.

We believe that specifically including advanced practice nurses in your plans for health care is very important for several reasons.

The population is aging. Chronic care is a big issue and nurses are very specialized in providing care for chronic illnesses and preventive care I might add.

That's one of the areas that nursing is very strong in. There are going to be many gaps in the health care system if we don't have enough providers, and advanced practice nurses can be one of the major providers.

And there's a very large pool of registered nurses in the State of Illinois as other states, so there's the opportunity to increase access by increasing providers in the State, helping with education as well as making sure that advanced practice nurses are specifically included in any laws or legislation.

Advanced practice nurses increase access to care by providing care in all kinds of arenas; private offices, in schools, in college health services, hospitals, long term care, public health, home health agencies, prisons, and correctional institutions, psychiatric facilities for employee health services, and practice in many of the rural and deprived areas where health care providers are not easily accessible.

Advanced practice nurses make health care more affordable by focusing on preventive care. As I said, a strength in nursing focusing on lifestyle changes, educating and counseling first, and then, then utilizing more costly services as they're needed, such as drugs which have been mentioned several times today.

Also, advanced practice nurses can improve the quality of care. Typically, advanced practice nurses spend a great deal of time with their patients counseling and educating and have been shown in many studies to provide excellent outcomes for a similar type of services.

The outcomes for advanced practice nurses equal those of physicians, and the patient's satisfaction with their care is higher with advanced practice nurses.

So I would just like to encourage you to make sure that Illinois residents have access to advanced practice nurses in all the specialties, and that they are also, you are looking for ways to improve the funding for education of advanced practice nurses. Thank you.

MR. KOEHLER: Thank you. Jeanette Luschen.

MS. LUSCHEN: My name is Jeanette Luschen, J-E-A-N-E-T-T-E. Last name, L-U-S-C-H-E-N. I'm a native Peorian.

In February of 2005 I became unemployed and fell into that quicksand that is sometimes referred to as the American health care system.

I elected to pay for COBRA insurance coverage as a stop-gap measure until I could achieve full-time employment status with benefits.

At this time in February of 2006 I am still diligently seeking full-time employment. I am entitled to COBRA coverage for which I pay a monthly premium of $680.00 per month.

I have been denied individual insurance coverage by three companies, partly because of my age, 57, and partly because of pre-existing conditions, none of which are life threatening or resulted in enough medical claims to satisfy my $500.00 deductible in 2005.

I cannot qualify for the State CHIP program until I have exhausted my COBRA benefits, no matter what the premium, which will not be until 18 months from the date of my employment termination.

If I were eligible for CHIP coverage at this time the monthly premiums would be anywhere from 400 to $500.00 per month. And that's the coverage for people who can't get anything else.

My current COBRA monthly premium can be best understood in the following terms. It is my highest monthly expense, more than my combined mortgage and car payment.

Out of my monthly take home pay 39.6 percent pays my COBRA premium. 2.4

percent satisfies my $500.00 deductible. 5.8 percent pays my out-of-pocket prescription costs.

In other words, my monthly health care costs total 47.8 percent of my monthly take home pay. All of my expenses just for gas to go to both jobs, my mortgage, my utility bill, my car payment, and my health care costs, add up to 102.7 percent of my monthly take home pay.

And of course that doesn't include such frivolous expenses as food, clothing, car insurance or telephone.

I slide further and further into debt each month. And at $12.00 an hour take home pay and no one else depending on me for their survival I count myself among the lucky ones. And I get by with a lot of help from my friends.

I would also like to read something from a recent survey by the National Opinion Research Center based at the University of Chicago.

It reports the results of interviews with more than 1300 adults nationwide. According to researchers the results are disheartening.

Most Americans report suffering significantly more misery in their lives today than a decade ago.

Among the current Center for respondents to the survey a staggering 92 percent suffered at least one significant negative life event in the past year.

That number is up from 88 percent in 1991. Compared with a decade ago more adults report the source of their unhappiness to be illness or poor health, inability to afford adequate medical care, and mounting personal debt.

The proportion of adults nationwide who were unable to afford health care costs rose to 11 percent from seven percent in 1991.

Meanwhile, the number without health insurance increased from 12 percent to

18 percent over the same time period. The system is broken.

I don't have the answers to fix it but I agree with Miss Taylor who said that I know there are a lot of smart people out there who can figure this out, and I hope they figure it out pretty quickly because I'll never get all my credit card bills paid off either.

I have a choice; I could file bankruptcy, but I don't want to do that. And there are a lot of people out there who don't want to.

MR. KOEHLER: Thank you. Bob Tudor.

MR. TUDOR: My name is Bob Tudor, T-U-D-O-R, and I am group administrator for Peoria Ear, Nose and Throat Group, although I'm here to speak as a private citizen.

I really had no intent to speak at this meeting. I knew I was going to attend here today but I decided actually last night after listening to the State of the Union address that I did want to speak today.

I'll get to that in just a moment. As a private citizen and certainly as a consumer of health care services and also the father of two handicapped children, I am acutely aware of the system and how it works, and certainly the road blocks that insurance companies put up in front of people as to where they can go for their care and certainly making sure that your doctor and your hospital, and as was mentioned before, the anesthesiologists and so forth and so on, are all in your group and are participating providers.

I've been fortunate enough to not lose coverage as I have worked the last 30 years, and certainly I was limited to certain jobs that I could take or not take based on making sure that I didn't lose coverage for my children with their pre-existing conditions.

But really, as I listened to the State of the Union last night I noticed that the focus certainly on the health care side of it was on HSA accounts as a savings vehicle for expenses for individuals.

And I wanted to make sure that everybody understands that health savings accounts carry with them a high deductible and can only be used for high deductible health insurance plans. And that right now approaches $2500.00 for a single individual, that deductible.

This emphasis by the government on HSA accounts does nothing toward addressing the problem of out of control health care costs. It merely shifts the cost somewhat from the employer to the employee.

It does not address the underlying problem of escalating health care costs in general.

As a group administrator I recently bid out our health insurance plan asking for these bids to include an HSA component.

When the numbers came back, and I did the assumption of taking about 30 percent of our employees and moving them into the HSA component, I was somewhat surprised to see that the premium quoted by these insurance companies was the same as the premium it is, was currently, for the current year with no HSA component.

Yet obviously their liability as an insurance company was less. And I was moving our employees from a $500.00 deductible, which is pretty low out there today, to a $2500.00 deductible.

You know, the funny thing there again was, I was kind of in shock over this, I took a little bit more than 30 days to make this decision and the insurance company would only hold that quote for 30 days.

When I went back to them and said okay, we think we're going to do this, they requoted the premium with an 11 percent increase over a 30 day period.

Needless to say, we are not going with the HSA component and subject my employers to that increased premium and the employees to that higher deductible.

So I'm out of time. I did have a

little bit more to say but I think you're getting the idea. Thank you.

MR. KOEHLER: Thank you. Nate German.

MR. GERMAN: My name's Nathan German. That's N-A-T-H-A-N, G-E-R-M-A-N. I'm the business representative for the carpenter's union here in Peoria.

Today I'm, tonight I'm going to speak on my own, although I will be alluding to a few of the facts that I have learned through my occupation.

I'm not educated on any, on health I guess per se, but I do have some insight here, and it's a personal insight I guess.

First off, health care is a, it's a traumatic problem. Within us, our organization, we are a self-insured organization as far as our members.

Our thousand man local here combined with several other locals for several thousand men, we provide a full family health care coverage for the members and their families. Nobody's excluded.

Our health care currently runs six and a half dollars per hour for each member. That's taken away from his wages.

When we receive our wages we make a determination if we're going to put them towards our health care or towards the cost of living.

That has increased over one hundred percent since 2000, and during that time we have lost, we've had higher deductibles.

We went to, we had a Cadillac plan and we've dropped, the deductible has went down. We've had to drop some of our services.

We have done different things. We're not educated people per se. We rely upon health care administrators and analysts to let us know what to do.

I've heard tonight it spoken about wellness and stuff. We've incorporated a wellness payment program into our insurance to try to control costs.

We've increased, we're actually looking right now to pool more locals into our plan to try to control the cost because numbers seem to help a little bit.

But I guess on a personal note I guess I bring those to you. It is such a large factor, I think it was spoken to earlier, in dealing with contracts.

I just finished a contract. I got it ratified on Tuesday. The largest, one of the largest issues there is purely the health care.

Actually, the entire raise that the individuals receive will go towards health care.

That was a hard fought battle in the fact that the economics are hard for the company, and with that these guys cannot afford to go backwards again as they have seen their increase the last three years be taken up by health care.

With that, I guess that I came

here this evening, I guess I thought it was to see what we could do for provision of health care and contain the cost.

I certainly believe that we have some of the best health care in the country. I think Dr. Chiou and Dr. Smart and all them, I thank them for providing health care to people who don't have the insurance or the ability to pay it.

And I guess what I'm here for is, although we work hard to do that all of our employers compensate our employees in that we maybe provide health care to them, I believe that this, what I'm here to do is to try to contain that cost of health care as to provide some insight I guess and to learn about that.

One thing on a personal note; I guess what I've seen, when I was here about a year or so ago there was a health care seminar downstairs, and I forget the name of it.

I don't know if that's the Health Care Justice Group or, I think you were here when we had that. And they talked then about the health care in Massachusetts.

I heard Dr. Chiou say something about the students and him having three thousand dollars, but I'm not sure how that works.

But that seemed to me, that is a huge thing when employers are not all providing health care to their employees.

Particularly when you take large corporations such as Wal-Mart is one of the richest companies in the world, and although they make health care affordable they pay such a low wage a vast percentage of their employees cannot afford it.

I'm not sure, I'm not going to quote numbers. I think anybody could look it up and probably find it, but I would assume probably half a million from what I understand out of 1.3 million people do not have health care, and they're the richest company in the world.

I wouldn't want to put a burden on the small companies in the State of

Illinois. However, I do feel that every company should provide health care for their employees.

I don't think that it's unreasonable to, and it doesn't need to be a cadillac plan, but some kind of major health care coverage should be provided by them.

And with that, I think we talked before at that meeting and, or I've listened before at that meeting and I thought it was a good idea that they should, you know, the State would then provide some sort of a basic major medical coverage for people in our companies, small companies, small businesses, that couldn't afford that.

The one thing about doing that is that when doctors such as Dr. Chiou and Dr. Smart and such, they shouldn't have to go without pay for their services.

And what they're going with pay, without payment, I'm also looking at all the other people in the hospital, people I can relate to such as the janitors, the clerical staff, the nurses, everybody in that hospital needs payment for their services.

They're one of the largest employers. I believe they may be the largest employer in the Peoria community. Actually a lot of communities.

I believe the Galesburg community was represented earlier this evening in Knox County, and I believe they're one of the largest employers there in Knox County also.

With that, I would like to say that I believe that there should be insurance, some kind of way to make every company pay for insurance in this country, or in this State. I'm sorry. Because we are just referring to the State.

The other issue would be because of that, and this is, I know I'm out of time, but real quickly on that note with our shops.

We had one shop in particular, and this goes both directions, our insurance group has to pay when somebody else has a wife that's working, she chooses to drop her insurance, take a job without insurance, we pick up all the insurance.

If both people are working they should both carry the insurance. The primary coverage goes however. They've got an equation for that.

We had one shop in particular which dropped their insurance because all the employees said we'll get it through our wives.

That left a couple of people out, and with that those individuals moved to different areas within our industry.

They're still members but they just said they would leave the shop so that the other guys could get reduced coverage and get the money back on their checks so that they can live.

And I guess that sums up what I have to say. I guess I came here this evening thinking it was going to be more of a conversation along the same or other ideas.

And that's why I'm here for is to just, my personal viewpoint on that. I do know it affects a lot of people and it's certainly, by causing other companies or having some kind of general pool, I would like to say would not make us quit having insurance if there's, if all it would do is help us contain our insurance and be able to provide a better living for our people. Thank you.

MR. KOEHLER: Thank you. Ashley, do we have anybody else that signed up?

ASHLEY WALTER: No.

MR. KOEHLER: I have almost a quarter after 6:00, so with that I want to bring the Task Force hearing to a close and thank you all for coming and participating.

Again, you can look this up on the web site. What is the web site address, David?

DAVID: Go to the Illinois Department of Public Health web site, and under our alphabetical listings there's Health Care Justice Act.

The Illinois Department of Public Health web site is www.IDPH, for Illinois

Department of Public Health, IDPH.State.IL.U.

ASHLEY WALTER: It's also on the handout on the table.

MR. KOEHLER: Again, our thanks for coming.

(Whereupon, the meeting concluded at 6:15 p.m.)

CERTIFICATE OF REPORTER

I, KATHY L. JOHNSON, a Certified Shorthand Reporter in and for the State of Illinois, hereby certify that I reported the evidence in the hearing of the above-entitled cause, before members of the Adequate Health Care Task Force, and that the above and foregoing typewritten transcript is a full, true and complete translation and transcript of all the shorthand notes of the evidence taken down and reported by me at the hearing of said cause and contains a full, true and complete report of all the evidence offered or introduced.

In witness whereof, I have hereunto set my hand the 7th day of February, 2006.

Kathy Johnson

CSR, NOTARY PUBLIC