1ST CONGRESSIONAL DISTRICT PUBLIC HEARING
OF
THE ADEQUATE HEALTH CARE TASK FORCE

IN THE MATTER OF:)
)
THE HEALTH CARE JUSTICE ACT)

TRANSCRIPT OF PROCEEDINGS, had in the above-entitled matter at 400 West 95th Street, Trinity United Church of Christ, Main Sanctuary, Chicago, Illinois, on the 4th Day of October, A.D, 2005, at 4 o'clock, p.m.

BEFORE:

MR. DAVID KOEHLER
MR. JAMES A. DUFFETT
MS. PAMELA MITROFF
MS. NIVA LUBIN-JOHNSON, M.D.
MR. QUENTIN YOUNG
MS. RUTH M. ROTHSTEIN
MR. KEN ROBBINS
MS. MONIQUE DAVIS
MS. KATHERINE BRESSLER
MR. ARTHUR JONES
MR. DONNE TROTTER

MR. KOEHLER: We're going to start the first hearing of the Adequate Healthcare Task Force on time. It is 4 o'clock, and we've got a lot of people who want to make a statement.

We're going to get right to it. I'm David Koehler. I'm the Vice-Chairman of the Health Care Task Force. I'm going to introduce the Task Force Members of the unit.

I'll start again. Welcome. I'm David Koehler. I'm the Vice-Chairman of the Adequate Health Care Task Force. This is our first hearing that happens to be in the District of Congressman Bobby Rush. We're glad to be here at Trinity United Church of Christ.

Let me just mention a couple of things, one, is that they've asked that no food or drink be allowed in here in the sanctuary. Secondly, that, we be respectful, because this is a house of worship, so I think you know what that means just in terms of how we'll cooperate. I'm sure we will. Let me just explain why the Adequate Health Care Task Force was formed. Many of you already know this, but the Health Care Justice Act of 2004, set up this process by which

a Task Force will be appointed by the legislative leaders and the governor to take a period of time to gather testimony and gather input, so that we can begin to deliberate about how we could really effect a change, a positive change, in the healthcare delivery system in Illinois. We'll take it back to the legislature in the form of recommendation or set of recommendations sometime in the fall of 2004. Hopefully, thereafter, we'll see legislation that will change the

various -- how healthcare is delivered in Illinois. You all know that. We'll get into hearing your testimony in just a second.

Let me introduce the members of the Task Force. First of all, I'll start here; Jim Duffett, who is appointed by the Governor. We have Margaret Davis. I'm looking for your name on the list of whom you were appointed by, by the Senate's President. We have Mike Murphy, who was appointed by the Minority Leader of the House. We have Pam Mitroff, who was appointed by the Minority Leader of the Senate. We have Niva Lubin-Johnson, M.D, who was appointed by the Governor. We have Quentin Young, M.D, who is

appointed by the President of the Senate. We have Ruth Rothstein, who is appointed by the Governor, and, myself, so they are your Task Force Members who are here tonight.

I'm now going to turn the meeting over to David Carvallo, who will give the linguistics in terms of how we're going to function tonight. Again, when you come up -- we've set the microphones in this order. I'll read a list of five names. You'll be asked to come up here and sit here, and we'll try and go through this as fast as we can. The microphones are setup, so you could address both the Task Force and the members seated here. We didn't want anybody to try to be in the back or something. Hopefully, this works. David is the

Deputy Director of The Illinois Department of Public Health. David?

MR. CARVALLO: Thank you, David. Before we get started, there are a couple of housekeeping items that need to be addressed. First, if you've not already done so, I ask that you please sign in at one of the tables in the narthax, which is the area just outside the doors

of the church. There are three tables on either side in which you could sign in. This is simply a sign-in to indicate that you are here. The tables to sign-in, if you'd like to testify, are over on the sides of the church inside to the left and to the right.

Second, if you are in need of an American sign-language interpretation, please feel free to move to the reserved seating in the front of the church, in order, to get a better view of the interpreter. Should you wish to testify, please be sure to sign in at one of the tables. Individuals will be called to testify in the order in which they've signed up. If you've brought written testimony to submit, you may, also, do that at one of the tables on either side of the church.

As you sign in, you may have picked up two one-page handouts. Both of these handouts lists the web address for which you could link to the Health Care Justice Act Website. The link is not, yet, operating, even

though it should be in the next few days, so please keep checking.

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We'll begin the hearing by calling out the first ten speakers and ask them to sit in the front pew. We ask that you sit in the order that you are called, so it is more convenient for when you come up here. When you come up to testify, please state your first and last name and spell them for the court reporter. These proceedings will all be transcribed, so the entire membership of the Task Force will have access to the verbal/oral testimony; and, of course, any written testimony you provide will, also, be distributed to all 29 members of the Task Force, so that everyone who's here tonight, who would like to testify, will have an opportunity to do so.

We're asking that your oral testimony be limited to three minutes. I'm always sitting in the front row with a sheet indicating that your time is expiring. Your written testimony, of course, could be longer, but for purposes of this evening and this afternoon, we would ask that you keep your oral testimony to three minutes. Do you have the names of the first ten people?

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MR. KOEHLER: Yes, I do. I ask Dennis Ryan to go ahead and come up to this microphone

here. We're going to use stage right. Would everybody else come up here and sit down here, actually, to your left, stage right. Mark Karner, Jim Duffet, and Hong Liu, just take a seat right here. Dennis?

MR. RYAN: Yes.

MR. KOEHLER: You have three minutes. Everyone we ask to be respectful to the time, so we could get as many people to make comments as possible, so go ahead.

MR. RYAN: I'm Dennis Ryan, D-E-N-N-I-S, R-Y-A-N, from Holy Cross Hospital. Thank you for being involved in this mission. It is very, very important and vital. The system isn't working, and it is getting worse rapidly for many people. Holy Cross Hospital is a hospital that's in Marquette Park on the southwest side of Chicago. We are sponsored by the Sisters of Saint Cashmere and have been for over 75 years, and some of the sisters are here today. We serve an area, geographically, that is home for about a half a million people. We are

the alone geographic hospital in that area. As a result of that, we have the largest number of ambulance runs of any hospital in the State of Illinois. Our emergency room handles -- last year handled 52,000 visits during the year. It is an emergency room that was built to handle about 35,000 visits. You can guess that, that cause lots of problems in terms of grouping, but

33 percent of the patients in our emergency room do not have insurance.

As a result of that, over the past six years Holy Cross Hospital has lost almost $70 million. We've been able to continue, thanks to the commitment admission of the Sisters of Saint Cashmere and help from the State of Illinois, which some of that help has put a Band-Aid on a gaping wound. There's an erosion going on, and it is just not for hospitals. It is in primary care. It is in specialty care. It is in preventative care, and there is an increasing number of people in the state who are without care; and what that means is, that, the costs that are associated with that later on in the system are much, much higher than they need

to be. A very large number of the people, who use our emergency room, don't need to be in the emergency room, but they have no plan of care whatsoever. They have no primary care, and as a result of that, they put off care for much longer than needs to happen. When you see people with medical situations regarding -- where people come in a much, much worse situation where they need to be.

We feel that the playing field has, actually, been reversed. Hospitals that are in place, where people don't have care, are going to be extremely challenged both in the technological capacity, a capital capacity, and a

sadful capacity in the ability to attract and get good quality physicians.

I want to thank you for your mission. You have a very, very important mission, and we hope that you will be able to come up with a formula for the state that could be put into practice that will achieve healthcare which is effective, efficient, caring, and accessible to all. Thank you very much.

MR. KOEHLER: Thank you.

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MR. KARNER: My name is Mark Karner, M-A-R-K, K-A-R-N-E-R. Many people with significant disabilities are living longer healthier more productive lives with the help of ventilators and other devices that assist breathing. Advances in technology are making ventilators more portable, reliable, efficient, and easy to use enabling many more ventilator users to live active lives in the community.

However, under pressure to reduce Medicaid costs, policies are being formulated or adopted that would either deny payment for home-ventilation devices or would require ventilator users to enter into nursing facilities in order to keep or obtain such equipment. These new policies would adversely affect the abilities of many ventilator users to contribute to their communities through their daily work, professional achievements, or other activities.

Additionally, these new policies

would adversely affect the abilities of many ventilator users to contribute to local and national economies by paying taxes and purchasing goods and services. It must, also, be made clear

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that these new policies are contrary to the U.S. Supreme Court's 1999 Olmstead Decision, which upheld the right of people with disabilities to live in the least restrictive setting appropriate to their needs and ruling that unnecessary institutionalization violates the Americans with Disabilities Act.

Our constitution guarantees life and liberty, two of the most basic human rights that cannot be denied to anyone. Denial of essential ventilation support devices jeopardize the lives of people who depend on them, and forcing ventilator users into nursing facilities deprive them of liberty. We must ensure the basic rights of ventilator users to live, to be healthy, and to remain free in the community as contributing members of society.

We must ensure that services for ventilator users and other people with disabilities be guided by the goal of sustaining people's health in the least restrictive setting appropriate to their needs, and, that, people with disabilities, including ventilator users, be invited to participate in developing and

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directing their healthcare related policies. We

must focus our cost-cutting efforts to the prevention of bureaucratic waste and provider abuse rather than to the reduction of home-based essential life-sustaining services and equipment. Thank you.

MR. KOEHLER: I'd like to introduce Mr. Ken Robbins, a Task Force Member.

MR. DUFFETT: Jim Duffett, D-U-F-F-E-T-T. I'm the Executive Director of the Campaign for Better Health Care. My board of directors asked me to give a statement on behalf of the Campaign. We fight for and continue to work for everybody in and nobody out. We definitely want to thank the TUCC for allowing this hearing to be held in your place of worhip, which reinforces how much of a moral issue, the need for affordable, accessible, involving all care, pro all kids quality; because of the healthcare crisis, the economic and social fabric of our sane society has unraveled.

It will continue to get worse, and we as a society are losing economically and immorally. Throughout this process there's going

to be a lot of series attempts, a variety of different proposals. Some are going to be good. Some are going to be a lot of smoke in ears. I know the handout that people got coming in, there are some very deep principles of criteria that we're going to be judging plan-after-plan on.

Accessibility, is this plan going

to be accessible for all Illinois residents, everybody in and nobody out? It is not going to be a voluntary program, you know, you do not volunteer yourself to get sick or to get cancer. Everyone needs to be in this plan. It has to be comprehensive. We're not talking about a Yugo type of a plan. Some of you people may remember the Yugo car. This is going to be a comprehensive plan that includes a wide range of benefits, continuity of care, and an effort of health care facilities to maximize consumer's choice; affordability, is affordable; fairness to individuals, to families, to businesses, and to taxpayers. It is timely and has adequate payments to our providers. Quality, it eliminates disparities to the racism that exists in our current healthcare system; promotes

prevention and early intervention; provides evidence based on the health care of others; costs-containment, spending maximum amount of dollars on direct-patient care, not on flashy TV ads, not on administration and paperwork. It is easy for patients, providers, and practitioners to use and reduce this on paperwork. There's some key criteria. Is sharing the risks among society fair for all income levels? Does it utilize purchasing power, and the continuity of the affordability of care?

This is the first time in Illinois history that there's a clear commitment for an

affordable, accessible, quality healthcare insurance plan for all. Having access to care and having some form of insurance are not the same. This type of plan must and will have both. This is not going to be an easy battle. We want Chapter 1 (phonetic) to stay involved and get active in this effort. Thank you.

MR. KOEHLER: Before I call our next speaker up, I'm going to read the next list of names who are to come up to the stage left, but your right, and sit in this front pew. Hong Liu,

Ben Gibson, Megan Drilling, Joe Patton, Addison Woodward, and Carolyn Estes. Now, Hong Liu.

MS. LIU: My name is Hong Liu, and I'm the Executive Director of Asian Coalition of Illinois. I'm here to represent the Asian Health Coalition of Illinois and to testify to the access barriers to healthcare among Asian-Americans and make recommendations of how to reduce disparity.

The Asian Coalition of Illinois is conducting an advocate health care access project founded by the Illinois Department of Public Health in corroboration with some Asian community organizations. The purpose of this project is to understand the needs and access better to healthcare among Asian-Americans, in Illinois, to provide some recommendations to the State and to ensure the inclusion of Asian-Americans' concern with the State's agenda.

Language, as a public barrier can make communication and visitation to the physician very difficult. An adequate translation can be a better understanding of the disease and the treatment plan. This is even

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more important in the Asian community. We're compelled to honor minorities' communities, since over 65 percent of all Asian-Americans are foreign born, speaking over hundreds of different languages -- access in our community, therefore, is not limited to social, economic standards. There are so many stories of Asians who suffer quietly unable to communicate their needs with their physicians, who do not know how to access the healthcare system. This must change.

The numbers have increased faster in the Asian communities than any other communities. All other communities have seen a decrease in breast cancer rates, only ours have received a dramatic increase. The Health Care Justice Act can change these. Findings from our policy access project are complete with international data. It is overwhelming, that, there are people who are seeking interviews mention language in the cultural content as the primary barrier to healthcare.

Based on the outcome of our study and the Health Care Justice Act, we make the following recommendations: The language barrier

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can be reduced by increasing the number of professionals who speak and understand the language and the culture. We made recommendation to the State to review and revise the communication requirements for those with a foreign degree and for those whose primary languages are English. Instead, we should change the program for foreign health care and many health providers to help re-enter the healthcare wilful, establish a health career and policy program for anyone who's going to present in the health profession, including -- we require appropriate standing for all state licensure of health and mental health professionals that are provided institutions, as well as for the continuing education classes, credit requirements, and provide funding for the Asian-American culture program; mandate that hospitals that receive State funding to include a change in their activities, require health and medical providers with patient capacity and the need of intake. You force language access as provided by
Title 5 and the Language Assistance Act in all

healthcare settings, mandate language access --

MR. KOEHLER: Your time is up.

THE WITNESS: Thank you.

MR. KOEHLER: Before we call our next witness, let me introduce to you State

Representative Monique Davis. If there are others out in the audience wave at us, if not, Ben Gibson. If you could get that microphone?

MR. GIBSON: Good afternoon. My name is Ben, B-E-N, Gibson, G-I-B-S-O-N. I'm the Director of Governmental Affairs at the University of Chicago Hospitals. I commend the members of this Task Force for hosting this important hearing. Our state faces no more critical issue on the availability of quality healthcare for all Americans. University of Chicago Hospitals stand ready to assist this Task Force as you undertake this dyer important mission.

Our hospitals, like hospitals around the state, are committing to serving the healthcare needs of people in our community. We treat patients in every segment of society. The University of Chicago Hospitals is one of the

largest Medicaid providers among children and adults in the State of Illinois. As a pediatric traumatic center on the south side of Chicago, we routinely assist children who are among the sick in the state's region. Approximately, two-thirds of the children we treat are Medicaid beneficiaries. We're opening our new children's hospital, and the construction is underway for a new pediatric emergency room. We have predicated our efforts to provide our state care to the new generation of children, who often present with

medical in a less financial circumstance.

Our hospital has been very supportive of initiatives to help the State maintain increased funding of Medicaid. A new three-year assessment program now being considered by the Federal Government will bring Illinois $1 billion in, critically, Medicaid funding to hope fair for our state's most memorable populations, our efforts to assist the underserved indigent, the Department -- to provide additional care.

Last year, we launched a new program purchased by environmental funds to

assist patients who are considering -- who need permanent primary care providers. The Health and Community Access Program targets low-income, uninsured, and under-insured residents of the south side of Chicago. The program meets patients with primary care and reduces the need for extensive emergency services and provide services for patients who are needy.

We are very grateful for the efforts being made by the members of the Task Forced as you begin. We look forward to assisting you in any way that we can. Thank you very much.

MS. JOHNSON: One question.

MR. GIBSON: Yes.

MS. JOHNSON: Our previous speaker spoke of the means of having culturally competent

professionals trained to take care of those patients that we serve.

MR. GIBSON: Right.

DR. JOHNSON: In the community, for two-thirds of the children on Medicaid many are African-American. I know that the medical school has done a good job with African Americans. My

only concern is about how that continues through the pipeline. We'd like for the hospital to be -- I would like to hear something about what the hospital tends to do in terms of having professionals and particular physicians, not colleagues --

MR. GIBSON: Right.

MS. JOHNSON: -- to be there to take care of those who are benefitting by the services other than --

MR. GIBSON: Okay. It is, certainly, an important goal for our hospital, and it is something that we're obviously working on. We agree that the cultural competence issue is of critical importance, and we have, indeed, in our working efforts seen some improvements over the years. I can, certainly, provide for you specific data on that subject.

MS. JOHNSON: We would like that very much.

MR. GIBSON: No problem.

MR. KOEHLER: Before I call the next speaker, I want to introduce Director Michael

McGrant (phonetic) from the Department of

Insurance.

MS. DRILLING: My name is Megan Drilling, M-E-G-AN, D-R-I-L-L-I-N-G. I'm here to tell you what I believe in health care. I believe that healthcare is a human right, not an employment benefit. I believe healthcare should not be a-for-profit industry. I believe that health insurance companies pay their top management large bonuses as to how high and profitable their businesses are. CEO's of healthcare insurance companies receive multi-million dollar bonuses on top of their multi-million dollar salary. I wrote down how many uninsured people healthcare costs could be covered by those multi-million dollar bonuses. I believe that, that amount is just for one CEO of one insurance company, and I believe we have many large insurance companies. Some of these stay in the State of Illinois.

I believe that health insurance companies are making these sized-profits, yet, our premiums and healthcare costs continue to rise. I believe I have a potential solution to the healthcare problem, and I offer it to you

guys for consideration. I do believe in health -- I believe we should abolish insurance companies in Illinois. I believe we should take the multi-million dollar bonuses, and I'm sure we

could find more -- other than the CEO's and the top managers, and use it to pay for the healthcare costs of the uninsured.

During this transition from private healthcare insurance companies to the state Single-Payer System, I believe that businesses will have to continue to pay insurance benefits to their employees just until the transition can complete. It may seem unfair at this moment, but at least there will be an end on the horizon of these rising costs. I could tell you from talking to people I know, that, this will scare many wealthy people who have money to pay for top care. A state-run healthcare does not include bad healthcare. We have to recreate the system, pay good doctors adequate amounts. Let the bad doctors go. Relook at how medical school is paid for. We have determined the true costs of healthcare. Healthcare costs have risen through the manage care policy setting what

percentage of costs would be paid. In turn, hospitals have increased costs in order for the percentage paid to equal the true cost, a vicious cycle that just keeps exploding.

Hospitals should not have a blank check for costs, but a committee could be created to determine true costs in doctors' salaries, including yearly increases and performance bonuses. We have to appropriately market the system. Most people are afraid of the term

"Medicare". We would have to repackage it some more on how the prunes are not all dried cloves. With the Single-Payer System, we would have to narrow down to 30 percent of healthcare costs and administration, and I believe we could narrow it down to at least two-thirds of that amount. I am not asking you to create --

MR. KOEHLER: Okay. Thank you very much.

MR. PATTON: Hi. Joe Patton, P-A-T-T-O-N. I'm with the American Federation of State, County, and Municipal employees, and I'm, also, a resident in the First District.

MR. KOEHLER: Can you get a little

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closer to the microphone?

MR. PATTON: We represent 75,000 employees throughout the State of Illinois. That includes correctional officers in down-state Vandanlia, nursing home employees, in Champaign County, and librarians, in Evanston; and part of our job is to negotiate health insurance benefits for those employees and their families. That's a total of 200,000 individuals, so why is -- so why be concerned about the issue of people without insurance? I think it is pretty obvious. We believe that this is the biggest challenge in this state. We think the only way to attack this is by looking at a range of options, and, certainly, this Task Force is an important part of that.

I know that over the next many months of hearings, you will hear a lot of stories similar to the ones I've heard in my hospital. They're stories of families who don't get medical care, because they don't have the insurance. They're stories of people who are under-insured and so don't get the prescriptions they need for the preventative care they need.

They're stories of the people who have medical bills that they can't pay and as a result often end up in bankruptcy, and they're stories of businesses that are at a competitive disadvantage, if they want to provide decent healthcare coverage to their employees.

These are stories that make it very clear that the system is broken. Health security funds give a healthy Illinois. It is a proposal that's been endorsed from a thousand small businesses, municipalities, religious organizations, and others around the state, including labor unions. It creates a voluntary plan that would allow people who are self-employed, who work for small businesses, or, otherwise, uninsured to participate at an affordable rate -- low-income residents would be able to have their premiums based on a sliding scale, and part of the funding for that sliding scale portion would come from the insurance companies. We think this plan it out there already in legislation, and we urge that the Task

Force take a long hard look at it and support this proposal as an important step forward in the goal -- the ultimate goal of making sure that every single resident is covered. Thank you.

MR. KOEHLER: Addison Woodward?

MR. WOODWARD: Good afternoon. My name is Addison, A-D-D-I-S-O-N, Woodward, W-O-O-D-A-R-D. I am a retired faculty member of Kentucky State. I'm the ex-president of their group association. That is an association representing the university employees, and it is one of the 50 essential organizations in the state. From the state, we have 240 chapter members across the state and faculty members.

I'm speaking on behalf of the members of the chapter, which is a statement of support that I'll read. We ask you to look at the executive board that is concerned about the number of citizens in Illinois, who have no health insurance, in addition, which seems to be inadequate or minimal health insurance.

The executive board realizes that not only is there a narrow -- citizens have access to a full range of healthcare services, but, also, the fact of providing services to those uninsured is inefficient and costly. The executive board is enthusiastic about the Health Care Justice Act and the statewide hearings of

that act. I ask the State's Senator Representatives to look hard in developing and supporting a plan that provides a full range of health services to all citizens in Illinois. In doing that, our elected officials will be providing leadership to the rest of the country. Thank you.

MR. KOEHLER: Carolyn Estes, Judy Lewis, Cheryl Pomeroy, Sidney Bill, Michael Brennan, and Maureen Craig can come up and sit in the seat here.

MS. ESTES: My name is Carolyn Estes, C-A-R-O-L-Y-N, E-S-T-E-S. I'm here for Governor State University. I'm a graduate student, and I'm, also, a staff member as the special projects manager. I'm, also, a health educator, so I'm just, basically, here to speak as a health educator and as a graduate student in the program. As a health educator, we're dealing with a lot of people from under-privileged communities, who do not have access to healthcare or to other services that we provide as an

addiction counselor. We've had to turn people away, because they do not have insurance based on company policies. As a public educator, I'm here to advocate for those that the Task Force is able to provide cultural awareness of the needs of people who are in the positions of dealing with people who are in under-privileged communities, that, you are able to come up with some type of a

plan to offer insurance, so we could, also, be better service providers and provide equal opportunities for those, whatever the opportunities are.

MR. KOEHLER: Thank you. We've had another member, Katherine Bressler, Katherine, raise your hand to show who you are. Where are we at now? Judy Lewis.

MS. LEWIS: Good afternoon. I'm Judy, J-U-D-Y, Lewis, L-E-W-I-S. I am the Chair of The Addiction Studies in the Behavioral Health Department at the College of Health Professions, at Governor State University. In that capacity, I would like to mention how very meaningful it will be to have an everybody-in-and-nobody-out plan for people who need medical health,

addiction and behavioral health services, where there's access to treatment. Now, their access to treatment now is complicated at best, and I think it is something that's going to be very important for this group; but I, also, want to share with you given the location of this particular hearing, a study that was done by Dr. Ralph Bell, one of our faculty members in the College of Health Professions. Our focus for research in the college, it is health disparity.

Dr. Bell recently did a study in which he looked at health disparities on the south side of Chicago and south suburbs. I will not, of course, read the whole paper, although, I

have submitted that in writing, but I want to mention that in that area which he studied, he found higher unemployment rates than for the rest of the state or the nation, a higher percentage of people living in poverty, a higher likelihood that residents do not get health insurance, a higher infant mortality rate, which means that people in that area of this country will very likely have problems in terms of accessing healthcare.

One thing he found interesting was that some of the hospitals in that area do have access capacity. What that means is, that, some people in the neighborhood will be able to get access to healthcare. What we hope will happen -- what we're sure will happen as a result of the work that you're doing here is, that, this will be available to all of the people. I want to congratulate, certainly, the Task Force and all the other people who are in this room today for recognizing that this is a unique window of opportunity, a once in a lifetime opportunity to make a difference in people's lives. Thank you.

MR. KOEHLER: Thank you. We have Task Force Members Arthur Jones, and Mr. -- sitting in for Tim Boyd. Thank you. Next, we have Cheryl Pomeroy up.

MS. POMEROY: Thank you. Cheryl, C-H-E-R-Y-L, Pomeroy, P-O-M-E-R-O-Y. The current healthcare system in our country is morally and

financially bankrupt. It is like the cancer on our system of democracy, and unless it is removed, I fear that our country as we have known it will wither away and die from this cancer.

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I'm here in support of universal healthcare for every citizen in Illinois. I am with a grass-roots organization called "Illinois Healthcare Referendum 2006". Our website is WWW.Illinoishealthcarenow.org. We plan to get a referendum on the ballot for November of 2006, that, would ask the citizens of Illinois if they want the state to provide all state residents with full-prescription benefits, the right to choose one's own doctors under a publicly financed comprehensive health insurance system. We think they will overwhelmingly say yes.

Although, I'm here as part of a grass-roots organization advocating for a Single-Payer System. I'm, also, here as a working person, who is personally confronting the mess that is our so-called healthcare system. After nearly 15 years as a Union carpenter, my body was too beaten up to continue. I had to change careers for my own health. Now, I am in business for myself, but I am finding that getting health insurance at the age of 50 with pre-existing conditions is a nightmare.

I have been denied coverage once

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and been told I would have to pay higher premiums

for pre-existing conditions, then, I decided I might as well pay for COBRA for myself at $455, per month, because I, probably, needed expensive Shock Wave Therapy, then, when I did not need this therapy, decided I might save a little money by going with a high deductible policy, only to find that my prescriptions cost more than I had realized; and, now, I cannot decided which type of policy is more cost-effective for me.

Truthfully, I could only make the right decision, if I could see into the future and predict my future medical needs, so I will just have to guess at the future; and any way I do it, it will be very expensive. Although, I love working for myself. The uncertainty about my medical coverage and the sudden high costs have been very stressful and time-consuming. I have applied to four health insurance companies for coverage and been denied by one, and I am waiting replies from two presently. I would stay on COBRA for the full 18 months; however, I know that if I develop a really serious medical

condition in that time, I risk becoming uninsurable or having my premiums become much higher, so I'm planning to discontinued COBRA, even though the coverage is excellent.

It feels like playing high-stakes poker, and I know who always come out the winner, the health insurance and the pharmaceutical

companies. It is time to change this. It is time for me and you, and all the people in Illinois, to be winners. Let's stop playing poker with people's health. I would like to see the State of Illinois be a leader in the movement for the Single-Payer System of healthcare and provide health insurance for all of its' resident. Thank you very much for your time.

MR. KOEHLER: Thank you. Senator Trotter has joined us. Sidney Bill, please.

MR. BILL: My name is Sidney Bill, and I am a member of Metro Seniors in Action, Chairman of the Health Committee. As a physician with considerable experience in private practice and, also, under-managed care, I have been a witness to the literal taking over of our healthcare system by the insurance industry. To

me it is no longer that the head of HHS, Tommy Thompson (phonetic), and the spokesman for the Institute of Health, that says, that, the U.S. Health System is in a crisis. We have a healthcare system, which depends upon income for -- personal income for its' payment and results in fragmentation. I have objection to the source being advertised, but I think that -- the guidelines began in advertising whether for hospitals, or physicians, or insurance companies is our judgment.

People's healthcare depends on the kind of income that they have, and it results in

fragmented healthcare. There's a fairness issue. The City versus the Countryside, but the Countryside having less facilities to the need. Quality is an issue for our healthcare system. We are ranked 37th in the world by the World Healthcare Organization, With France being Number 1. We're the only country, civilized country, which does not have a universal healthcare system in place with government assurance.

What the State of Illinois needs is just that, we need to have government

assurance for this strong public health input. We need to have a hospital system that is economical. Physicians who treat diabetes should be held accountable for doing the proper eye examination for cataracts and blindness. The satisfactory treatment on many illnesses are held -- people are held hostage to the HMO System, which forces physicians to act as gatekeepers. This public health hearing today is gratification. I think that the State of Illinois needs a healthcare system that has government assurance behind its' payment process. We need to have a healthcare system that does not depend on a person's ability to pay. We need a healthcare system that delivers healthcare to everybody regardless of their status in life. Thank you very much.

MR. KOEHLER: Thank you. I forgot to say, Senator Trotter is a member of the Task

Force appointed by President of the Senate. Michael Brenan?

MR. BRENAN: Hi. I won't go far, but I'd just love to have a chance to look out at everybody. Can you hear me in the back? Thank

you very much for being here. I want to thank you for whatever you're going to do about this. You're going to stabilize whatever to do. I want to point out the one special area that might miss a lot of people, and that is prescription medicine; because the State has all of these programs, and now we have the Federal Government saying they've got something for us. I've got some bad news about that program, I want to make sure that everybody knows about.

Supposing that your income in the year is 14,400 and supposing -- or that your family's income, with your spouse have -- is $19,400. If you're in that situation, supposing you had 7,000 in prescription costs, if that happens, they're going to say you're going to save a lot, because you're only going to have to spend $4,000 for your medical expenses for your healthcare and premiums; $4,000 of your income, it is only 14,400.

Is there anybody sitting here today that thinks that a person ought to be able to be faced with that kind of oppression burden to pay $4,000 for healthcare when your income is

14,400?

THE AUDIENCE: No.

THE WITNESS: Thank you. I hope that you all are saying no in your hearts, too. I think you are. You are decent people. You don't want to see people suffer, and that's why you're here. I want to, also, point out that when they talk about the medicine that they're covering, this is a roulette. We've signed up for a drug program, and we think we're being covered for our medication, next month they could change that. They're not going to cover your medication anymore, and what can you do about it? You're stuck in that program for the rest of the year.

So this new program is no guarantee. We've got good programs in Illinois, but we need more than that. I want to thank each one of you for everything that you're doing on this, because you're going to be saving lives. Thank you very much. My name is Mike Brenan, and I'm President of Veteran Union Action. That's B-R-E-N-A-N, Brenan.

MR. KOEHLER: I appreciate you wanting to hold the microphone, but I think that we're

trying to tape this. For any other speakers, do not do that, because it is going to goof up the audio. Before I call the next speaker -- the next five groups of people to come up here to your right and left, Tom Wilson, Elli Hoppelep,

Gloria Jean Sykes, and Cila Fleming. Come up and please sit in the front row here. The next speaker is Maureen Craig.

MS. CRAIG: Hi. I'm Maureen Craig, M-A-U-R-E-E-N, C-R-A-I-G. I'm a senior majoring in mathematics at the University of Chicago, and in June, I'll either have to get a job or lose my health insurance. From the time I was about 10 until I was 18, I was like the shoe cobbler's daughter.

My father, a chiropractor, had just found out that our individual health coverage had been transferred from one company to another. Our previous health policy had been quite generous giving excellent coverage for mental healthcare issues; but this new policy gave very little coverage for psychiatric care. About a year later, I was diagnosed with clinical depression. My family had to pay for my

medication and my therapy out-of-pocket.

Additionally, since my mother and father, also, had pre-existing conditions, it wasn't like they could go and start shopping around for other healthcare companies. Meanwhile, as the healthcare industry was taking more and more money out of our pockets for less and less coverage, my father was being paid less by the insurance companies for the healthcare he was giving to others, if he was paid at all.

Earlier in the 1990s, my father

had been involved in a car accident. That had taken away his ability to work for a couple of years. During this time the main industries in our town had all switched over to health management organizations, and my father had failed to get on the approved list of doctors. My father was driven out of business like so many other healthcare professionals, who claim to care about health. Just imagine the irony.

He began working sales jobs, but most of those really didn't cover health insurance. Let's just say, it is a good thing that, except for my depression, I had a fairly

decent immune system. When I began college, I was finally able to get a comprehensive healthcare even though the premiums are a little high, but, hey, it is health coverage. I'll take it as I could get it, but for quite a while my parents didn't -- still didn't have comprehensive health coverage.

Finally, about this time last year my parents got health coverage through my father's employment. However, this coverage won't protect me, because all of the doctors on that health insurance plan are in Tennessee, so either I've got -- so when I graduate, either I got to start looking for a job that has excellent healthcare or I'm going to have to drive to Memphis to get to a doctor. Thank you.

MR. KOEHLER: Time.

MS. CRAIG: Thank you.

MR. KOEHLER: Tom Wilson?

MR. WILSON: Tom Wilson, W-I-L-S-O-N, from Access Living. I will be testifying about the need to include home and community services in a comprehensive plan for universal healthcare in Illinois. Recent information shows that the

majority over 50 percent of healthcare in the U.S. is provided by public sources or government entities. These sources include Medicare and Medicaid. I believe that we need to expand our public funding system and combine all healthcare services into one public sector funded program. This provides the only way to meet the principles of the value. We need a system that is accessible to all, that is affordable to all, and that provides quality healthcare and eliminates health disparities which spend the maximum healthcare dollars on health services, not paperwork.

We should not have different healthcare programs for different social classes, different age groups, different health categories or with different documentation. Healthcare should be a full right for all of us. Access to needed long-term care services with public funding when necessary should be seen as a human right. While families still provide the majority of the long-term care, the vast majority of funded services have been paid for by Medicaid

and not private insurance. Unfortunately, in

Illinois and in most other states, we spend more of this money on institutional placements than home and community services. In Illinois, 80 percent of our long-term care dollars are spent on nursing homes and institutions and 20 percent on home community services. This is the opposite of what most people want.

A federal study for the Year 2000 found that only 19 percent of the nursing homes, in Chicago, were in full or substantial compliance with Federal standards during our most recent annual inspection. Institutional care does not provide the dignity, freedom, and safety that people want when they need these services. We know from experience that home and community services are cheaper in institutions and nursing homes, and, thus, financial resources go farther. Even if this weren't true, home services would be the right thing to do.

As long-term care is an important part of Medicaid, we need to make home and community services a part of the health plan we adopt in Illinois. We can continue to use Medicaid dollars to support home and community

services; thus, we need to include a commitment to expand our own community options and keep our people out of the nursing homes and institutions. We support high quality community

services, but not overly medicalized (phonetic). It is important to keep the control in the hands of the consumer. None-medicalized personal care services keep costs down, and consumer control helps keep quality high when the consumer can control who's coming into the home to provide healthcare services.

We support the following for long-term care: A wide range of home-based services that address physical, cognitive, and social needs. They need to be available for all types of disabilities and all ages. Consumer control is very important when providing quality services and consumer satisfaction, and we need a well paying Healthcare Task Force with healthcare. Thank you.

MR. KOEHLER: Thank you. Elliot Hopperfeld?

MR. HOPPERFELD: Elliot Hopperfeld, E-L-L-I-O-T, H-O-P-P-E-R-F-E-L-D. Several years

ago, I left my nursing home. I had to pay someone to come and take care of me. (Inaudible.) come and everything to take care of me. If anything goes very wrong, she is to help. Today, her son got sick. He had to go to my doctor. He didn't have his own doctor. He has no health insurance. I had to take money out of my own bank account to give her money, because he had no job. I gave him 200, so the doctor would see him. I think people are honest. I met

a man that lost his job in January. He's 50 years old. He doesn't have health insurance. (Inaudible.)

MR. KOEHLER: Thank you. Gloria Jean?

MS. SYKES: My name is Gloria Jean Sykes, G-L-O-R-I-A, J-E-A-N, S-Y-K-E-S, and I'm a breast cancer survivor. In March of 2003, four months after enduring six and-a-half weeks of radiation treatment, I asked Blue Cross/Blue Shield if I was covered for a baseline MRI. I was informed that my PPO policy did cover the MRI with preventative care.

During that telephone conversation, I was, also, told that my

healthcare insurance had risen, again, 20 percent, because I'd just turned 51 years old. In 2002, the premium increased 20 percent, because I turned 50. I paid the increased premium, but soon after that important telephone conversation my insurance was cancelled. I was told that I had the option of appealing the decision at the Illinois Department of Insurance and with Blue Cross/Blue Shield, but since I had suffered breast cancer there is a slim chance that they'd reinstate me.

By being told that I had a rare invasive breast cancer, it was the darkest moment in my life. Having no health insurance coverage was definitely the most stressful and scariest.

While the insurance company is in

the business of making money, I and other victims are in the business of living. Blue Cross/Blue Shield cancelled the policy not because of a missed payment, no. They cancelled the policy, because they didn't want to assume the financial burden of preventative care when the disease was cancer and the required care, MRI, ultrasounds, biopsies, blood tests, and related follow-up

treatments, which costs a lot of money.

In the world that we live in, the lost of healthcare benefits is not only an economic issue impacting lower income people, but it has become a crisis, as well. For cancer survivors at the time, it is an unimaginable reality. One of the most important points I want to make about being a breast cancer survivor is the knowledge that I could pick up a phone at any time and talk to a breast cancer specialist, surgeon, and/or oncologist.

As I stand here, I cannot afford breast -- health insurance. My message today is this, cancer survivors should not get punished by corporate America, because they contracted cancer. Their life was turned upside down. Hour-by-hour lobbiests for big insurance companies, who roam the borders of government in Springfield, and in Washington, give us more reasons to pour our hearts and souls in the crafting of new legislation that will help all the people and remedying insurance coverage the

most.

If you want to change the quality

of healthcare insurance, we must first change the face of legislation, but whatever you think or say, please act now. We urgently need your help, so everybody can afford health insurance, and, therefore, a peace of mind that all necessary procedures, treatments, and exams are covered without question, delay, or cancellation. I still have not had a baseline MRI. Thank you for your time.

MR. KOEHLER: Next?

MS. MILLHONE: I'm a 69-year-old --

MR. KOEHLER: You have to step real close to the mic.

MS. MILLHONE: Can you hear me now? I'm a 69-year-old semi-retired teacher and editor. We moved to Chicago from Iowa the fall that Harold Washington died. That makes it over 15 years ago. I have paid health insurance premiums all of my life, which is to say for over 50 years, so I can still feel that anger and helpless that I experienced when I could no longer afford it, about five years after I moved to Chicago.

Now, we have Medicare. My health

is good, and my day-to-day anxiety is somewhat reduced, but it still questions will these

prescription drug plans be the most benefit to me, if any, I don't know. I'll, probably, spend a lot of time between now and January trying to figure out, but that's a question. Then is the ultimate question, if catastrophic arrives, prolong nursing care, what will happen to me?

My family in California says, Mary Ann, we're not going to let you starve to death, but who knows what the resources will be. I'd grown up middle-class in the depression of World War II. I've never dreamed in earlier years that a social safety net would be unavailable to me in this country.

Today, what I want to do is to give you some specifics on those concerns, and if there's time, I'll go to the current status. My family, in Iowa, had paid about 250 or $300 a month for coverage for the three of us. Our income is around 39,000, so my insurance coverage was about the same as the payments on our four-bedroom house. Three years later, I made my first health payment on my own, my health

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insurance premiums, and instead of 250, it exceeded $600. The different Blue Cross/Blue Shield plan stinks, the medical costs as both premiums. There was a prior illness involved, surgery for cancer. That was 12 years earlier, but the insurance premiums are 600 Bucks. I paid them dipping in savings to do so.

MR. KOEHLER: Thank you very much. I

want to call the next five speakers: Chris Meckstroth, Catherine Tymkow, Wendy Cox, Marian Humes, Giudi Weiss. Clara Fleming?

MS. FLEMING: I'm Clara Fleming, C-L-A-R-A, F-L-E-M-I-N-G. I'm a member of The League of Women Voters of Chicago. I wanted to share with you just a little bit about the study in healthcare, in 1992, '93, not that we were the only organization doing the study on healthcare. In fact, I think we're almost to the stage that we studied it to death, and it is time to move on and do something about it. It doesn't get any better. It gets a bit worse each time. We did do a study, and it was a nation-wide study in the United States, and we were very, very active in it.

Our company, the way we came up with, that's how we did. It was not too important. We did a two-year study that was based on delivery and policy of our healthcare system, healthcare financing, and administration. We had 100 national and state local organizations, in 1994, that urged the passage of the healthcare legislature. Now, that will definite a great help to healthcare in the United States.

In 1998, the Bill of Rights aimed at the Americans to participate in United Healthcare Plans, access to specialists without going to the gatekeeper, the right to emergency

room use, raise the bulk to persons, and, then, in the first place about -- in 1998 or '99, we did a project that had 6500 participants participating in focus groups and advocately committed a book called "How Americans Talk About Medicare Reform in The Public Voice". Of course, our goals are the same as the goals we are asking for in the Healthcare Justice Act. We believe that the basic level of quality healthcare at an affordable price should be available to all U.S.

residents. All United Healthcare policy goals should have adequate distribution of services, economical care, advance in the medical research, and reasonable manage expenditure level for healthcare.

Financing and administration, we do feel should simply favor a national health insurance plan. Again, individual insurance premiums -- I'm out of time already. I can't go through all of it. If you want more information, we'd, certainly, be glad to share our studies with you. Thank you.

MR. KOEHLER: Thank you very much. Say your name and spell it.

MR. MECKSTEROTH: Okay. My name is Chris Mecksteroth, C-H-R-I-S, M-E-C-K-S-T-E-R-O-T-H. I'm a graduate student at the University of Chicago. I'm, also, a member of Democracy for America, the chapter on Chicago's south side. In my own case, I was

fortunate enough to graduate from the top university college, but I was still without healthcare for over a year, shortly after graduation. It is becoming more and more

prominent as the economy is changing in Illinois, and it is more likely to change jobs and starting careers. I was in training for a job, and, then, I changed jobs. I was waiting for the healthcare to start in one job and -- I think the point is taken that while it is certainly true, that, our particularly -- this truly has to be addressed. Also, the fact that more and more a mental health problems, it is a problem across economical and education levels and across age levels.

What I want to focus on is, as a member of Democracy for America on Chicago's south side, we've been talking with a lot of people in and around the community and in our neighborhood in the last few days, and we were overwhelmed by the response. Everyone is talking about problems with healthcare. Everyone is very excited about the Healthcare Task Force working on this problem. Even though we've only had a few days to throw something together, we were able to get over 300 signatures in a matter of days from people on the street saying, that, they want to make sure that the plan that comes out of this process is really a plan for everybody in

the State of Illinois.

We're very insistent, that, people we talk to that don't want to see people only -- they want to see something like a solution. People say they want a guarantee of healthcare for everyone in the State of Illinois. There's 300 people here, which submitted; in addition to that, 850 members of our February chapter is just here on the south side of Chicago. We're, also, working from other chapters in other organizations in the state and doing similar things.

The thing that I think is really important for people to understand is, that, in the last month we've seen examples of the -- I think one of the biggest lessons they've seen from that and all learned from that is, that, when there's a huge crisis affecting a huge number of people in the state and country, it effects their security, their health, and their lives. The government of the United States has a responsibility, and we have more of a responsibility to step in and provide guarantee to make sure that everything is taken

care of. We can't go on with a system where some people get some healthcare and some don't. We have to make sure that everyone is getting the healthcare that they need. The same way the government has the responsibility to make sure that everyone is getting taking care of in that situation.

In close, I just want to let everyone know that we will be continuing to work on this issue and following things and talking to your legislators around the state supporting that. Thank you.

MR. KOEHLER: Thank you.

MS. TYMKOW: Good evening, Senators and State representatives. My name is Dr. Catherine Tymkow, C-A-T-H-E-R-I-N-E, T-Y-M-K-O-W. I'm Professor of Nursing at Governors State University, in University Park, Illinois. I am here with a cohort of graduate nursing students from the University of Chicago Hospitals.

We are concerned about the state of healthcare in Illinois and in the nation. We see firsthand what happens when patients go too long without adequate care due to lack of funds.

The wealth of the nation is measured in the strength of its' citizens, and, certainly, any measure of strength would include health. As the richest nation in the world, we believe that it is travesty that in any given time, in the State of Illinois, 1.8 million people in Illinois and over 46 million Americans are unable to access healthcare services because of inadequate insurance.

A recent article in the Nation's Health, a publication of the American Public Health Association, noted, that, the fate of public hospitals across the nation is vulnerable

to healthcare cuts. At the same time, emergency rooms are overcrowded with sick individuals who are not trauma victims, but rather those who cannot find care for common conditions, infections, minor injuries that require treatment but not expensive emergency room care.

Women are risking the possibility of fetal death or the long-term health of their infants, because they lack the resources to obtain prenatal care in a timely manner when preventative measures could make a difference in

pregnancy outcomes for both mother and baby. These phenomena are all due to a healthcare system that needs a series overhaul to include priorities that span the continuum of life from birth to death, to maintain health and to prevent illness.

Implementation of the Healthcare Justice Act will go a long way in fixing an ailing healthcare system. As a nurse, educator, and user of healthcare services, I encourage you to make access to healthcare available to all citizens, in Illinois, and to include nurses as key players in this process. Thank you.

MR. KOEHLER: Thank you.

MS. COX: Good afternoon. My name is Wendy Cox, W-E-N-D-Y, C-O-X, and I'm the CEO of Chicago Family Health Center. We're a not-for-profit community health center providing primary healthcare in South Chicago, Roseland,

and the surrounding communities. I appreciate the opportunity to talk to you today about some of our concerns, and we were going to focus, actually, on one particular area, primary care; and that, specifically, is the lack of dental

care in our communities. High-quality dental care is important for everyone. Good dental care for pregnant women can prevent low-birth rate babies. There's research that shows there's a strong link between oral health and expectant mothers and how they could pre-term low-birth rate babies. Even after the babies are born, the mother's can transmit the decay containing bacteria through the day-to-day living. All pregnant women should be seeing the dentist during their pregnancies for at least preventative cleaning. The Illinois Department of Public Health reports that only 38 percent of new mothers, in Illinois, reported going to the dentist in their pregnancy.

Children, as they're growing up need to be taught about good oral health prevention and how to keep their teeth healthy and gums healthy. This will help our children grow up healthy and strong permitting good nutrition and self-esteem of the child. Tooth decay affects nearly one-fifth of two year olds and only half of eight years olds. The hardest hit are the low-income children in our

communities. They're reporting that dental disease is the number one cause of absenteeism amongst elementary school children, with more than $51 million lost each year due to dental related illnesses. Good oral health can help prevent periodontal disease in folks with diabetes. In fact, periodontal disease is often considered the sixth complication of diabetes. Adequate oral care for both children and adults continue to be a problem, particularly, those in low-income groups. This is evidenced by a long waiting time in the lack of providers at all, especially in the communities that we're serving.

Chicago Public Health Center has a clinic in one of our sites. We have more than a four-month wait for existing patients, and, certainly, longer if you're a new patient into our system. The largest barrier is simply the lack of available healthcare services, but, also, many providers are reluctant to participate in public programs such as Public Aid, often cited in a social service rate, low reimbursement rates that would be decent. At the health center the

current rate theology, actually, discourages and is a disincentive for expansions in programs. It is our job at Chicago Family to help those that are medically underserved and to provide primary health and dental care, as they're richly

deserved. We're here today to encourage the community to not forget dental healthcare as an important component of primary health.

MR. KOEHLER: Thank you

MS. HUMES: Good evening all. Marian Humes, M-A-R-I-A-N, H-U-M-E-S. I represent Human Resources Development Institute, a 31-year-old not-for-profit organization in behavioral health; and I will read my remarks, so that I might make sure I stick to the time limit. To the Task Force, to the elected officials, to Reverend, Clergy, and to Community Leaders who are here, I just want to call your attention to the fact, that, in the behavioral health community we've cared for those addicted. We've cared for those in mental health, and what we've watched is the fact that we have less services than we've had in the past. Those addicted were at one time able to have treatment, because the Federal Government

paid for it. At this point, we're dependent upon the State, whose funds are lacking.

For the mentally ill, we are facing a real crisis. The demand for the treatment -- the treatment on the demand was passed in the last election by over a million and-a-half people, and, yet, we've had no movement on that issue in this state.

We're seeing doors being closed to persons in need of medical care. We're seeing doors being closed to those who are at least

unable to speak for themselves, the mentally ill. We stand as an advocate for them. It has been the most serious kind of situation that happens to be, that, medicine such as Dyprexa and Cerebral are no longer available in The States' formulator. According to most psychologists, psychiatrists, and physicians, they were the most effective medicines used for the mentally ill.

In addition to that, I bet most of you do not know that any medicine that will encourage sleep in the mentally ill is no longer on the States' formulator. What, then, are we to do for people who need the help? How cruel is

that to not afford them those medications that they really need. I would like to say, that, the policies that have been set by our governor interfere with the most sacred thing that there is, and that is the relationship between a patient and their physician; because a physician may prescribe, but because there's not the funds, then, that patient may not be able to have those prescriptions.

MR. KOEHLER: Thank you. Giudi Weiss, before you start, State Representative Mary Farrs (phonetic) is with us. Can you acknowledge where you are?

MS. WEISS: My name is, actually, Giudi Weiss, G-I-U-D-I, W-E-I-S-S.

MR. KOEHLER: I'm sorry.

MS. WEISS: That's okay. You're not

the first to make that error. I'm speaking today on behalf of the Gray Panthers. I got interested in healthcare reform about 15 years ago, including marketing work for hospitals, and I was struck by how much money they spent, not on mental care, but on competing to get the most profitable patients. It was only much later that

I learned just how much money is wasted by our market base for profit system. Marketing, processing claims, and other administrative costs are up to at least 15 percent of the money paying premiums provided to insurers. By contrast, public insurance programs like Medicare use only about 4 percent of their budgeted costs. We're the consequences of this tremendous waste of money.

Insurance companies and hospital executives get rich. The industry gets rich. Pharmaceutical companies are incredibly rich, and millions of Americans don't get the healthcare they need. They don't get the preventative care that would assist them well and the diagnostic tests to catch the disease early, and they don't get the treatment to let them live longer healthier and longer productive lives. About a third of the people in this country don't have the insurance they need to get the kind of care. It fluctuates a bit on how many people are working and have jobs, because in this country health insurance is tied to jobs -- tied to some

jobs, not freelance work like I do, not part-time

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jobs like Walmart or adjunct professors, and not a lot of low wage jobs, jobs for small employers who cannot longer afford to give their workers health insurance.

One-third of Americans are uninsured or seriously under-insured. I look around at the kids in my neighborhood, and I think one of three of these kids are not going to get the biggest -- is not going to get the healthcare that they need. Our riches in the world has made that political decision, and it is a political decision. If I had to pick those kids, the one in three, which ones will I chose? Who will I tell a working mother, I'm sorry your kids will have to be sick? The health of the insurance industry is more important than the health of your children.

We support Single-Payer universal healthcare. We have a vision of what this country can be. That vision is the right of everyone to live without the fear that a serious illness will leave us in poverty or worse. Every other developed country does it, every one, and we can too. What does the healthcare system look

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like? We think the system should have five major elements: Equal opportunity, the same high quality benefits for everyone. Number 2, comprehensive benefits covering all medically

necessary evidence based care for body and mind. Number 3, the right to choose your own provider. Number 4, a role for consumers and providers in all levels of planning and implementation; and, finally, a guaranteed equitable system of financing. Thank you for this opportunity to share our views.

MR. KOEHLER: Nicholas Skala, go ahead and take the microphone; Marcia Rothmebereg, William McNary, Gregory Vachon, and Beatrice Lumpkin.

THE WITNESS: Good evening. My name is Nicholas Skala, N-I-C-H-O-L-A-S, S-K-A-L-A. I'm a research associate for health policy physicians for the National Health Program. I've come to encourage the committee to recommend the adoption of a comprehensive, exclusively, not-for-profit Single-Payer statewide insurance system. None of us have any doubt that our healthcare system is failing in Illinois, as it is failing in the rest

of the nation.

1.8 million Illinoisans lacked health insurance, in 2004, the best empirical data suggests that twice that many went uncovered for at least a month, and the rest of us face rapidly escalating costs for increasingly woefully inadequate coverage.

To this I would add an additional consideration. The devastating effect of rising healthcare costs on the competitiveness of

American business. Private employers pay 20 percent of the total U.S. health expenditures, $600 billion a year. Large employers are assuming massive liabilities for current and future retirees. In GM's loan case, it is estimated around 63 billion.

Businesses that offer coverage often pay 10 percent or more of payroll in health benefits, and those that want to provide coverage for their employees are forced into a competitive disadvantage with firms offering little or no coverage at all. Out of control healthcare costs stand poised to wreak havoc on the U.S. economy. Health benefits now add $1500 to the cost of

producing an automobile in America. Ontario produces more cars per year than Michigan. After intense lobbying by a number of states, Toyota decided to locate its' twelfth North American plant, in Canada, due to lower health costs. The problems that face other states besides Illinois.

Fortunately, the experience of other nations show the same solution works in businesses and patients alike. The U.S. manages to spend twice as much for cancer, breast care, because a large proportion of our health -- to the business administration and paperwork. The process, an eligibility determining who pays, full profit sales and marketing conditions of business' burden of administering their own

health benefits.

I call the communities attention to Dr. Handler, who last year found that of Illinois $64 billion health spending, 12.5 billion of that was needlessly wasted on paper pushing, a fragment of the full process. There's more than $7,000 for everyone uninsured resident in the state and more than enough to provide

comprehensive coverage to everyone will relieve business' burden of health expenses. These savings could only be realized if we commit ourselves to a Single-Pay System. By contrast, able to perform and preserve our process will only exacerbate the existing problems for businesses and patients. Single-pay is the only opportunity to restore the health of our population and our economy. I hope this community sees fit to take it.

MR. KOEHLER: Thank you. Marcia Rothenberg.

MS. ROTHENBERG: Marcia, M-A-R-I-A, Rothenberg, R-O-T-H-E-N-B-E-R-G. I'm the Health Policy and Senior Outreach Coordinator of Access Living, and I'm a retired registered nurse. I was going to present some principles for health reform from a disability perspective, which I said in many ways is different from the respective population as a whole. Everybody has presented those principles, and they are very different from the needs of the population as a

whole.

I'll just very quickly say, it is

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non-discrimination, comprehensiveness, appropriateness of services based on individual needs, equity, efficiency and simplicity, and consumer control; and people have said this in various ways, and we agree. We at Access Living believe that these principles can only be met by a not-for-profit Single-Payer healthcare system. People with disabilities, including many seniors, suffer from the onus of being a drag on the healthcare system. Disability is a natural part of the human experience and not a special interest. Disability is often random and sudden. It is impossible to look at healthcare for a profitable business, and at the same time to provide needed and equal healthcare for all. It has not worked. It never will work.

Almost as important as uncoupling healthcare access to profit is separating it from employment. For people with disabilities, it has kept employees from hiring them since they raised the cost of medical benefits; and for those whose disabilities prevent them from working, they're separated out as charity cases and often required to prove their legitimacy over and over

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again. For those people who lose their jobs or who are between jobs, a continuity of care is

interrupted and access is completely lost. The insurance pool should include everyone.

I have a personal story. I hurt my shoulder in New York last week. I took my Single-Payer Medicare card to an emergency room. I was given some relief. I came back here. I went to my doctor, and I was able to choose a physical therapist in my neighborhood, Hyde Park, and that's what everybody should have. Although, ultimately, the Federal Government has to institute the Single-Payer System. Illinois has a chance to make history leading the way with real healthcare reform. Hopefully, the formidal power of the healthcare industry in its' various manifestations will not cloud the judgement of law makers from doing what is morally and rationally correct.

MR. MCNARY: Good afternoon to Chairman Koehler and Members of the Adequate Healthcare Task Force. My name is William McNary, M-C-N-A-R-Y. I'm the president of U.S. Action and the co-director of its' Illinois

affiliate, Citizen Action/Illinois. My wife and I are, also, Members of Trinity United Church of Christ, so I am both elephant-elated and peacock-proud to offer this testimony at this important hearing.

Citizen Action/Illinois is the state's largest progressive public interest coalition. We believe that a quality affordable

healthcare should be a right of guarantee to all. Citizens Action/Illinois has built a record of healthcare victories on behalf of consumers, including protecting HMO patients and providing relief from the high costs of prescription drugs for seniors and persons with disabilities.

Since 2003, Citizens Act of Illinois, along with Illinois for Healthcare, have been leaders of the Healthy Illinois Campaign. The Healthy Illinois Campaign is a statewide coalition of over 1,000 small businesses, healthcare providers, religious organizations, churches, elected officials, urban and civic organizations, not-for-profit organizations, all of us working together throughout the state to ensure that high quality

affordable healthcare is a right of guarantee to all, especially the 1.8 million uninsured in Illinois. What difference would it make if we offered high-quality healthcare to all, but it is unaffordable? That would merely be taxpayer subsidies to HMO's, drug companies, and insurance companies. It would break the bank, and that is fiscally irresponsible.

If healthcare was affordable and we offered it to all, but it is not high quality, it would lower everybody's healthcare standards, and that is socially unacceptable; or if the healthcare was high quality and affordable, but we did not offer it to all, that is healthcare

apartheid, and that is morally reprehensible. Healthy Illinois Proposal will create a statewide insurance plan to make quality affordable health insurance available to small businesses, the self-employed, and other uninsured residents. At the same time, Healthy Illinois will help bring in the skyrocketing healthcare costs and health insurance rates and will undertake a statewide effort to improve healthcare quality and eliminate some of the regional, economic, and

racial disparities in the healthcare system. The chief sponsors are State Representative Mary Flowers, who is, also, a member of Trinity, and State Senator Debbie Halvorson from the south suburb, whose district extends from Chicago Heights to Kankakee.

One of the campaign's founding principles is that comprehensive healthcare reform is possible, only if we in this room and beyond are willing to put aside our old assumption about who's on whose side; but as a noted philosopher, Moms Mabley, once put it, "If you always do what you've always done, you'll always get what you've always got" That's why we've been reaching out to both traditional and non-traditional allies. We've sat down with leading insurance companies. We've spoken to Chambers of Commerce downstate. We have held townhall meetings in Hyde Park and all across the state. We look forward to working with you to

achieve the goal and no less than high quality affordable healthcare as a right that is guaranteed to all. Thank you.

MR. KOEHLER: Okay.

MR. VACHON: My name is Gregory Vachon, V-A-C-H-O-N. I am in the position of the Medical Director of Austin Health Center of Cook County located at the corner of Chicago and Cicero Avenue, in the Austin community. The Austin community has more women than any other community who gets to the time of delivery -- to the time of delivering a baby without having any prenatal care. Late entry into prenatal care is a common occurrence and contributes to the high infant mortality. To impact this probe, we advertised on our busy corner for a free pregnancy tests. With the advertising and our process for quick entry care, we have observed that more and more women are coming in, in their first trimester of pregnancy for prenatal care.

Despite these positive trends, we had to pull down our signs advertising pregnancy testing and prenatal care, because we were unable to handle the high volume of parents, because we are under-staffed. Our health center and our community are experiencing the impact of Cook County's budget difficulties.

The problems with uninsured people

of the working age with chronic illnesses are

even worse. Currently, our waiting list for patients is well over 100 people long. Our current rate, we know that the person that goes on the list today will not get an appointment for over six months. We, also, know from screening programs that some of these people have untreated diabetes and some have blood pressure readings that should put them in the emergency room. It is sad and truly unjust that some of these people will suffer permanent organ damage, even death, for not being able to access care.

Many will, eventually, access care, but at a point where they will require expensive tertiary care for complication of untreated diseases. We should, of course, provide care equitably, despite the potential for increased costs; but, in fact, we know that treating these patients with chronic illnesses before they experience complications will cost less, and not more, if we do it right.

That is to say, structural changes in the delivery of care by a Single-Payer coverage, less money, more productive lives, real

gains, and lower infant mortality, real justice in healthcare, these are within our ability to deliver in the State of Illinois. I urge the Task Force to deliver bold recommendations to our legislators. The time to act is now.

MS. LUMPKIN: Beatrice Lumpkin, L-U-M-P-K-I-N, with Soar, S-O-A-R, Steel Workers

Organization of Active Retirees. The Steel Worker's Union asked us to be here, because healthcare for all is their top priority. I didn't have notes. I didn't intend to testify, but something happened yesterday that brings me up here.

The get-together of steel worker retirees, all of whom were put out on the street by companies that had closed losing their healthcare, and this woman not quite 60 came up to me and said, I can't come to the townhome meeting with Congressman Jessie Jackson. I have to see my doctor. I said, Well, maybe you could come after or before. She said, Well, I have a cancer issue, so what do you do when a friend says I have cancer? You put on your happy face and you say, which is true, Oh, I have so many

friends who are healthy survivors. I kept on until, finally, she blurted out the five words that throws my blood. She said, I have no health insurance. That day I lied. I said, Well, I hope you don't make your decision based on that, and I knew that she was getting ready to lose her house, which she shared with her 87-year-old mother, and she sold the house. Where could her mother go? I hope I didn't lie. I wasn't sure, and I said, Oh, I think there are organizations that might help you; but I really felt pretty stupid after saying, Well, just do what the doctor says.

So I'm here today to add my voice for all of the steel worker retirees to healthcare for all, but more than that I think -- there's enough money being spent on healthcare, so why aren't we all getting it? We've got to take the profit out of healthcare. Now, I don't mean people should not be well paid for their work, including the ones that scrub the floors of hospitals. Since there's 30 seconds left, the other thing I'd like to see be included in the legislation is coverage of prescription of drugs.

MR. KOEHLER: The next speaker is Victoria Bigelow.

MS. BIGELOW: Thank you. Victoria Bigelow, B-I-G-E-L-O-W. I'm Victoria Bigelow. I'm on the Access to Care Program, which is a charitable program which serves the uninsured working poor in suburban Cook County. We link eligible people who are under 200 percent of poverty not eligible for any public insurance and don't have private insurance, so truly the uninsured worker employee.

We link them with private physicians. They pay $5 for an office visit. They pay $5 for specimen drawn for tests, routine x-rays, or 10, 20, or 30 for prescription medication. We're funded largely by Cook County, also, by township, municipalities, foundations, clubs, churches, and so on. It is a wonderful program. I'm very proud of it. It doesn't meet

the need, folks. There are 250,000 people in suburban Cook County who could belong to Access to Care. I could take care of 28,000 with the doctor commitments I've been given, but we only have money to serve about 12,000. You do the

math, and that's a lot of people who are left out of the program. We cover people who are working for the most part; 57 percent of the people in our program had income below poverty, even though we go up to 200 percent; 40 percent, Hispanic; 30 percent, White, equally divided between African-American and Asian-American.

Our top diagnosis for adults are hypertension and diabetes. These are chronic diseases. We could keep people going, if they could see a doctor and if they could get the medication. Without that medication, they could have very serious health consequences. They could lose their job, and, then, they can't work.

I'm here to say this, please craft a system. It is very difficult. You've taken on a big job, but it is totally solvable, because we're paying for it anyway. We're paying for it through the back end. Let's pay for it through taxes from the front end, why not? Please implement a system that includes everyone and that insures that every physician will participate; because right know with the Medicaid

program, we have doctors who can say, I'm sorry, I don't take Medicaid, and, then, the patient has to search for a physician who can and who will. Let's make this comprehensive. Let's make this for everyone in Illinois, and it will be expensive; but if we cut down on the administration duplication, that will save some money. We have to recognize, and we have to do a good education job for everyone to recognize, that, we are paying for a very inefficient and a costly system right now that doesn't work for a lot of people.

If we pay for it in a straight forward manner, we could make it work for everyone. Thank you very much. My program's statistics on this group of people who are truly uninsured, 17 years worth of diagnosis, the utilization of cost information could be helpful for you, please call me.

MS. JOHNSON: While the mic is being adjusted, I want to take a moment. I'm Dr. Johnson. I'm a member of the Adequate Health Care Task Force; more importantly, I'm a member of Trinity United Church of Christ. I want to

say some words of thanks to the persons here at Trinity, who've been very helpful with coming about this hearing today. Of course, my pastor, Reverend Jeremiah Wright, Reverend Evelyn Williams, my Ministry, Church, and Society, which

have been greeting you and guiding you as you arrived today, Deacon Riley, who is responsible for the linguistics today, and, also everyone else here at Trinity, our security people and anyone else I forgot. I want to thank the Task Force for their attendance and patience.

Being here was an idea of mine, and it wouldn't have come to this without those here at Trinity, but, also, the Department of Public Health, our over-qualified timekeepers, the Deputy Director Dave Carvallo, and, also, Ashley -- and our volunteers from the Youth High School of Public Health. If I forgot anyone else, I just wanted to give those words of appreciation. Thank you.

MS. BROWN: My name is Dionda, D-I-O-N-D-A, and the last name is Brown. I'm representing Parents and Children, the first African-American advocate program under the

umbrella of the American Lung Association of Metropolitan Chicago. We have a slogan, "Asthma kills, but it doesn't have to". Unfortunately, with the lack of medications, it is killing a lot of our young African-American males in particular. I'm not here to talk about asthma today. Actually, I'm here to talk about a personal medical crisis that I've endured.

I've worked in the nursing field for over 20 years, and I've helped take care of people all of my life. I've been involved in my

high school for 28 years, and I'm the president of the alumni association there. Five years ago, I was properly finally diagnosed with metastatic breast cancer. I had insurance at that time, because I was a military dependent, so I wasn't afraid. I wasn't even scared or sad. When I was diagnosed, I prayed to God and said, Okay, what do I have to do to get better? I went through several surgeries, chemo, radiation, and the staff doctors did an excellent job with me. I'm in remission, and I thank God every day for my life.

When I'm over at Austin High

School volunteering, I look at those young people and know when they graduate they won't have insurance. Unless they have a job that gives them a full-time position, they won't have insurance unless they go to college. I look at those young people, and I try to do the best I can and motivate them and keep them focused as to what they need to do for themselves.

In 2003, I lost my medical coverage, because I got divorced a few years back, and I was covered under my ex-husband's coverage for a while. It may not seem as important for anybody, but someone who has had medical coverage all of your life and all of a sudden you're between surgeries -- I had a right mastectomy with partial reconstruction, so I had to walk around with a prosthesis and get

adjusted, back pain and everything, and wait for a year and-a-half to fight in order to get disability insurance.

I was told when I applied for a medical card that I was too intelligent, to intelligent to get a Public Aid medical card. With my intelligence, I was told that I should be

able to get a job. Mind you, I was swollen. I've lost 50 pounds since last year, so I was swollen, but they said no. You're too intelligent for us to give you a medical card. They said get out and get a job. I have documentation to prove it. Get a job and pay for your own medical bills. I rehabilitated myself. I prayed, and I volunteered at my school. I do get business disability for my medical. I refuse to be degraded again. I don't have a medical card. I pay for prescriptions. I avoid going in places where they smoke, because I'm asthmatic, and it is triggered by cigarette smoke and do what I can to keep myself healthy and strong and others. If we could pay for more, then, a lot people don't support medical coverage to people -- I think we should by now take time out and take care of our own people. We deserve to have medical coverage.

THE WITNESS: Good afternoon. My name is Beth Najberg, N-A-J-B-E-R-G. I would like to thank the Task Force. I want to thank you for listening to our concerns and our

recommendations, and I want to thank Trinity

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Church. I expected to be in a high school gymnasium, so this makes it easier for all of us. I, informally, represent all the self-insured in Illinois, 5 percent of Illinoisans, and the figure holds that the United States 5 percent are self-insured. In Illinois, that's 573,000 people. I pay $650 a month, about 8,000 a year, for premiums for HMO. I have many friends who spend 10,000, 12,000 a year, again, for much limited -- more limited coverage than people who work for Fortune 500 Companies or any public organization. We have no options.

You've heard other people explain some of the problems that we have. Insurers put up obstacles in the riders of the policy. By the time they've added all of the riders, it would have been more than I'm paying now. The people say the insurers, and, then, in reply to say, Oh, we've supposed to go for ICHIP (phonetic), ICHIP signed a law guaranteeing insurers 125 to 150 percent of the premiums paid by other people. They have an incentive not to offer us premiums. What do we want? I want -- one of the things, where does the money go? National figures say,

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that, it costs about $5300 a year, per healthcare, for an individual person across the United States. I'm paying 8,000. Other people pay lots more. Where does that money go? There

were two plans at the Federal level that have just been recently defeated that were interesting options. One was to live to buy insurance across state lines. I'm 61, so I don't need maternity care; the option of buying insurance in a state where I don't have to be charged for that option. The other option is association health plans.

Many years ago many organizations like AAW, American Association of -- they offered healthcare plans that were equal to those of an employer base. One suggestion to consider is not to allow any of the cherry-picking that all the -- that insurers offer. Pool the risks by having anyone self-insured, their insurance rates would be the same, whether you're 18 or your first job, 16, and eligible for Medicare. Thank you very much.

MR. KOEHLER: Thank you. Jacki White.

MS. WHITE: Good afternoon to the Task

Force and to all of the elected officials and everyone here this afternoon. I really didn't want to speak. The reason why I didn't want to speak, because nobody has talked about the people that are dying. There are so many people without health insurance that are dying. I am a cancer survivor, colon cancer. When I was in the hospital, there were people in the hospital with me who did not have health insurance. I'm the only one that came home alive. For that reason,

I didn't want to speak.

When they called me and asked me to represent where I live, Frances -- this comes from the Breast Cancer Coalition who asked me to come and speak. I didn't want to speak, because I am tired of seeing people die without health insurance. Recently, I just lost my job. I don't have health insurance. A friend of mine, who I've worked with for 15 years, was, also, laid-off in January, she's dead. Do you know why she's dead, because she had diabetes. I have Diabetes Type II, but she had full diabetes. What are we to do?

This folder says 1989, that, we've

been working on this. What's taking so long? People are dying. Let's stop the dying and save these people. This universal health insurance is needed in this country, not because we want to see everybody live, but we want to stop the people who are dying unnecessary deaths, unnecessary. A person should -- I mean, we have the best technology. I tell you I know it, because I've worked on my job for 15 years. I know what kind of technology this country has, and we have good technology. No one should be dying of colon cancer. No woman should be dying of breast cancer, not in this country. No man should be dying of prostate cancer.

There should be more doctors like Dr. Terri Mason. People should be living. No

babies should be dying, because their mother can't get prenatal care. We have the ability. Stop talking about it. I'm going to fill this out and do what you say, go over and talk to people; but I want you to help me, because see me talking and all of these people in this room talking is not going to get this done, unless this Task Force really means what they say.

We'll help you and you have to get behind us, too. Let's stop talking and stop the dying and save people's lives. Thank you.

MR. RICHARD: Bernie, B-E-R-N-I-E, and my last name is Richard. I flew in to Chicago -- southeast Chicago, where I am a social worker, counselor -- I want to invite you into my world. The world of the quiet conditions. My request is simple, that, we pay more attention to the conditions at a state level and all of our local levels creating educational programs and groups to cut into the quiet conditions.

Three examples of the quiet conditions that I spar with every day, post-immigration depression. We've all heard of postpartum depression. It is a head cold compared to the pneumonia of the post-immigration, which is much more serious and pervasive.

The second example, which I'm not going to say anything about, because we won't have time, domestic violence. The third example

is something I spar with every day, hopelessness. Now, I'm not a happy camper. In

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order to be a happy camper, I never want to hear the words "Yo ho que hacer" (Spanish spoken) I don't know what to do. I don't know what to do.

All I'm asking is that we all pay more attention to our funding and our imagination to provide preemptive and pro-active services at all levels, state levels and local levels. Thank you.

MR. KOEHLER: Salim AlNurridin, Rafael Gonzalez, if you'll come on up; Judith Trytten, Mark Blum, Larry Joseph. The next speaker is Salim AlNurridin.

MR. ALNURRIDIN: Thank you. Good evening. I'm trying not to be seen. First of all, good evening. I see a number of other very distinguished persons on the table, who I know, and so for that reason there are a few certain that the Task Force is equipped to represent the needs, I'm sure are going to be telling over the next few months. I'm, also, very happy that the legislature decided to use some funds, so you could come out here again on the public trail; because I think that you, probably, won't get as much going into the

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community that you would get knowing that someone is working on this. I appreciate the comments

that were made, but many are more hopeful; because working in this thing for the last 15 years or so, this is the closest I've seen us to it, so I have to believe that we'll just be in tracking distance. The question is how we move on it.

I don't want to spend a lot of time, because I think that many of the speakers before me covered many subjects, and you're going to hear a number of others. I'll try and hit things that are not covered. I know I'm concerned about healthcare finance. I know that no matter what we start talking about, eventually, you have to figure out how you're going to pay for it and how you're going to sustain. As like they say in governmental circles, how are we going to pay?

Healthcare started off as charity care by religious institutions like this one. It wasn't a-for-profit entity, but they forget that now, because people want to stay alive and get the newest field and newest machine. I'm

concerned about men's health. Since general assistance got taken off the books, men with no income are just lost. There's no place to go, except to the safety net, and that doesn't make any sense to me at all, but, again, I'll leave that to another day.

I'm interested in talking just for a moment about what I think is, probably, an

essential aspect of your plan when you present it. If in your plan you do not include how we're going to deal with healthcare shortage, how are we going to deal with the fact that we no longer have technical high schools, where we could be teaching some technical skills around some of these careers, if we're not going to talk about the three-year waiting list for nurses in community colleges, if you're not going to talk about the fact, that, if you're in a hospital overnight, you will see the tiers of healthcare; because you only have one nurse on the floor, and you have three or four different levels of who's going to clean the bathroom.

It is a miracle how we're suppose to manage, but the issue is we don't seem to be

interested when Cuba is giving away doctors' education. When you go to the Philippines and get trained for a nurse, and we import them over here, what's the matter with us that we're not developing education from the elementary school onto the fields that we need, in order, to deal with this, affordable, accessible healthcare; but you have shortages, and you can't get yourself taken care of anyway. Thank you.

MR. KOEHLER: Thank you.

MR. GONZALEZ: Good evening Task Force. My name is Rafael Gonzalez, R-A-F-A-E-L, G-O-N-A-L-E-Z. I'm a diabetes educator and health educator. Primarily, I'm working on

Chicago's southeast side and south suburbs. Many of the barriers -- I want to kind of back up with the young lady who was speaking about the diabetes. Many of the barriers, especially in the Hispanic community and African-American community that I go out and educate, a lot of barriers, that, we could educate on how to prevent diabetes and how to manage it, but there are barriers that have no access to insurance or Medicaid or Medicare. To put education on the

table for them and try to teach them what they respond with is, fine, teach us, but who is going to supply the medical needs? Who's going to supply the insulin? Who's going to supply the medical scripts for us to manage every day like our doctor says? For those who can afford them, they can't afford to buy them for long. The prices are going up. The costs are going up.

These are prescriptions that are prescribed by doctors, but the prescriptions are worthless if you can't afford to buy them. It is just a piece of paper. This is what you need, but who is going to pay for it? A lot of people are dying from chronic diseases. It is time for the taxpayers, as the lady said. I've been in many rooms where there's planning, but I've seen no action. It is time for that population, the African-American population, the White, the Asian, or anyone who lives in the State of Illinois to be serviced as equal. Thank you.

MR. KOEHLER: Julie Trytten.

MS. TRYTTEN: Judith Trytten T-R-Y-T-T-E-M, I'm a clinical psychologist in private practice and still working for the United

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Family Center, which serves Catholic schools and low income areas of Chicago. Most of this is my personal story, however.

I was laid-off by Bank of America in 1995. At that point, I decided to go back to school and get a Doctorate Degree in psychology. In the summer of 1996, I had to choose a insurance policy. I was having trouble reading the fineprint, so I decided to go to an insurance advisor. She advised me to get a temporary policy, and, then, later apply to Blue Cross/Blue Shield. Unfortunately, during the process I found a lump in my breast. I was faced with the decision to wait to get treatment, essentially, cheating the system and trying to apply -- to finish the plan for the policy or to go ahead with the treatment. I guess I didn't do that.

I decided I didn't want to risk my life, in spite of what some of my friends were saying, you're never going to get insurance again, at least, a low cost insurance. When I was halfway completed with the radiation, my temporary policy ran out, so after 51 years of paying into the insurance system, I was now

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uninsured. Michael Reese told me that, that was

no problem. I could simply arrive for my radiation every day for three weeks with $400 in hand on my student income, and I would get my treatment or I could go to Cook County.

Unfortunately, my -- I can't tell you how difficult it was to face mounting medical bills with my illness and to know that I was unable to pay them, also, simply walking down the street and knowing that I could not go into a hospital and expect to be treated, as I had all of my life. I know there are many people who have had that situation throughout their life, and I know I was very fortunate to have it that long; but the loss was very different from just knowing other people in that situation to suddenly being in that situation myself is really different.

I did choose, ultimately, to apply for ICHIP insurance and got it, but compared to the $100 that I was paying -- I was paid very well by Bank of America for my job. I'm now paying $475 a month to get the ICHIP insurance. Since then, and this is '96, my ICHIP has gone up

consistently. It now costs me $800. This is State of Illinois insurance for the people who can't get other insurance; $800 a month, that's for a $2500 premium deductible.

As a result of paying that, my student loans were really high. This whole system is grossly unfair as many people know. I

work with families. I work for people who are unable to pay medical expenses, who pay high insurance such as this. The healthcare system in this country is unfair. There's one for people with money and those who don't. We do need everybody in and nobody out, as in this case.

MR. KOEHLER: Mark Blum.

MR. BLUM: Thank you. Good afternoon. My name is Mark Blum. That's M-A-R-K, B-L-U-M. Unlike my colleagues who have spoken this afternoon, I'm not from Chicago. I'm from Washington D.C. My organization is American Agenda Healthcare for All and represents 20 international Unions. They collectively represent several hundred thousand workers in the State of Illinois. Unions that have collectively committed to the cause of winning affordable

healthcare for all, but, who, also, recognize; and I don't think it is going to come as a surprise to anyone in this room, that, the leadership to win affordable healthcare for all Americans is unlikely to come from Washington through the White House through to Congress.

We, originally, presented the first healthcare plan in 1949. We still haven't seen it move out of DC. Fortunately, there's a movement break through in healthcare, and other social health services protection is coming from leadership in the states; programs like ICHIP's, KidsCare here, in Illinois, beginning in

individual states, where courageous selective leaders and citizens like yourself organized in one tremendous victor to spend health coverage.

Social Security has that kind of program called "RX Plus", where states begin to pull citizen's purchases of prescription drugs -- it began in a state program under leadership, and defended that program. The process that -- we're just very excited to sit and observe beginning in this room today to the need of people who care what Illinois care about and in states all over

the country. I just want to commend your legislature, Barak Obama, who passed this bill, and, indeed, Governor Blagojevich has signed it.

Members of the Task Force who are carrying on the responsibilities, actually, implementing the charging for legislation to achieve the great goals of the bill and to the legislature and your governor who is going to, actually, sign this bill. You're serving as a deacon for hope and inspiration. Don't doubt this a second to American people across the country, who are looking at your example.

I've heard some references -- to the economic of healthcare and other speakers spoke to many other manufacturers moving across the water to Ontario. Indeed, the big three American manufacturers allowing vigorously for expansion in healthcare, in Canada, to take the costs or to share the costs of the healthcare for

their employees with the other members of that country. It is ironic, isn't it? We just received a letter before I left to come to this -- to come here to join you, which I want to share with you from a manufacturer's small paper

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product, who is, also, moving to Ontario. He said he's moving there with great regret. In this case, the State of Massachusetts always has been committed to providing comprehensive healthcare to all of its' employees. He could no longer afford to do it in this country. He's moving to Canada. He is saying, I'm an American. I'm, also, a businessman. I regret that I no longer will compete under these conditions in this country.

MR. KOEHLER: Thank you.

MR. BLUM: Thank you.

MR. KOEHLER: Larry Joseph?

MR. JOSEPH: My name is Larry Joseph, J-O-S-E-P-H. I'm a senior research associate at The Chapin Hall Center for Children at the University of Chicago. Much of my current research focuses on Medicaid and the state -- children's health insurance programs in Illinois. That's what I'm going to talk about briefly.

Since the late 1990s, Illinois has made major progress in extending healthcare coverage for low income children through its'

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KidsCare Program, which receives Federal matching funds from both Medicaid and SCHIP. The State has always been using SCHIP funds to gradually extend coverage for low-income parents through Family Care. These gains in healthcare coverage for children and families are in jeopardy, however, because the key budgetary problems are at both State level and Federal level.

During the past several years of fiscal stress, many states have curtailed outreach activities for Medicaid and SCHIP. Some states have instituted enrollment freezes, lowered income eligibility limits, and raised premiums and co-payments in their SCHIP programs. Illinois is one of the few states that's continued to expand eligibility; but the state's ongoing fiscal problems have led to heightened concern about the growth of Medicaid spending. Unfortunately, several prospective candidates for governor, in 2006, have equated expanding eligibility for medical assistance with increasing welfare dependence.

At the national level, mounting budget deficits have spurred efforts to curtail

Federal Medicaid funding. Various proposals to change the program's financing structure will be considered by the new Medicaid Advisory Commission, which is charged with producing a set of recommendations by the end of 2006. In

addition, the adequacy of future Federal funding for SCHIP is in doubt. Finally, there is an imminent danger to cut Medicaid funding that will be used to partially offset the costs of relief and recovery from Hurricane Katrina.

In developing a healthcare for Illinois, the Adequate Healthcare Task Force is likely to focus on people who are currently uninsured. My message to the Task Force is the State's recent and ongoing progress in health care coverage for low-income children and families should not be taken for granted. Don't forget about preserving and building on the gains that Illinois has made in Medicaid and SCHIP. Thank you.

MR. KOEHLER: Thank you.

MR. MCKERSIE: My name is Robert McKersie, M-C-K-E-R-S-I-E. Good evening. I'm a family physician at Chicago Family Health Center

on the southeast side of Chicago. I'm, also, a member of Physicians for National Health, PNHP; PNHP, it is a single-issue organization advocating for a universal comprehensive Single-Payer Health Care Program for Illinois. We started in 1987, and PNHP has more than 13,000 members and chapters across the United States. I'm testifying at this hearing as a strong advocate for Single-Payer Health Care Program for Illinois. The term "Single-Payer Medicare for All" and "National Health Program" are

interchangeable and will be used in my remarks.

Being a physician who has worked with the underserved, uninsured, and under-insured for the last seven years on the west side and south side of Chicago, I see every day the challenges that my patients face in securing adequate healthcare, and, unfortunately, I, also, see the consequences. Examples abound in my work highlights the need for Single-Payer or Medicare for All Health Care Program. We do a wonderful job at the clinic, but at the present due to financial restraints of qualified health centers by our healthcare team that goes to many

of the homeless shelters on the south side and offer homeless patients HIV Tests -- a homeless person or any patient for that matter being denied an HIV test is an opportunity missed in diagnosing, treating, and stopping the spread of this pan-epidemic. Many of my patients, also, cannot get affordable medications. The Cook County pharmacy is over-taxed, and our clinic, even with generous drug samples and our own pharmacy program that offers medication at a reduced price, is not able to meet all of our patient's medication needs.

In addition, due to a long waiting list for specialty care and procedures at Cook County Hospital, my un-insured patients sometimes have to wait months for proper care. A tragic example is a lovely African-American man, who

came to me two years ago with abdominal pain and thin stools. Six months later he was seen by a specialist at CCH, and, unfortunately, was diagnosed with invasive carcinoma of the colon. The waiting list at CCH for a diagnostic colonoscopy is now not six months, but 22 months. A Single-Payer Program would have alleviated all

of these access to care issues.

We know from peer reviewed health care research that our nation, the wealthiest in the world and a nation that spends more than twice as much per capita on healthcare as any other nation, has one of the worst life-expectancies for both men and women when compared to other developed nations. The U.S, also, has one of the highest infant mortality rates compared to these same developed nations. In fact, our infant mortality rate just increased for the first time in 40 years. The mortality rates for uninsured people have been shown to be 25% higher than those for insured people. This equates into roughly 18,000 Americans who die every year, because they don't have health insurance.

We, also, know from peer reviewed healthcare research, that, Single-Payer Healthcare Program to improve the health of our citizens, it is the only program that will convert the not-for-profit entities. For-profit hospitals and medical clinics have consistently

been shown to offer inferior healthcare when

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compared to not-for-profit hospital and medical clinics. For this reason, Single-Payer is the medically right thing to do.

MR. KOEHLER: Thank you. Time is up.

MR. MCKERSIE: I just urge you to consider a single payer.

MR. KOEHLER: Hatran, Carmen Velasquez, Rodney Bullock, Yvonne Mesa-Magee.

MR. HATRAN: Hi. My is Hatran, H-A-T-R-A-N, and I didn't anticipate standing here and speaking, and, also, I'm a little nervous. However, I work as a therapist on Asian Women Services, which is an agency serving the Asian Community and Uptown Chicago. What some of the concerns that I would like to share in working directly with Vietnamese elderly and, also, adults -- patients with chronic mental illnesses, is, that, I've heard so many stories about women in their 60's, 70s, and 80s, who's been five to ten years who's never been to a doctor. One being, that, they're afraid. They're afraid, because they don't know that there are things that are available for them, one being language.

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Language barrier is a huge barrier for these communities. I work a lot with Vietnamese, so language being one thing and another thing is cultural. A lot of Vietnamese

people in their countries have never been to doctors before or hospitals, and those are like the scariest places for them. For example, in Vietnam, if you are terribly hurt by a car accident and you are taken to the hospital, if you don't have the money, then, they don't care for you. People come here with that mentality, that, if you don't have money, no one is going to service you. That's what my clients are afraid of. They don't go to the doctor unless it is something very severe, so they wait and wait, and sometimes they have illness that's built up over the years without being detected.

I guess what I would like to ask you -- to talk about with you is the language and culture barrier issues. I know there will be more talk of it coming up soon, and I'm surprised there isn't already pursuant to the issue with the communities, specifically, the Southeast Asian community, who are later refugees here in

this country. Thank you for that opportunity to speak on that.

MR. KOEHLER: Thank you very much. Ms. Velasquez.

MS. VELASQUEZ: My name is Carmen, C-A-R-M-E-N, Velasquez, V-E-L-A-S-Q-U-E-Z. First of all, again, thank you for allowing me to speak. As I come today, on October 5, 2005, some of them -- the issues in this country are the following: When talking about universal

healthcare, and when we say "universal healthcare for Americans" we're talking about Iraq, we're talking about Katrina and how we responded as a nation to people who were disfranchised; but I'm going to throw another word in that's going to make us all nervous. To some it is a dirty word and to some it is who we are. We are the immigrants, and we are the undocumented; and what I'm asking here today is, that, this Panel and the challenge before itself, that, as you debate this issue and hear the recommendations come to the floor, including the costs of it all, that you include the people who are here in this country and who they call us the -- how do they

call it, the Galicians, like aliens; but, no, we're not aliens. We're from Mexico or Southeast Asia. We don't have papers, but we live here. We take care of your kids. We work in the restaurants. We work in the hotels.

Include us, because as I understand what's going to happen here, you as a Task Force have until 2007 to come forth with some recommendations. Some of us sat here very patient.

How long is that going to take? Well, let's see now, I'm 66 now. We have two more years, and I'll be 68; and, then, the recommendations go into the General Assembly. That's another two years. I will be 70. In those years that have gone by and when you make

those recommendations, you will have many people who will die. We'll have many immigrants undocumented, who will not have access to healthcare.

We need your serious -- I know you're serious, because you're here listening to all of us; but as you go forward, people have to tug and say keep that door open to all, and all

of us included, the immigrants.

MR. KOEHLER: Thank you.

MR. BULLOCK: Good evening, Members of the Task Force. My name is Rodney, R-O-D-N-E-Y, Bullock, B-U-L-L-O-C-K. I'm here on behalf of Illinois Johnson (phonetic) Association, and I chair the public policy and legislation of the -- I'm, also, a graduate student now at Governor State University, and I work on the mental health partnership that the government is working on right now.

With all of that said, up until about two months ago my family did not have health insurance. How that occurred, I was driving down the Bishop Ford one day, and a car came across the median and hit me head-on and fractured my neck. I worked for a company at that time, and the first communication I received from my company was a letter that said that my health insurance was terminated.

To save time, after surgeries, fusions, and metal plates in my neck, I had to

choose -- I had Medicare, but my family didn't have insurance. I had to choose between which of

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the $1200-a-month medications I would buy. The result was that sometimes I had to be hospitalized to get the care and treatment that I needed, but I had to make a choice. I still had a family.

Also, a few months ago my son broke his thumb. He had the KidsCare insurance, and he could get the primary treatment; but when he was referred to a specialist, because it was broken along a growth plate, we could not find a specialist to take the KidsCare. That was a very nervous time there. I could deal with myself going without medications, but I couldn't deal with that for my son.

As of right now, I'm in a second Master's program since all of this has happened. This one is addiction studies, another problem that we have. I just wanted to say, this is not a class issue. It can happen to anyone. I was just going to work one day, and my life flashed before me. I thank God that I'm still alive, but I believe that a calling is why I'm still here. I'm not in a wheelchair, and I can move, even though my neck was severed. I just ask you to

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continue the work that you're doing. If you're out there and listening or at home, you're only

one accident away, you're only one diagnosis away from being sick yourself.

Another, and I know my time is running short, but the process that you go through to get the Public Aid and Medicare is so humiliating. It is so bureaucratic. It makes you feel less than human, but you have to deal with it. Until you have to look and see that you have about 20 different medications that you have to take that you can't afford, you have doctors' offices and healthcare insurance companies calling, and you just -- you really don't care. You don't care about the bills. You care about your family.

I just want you to take one thing with you today, that, we have to have hope. My hope is in you, that, something can happen to change this situation. It is not right. Again, I have gone back to school. I'm still going to school, and after this I'm going to law school. I'm going to keep fighting because of the experiences I have. There are others who have

had far worse experiences. This is the richest country in the world, and these things need not happen in these United States of America. Thank you for your time.

MR. KOEHLER: Yvonne Mesa-Magee.

THE WITNESS: Good evening. My name is Yvonne Mesa-Magee, M-E-S-A-M-A-G-E-E. I represent Westside Health Authority, and we are

in full support of the Healthcare Justice Act. I can talk on a personal level, and, that, personal level is to say this, I am a professional, and my husband is a professional; and I'm the only one, realistically, who can afford to drop dead or get ill.

Just as the previous gentleman said, it is hard when you're trying to juggle how to pay -- all the things, tuition, gasoline, rent, gas, and all of those things, and not to mention food, and, then, try to make a decision about whether or not you're going to pay for healthcare every month.

Right now, I think it would cost me about $1400 a month to have healthcare on my job, and we just can't simply afford it. That is

the reality of it. Somehow we must band together and ensure that healthcare remains affordable for everyone in the United States. Thank you.

MR. KOEHLER: I think that was our last speaker. Are there any other speakers left? Let me just say to Reverend Johnson, thank you and to the individuals and the members of Trinity of Christ; but, certainly, thank you through the church and through all the staff that made our welcome here so wonderful.

Thank you to the staff of The Illinois Department of Public Health. Thank you to the stenographer. I'm always amazed at the skill. Thank you to the Task Force Members, and,

lastly, but the most thank you to all of you who have testified. I think your honesty was stunning, and good night.

We have this information both on tape and submitted written testimony, and we'll take that to heart. If you spoke from heart, we'll take that to heart. With that, I want to say thank you.

(WHICH WERE ALL THE PROCEEDINGS HAD

ON THE ABOVE-MENTIONED DATE IN THE ABOVE-MENTIONED MATTER.)

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

I, CHERLYANA SIMS, a Certified Shorthand Reporter, doing business in the County of Cook and State of Illinois, do hereby certify that I reported in machine shorthand the statement in the above-entitled cause.

I further certify that the foregoing is a true and correct transcript of said statement as appears from the stenographic notes so taken and transcribed by me, this 19th Day of October, 2005.

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CHERLYANA SIMS
Cook County, Illinois