ADEQUATE HEALTH CARE Task Force
PUBLIC HEARING - 5TH CONGRESSIONAL DISTRICT
JANUARY 4, 2006

TRANSCRIPT OF PROCEEDINGS had at the hearing of the above-entitled matter, taken before DEBORAH R. SANTI, a Notary Public within and for the County of Cook, State of Illinois, and a Certified Shorthand Reporter of said State, at Center Place Banquet Hall Community Center, 10040 Addison Street, Franklin Park, Illinois, on the 4th day of January A.D., 2006, at 4:00 p.m.

Reported by: Deborah R. Santi, CSR
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Task Force MEMBERS PRESENT:
Wayne Lerner, M.D. - Chairman

Timothy M. Carrigan
Margaret Davis
James Duffett
Quentin Young, M.D.
Ken Robbins

ALSO PRESENT:
Dave Carvalho - Senior Staff Liaison

CHAIRMAN LERNER: My name is Wayne Lerner, and I have the honor of chairing the Adequate Health Care Task Force. With me today are Margaret Davis and Doctor Quentin Young, who are members of the Task Force. We thank you for being with us. Also, David Carvalho, who is our senior staff liaison to the Illinois Department of Public Health. We appreciate David's attendance as well as his colleagues from IDPH. We really thank you for helping us make all of these arrangements. There are several other people in the audience I know who want to be recognized, and before I get started, if they would like to stand up and introduce themselves.

Jim?

MR. JORDAN: Sure. I'm Jim Jordan on behalf of Michael McGrath, Director of Insurance.

MR. HARMON: I'm Don Harmon, I represent this part of the world in the State Senate.

CHAIRMAN LERNER: Thank you, Senator. Thank you, Jim.

Any other individuals other than the people who want to speak who would like to introduce themselves for the record?

MS. DALEY: I'm Polly Daley from the Department of Human Services.

CHAIRMAN LERNER: Thank you, very much.

I would like to remind you that we have a court reporter with us, and so I ask you to speak loud enough and slow enough so that she can take down your words of wisdom as the transcript is available for everyone through public dissemination.

MS. DAVIS: There is one more, Wayne. The gentleman in the back.

MR. HAP: I'm Johnny Hap. I'm running for U.S. Congress here, in the Fifth District.

CHAIRMAN LERNER: Thank you, very much.

Please introduce yourself.

MR. SAVIANO: I'm Skip Saviano, State Representative for this area.

CHAIRMAN LERNER: Thanks. Thank

you very much.

MR. CARRIGAN: Tim Carrigan, I'm on the Task Force.

CHAIRMAN LERNER: Thanks, Tim.

Anybody else that I've missed?

Welcome to the Fifth Congressional District Public Hearing of the Adequate Health Care Task Force which was established under the Health Care Justice Act.

It's been well-demonstrated that a person's ability to gain access to the health care system influences the treatment that he or she receives, the outcomes of that treatment, and their health status as well as their functional status.

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

care services.

Many citizens of Illinois lack access to the health care system because they lack health insurance. On any given day an estimated 1.8 citizens of Illinois are without health insurance. Additionally, a growing number of us here, in Illinois, are under-insured and the consumer's share of the cost of health insurance is growing.

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

The Health Care Justice Act signed into law by the Governor in August of '04, encourages the State of Illinois to implement a health care plan that provides access to a full range of preventive, acute, and long-term health care services and

maintains and approves the quality of health services offered to Illinois' residents. In other words, we want to focus on continuous improvement and focus on quality outcomes while paying attention to cost recovery.

The Act creates the Adequate Health Care Task Force which has undertaken the task of developing this access plan. Twenty-nine members of the Task Force were appointed by the Governor, the President of Senate, the Minority Leader of the Senate, Speaker of the House, and Minority Leader of the House.

As part of its work, the Task Force will be holding at least one public hearing in each Congressional District to seek input from the public regarding the access plan which is clearly why we are here this afternoon.

As it turns out, I think instead of 19 public hearings we are now having 21 across the state of Illinois.

On behalf of the Task Force and the Illinois Department of Public Health,

I would like to thank each of you for coming out this afternoon to take part in this very important process.

Before we get started I have a couple of housekeeping items: First, if you have not already done so, please sign in at the table located at the back of the room. This will help us track the number of people who attend the hearing.

There are also several handouts available that provide more information about the Health Care Justice Act, the task force, and the public hearing, and those are available to you as well.

Second, should you wish to testify, please be sure to sign up at the table near the entrance to the room. Individuals will be called to testify in order in which they sign up. And if you brought written testimony to submit, you may also do so at that same table.

We will begin the hearing by calling out the first five speakers. Please sit at the front of the room where we can

recognize you in the order in which you were called. Before you testify, please be sure to say your name and spell your name, first and last names, for the court reporter. And please be reminded that oral testimony will be limited to three minutes.

Also joining us is a member of the Task Force, Jim Duffett. Jim, thanks for joining us.

Okay. Let's get started. We have the first set of five speakers in order: Susan Gordon, Ed Roberts, Noreen Baid, Susan Swider, and Rodney Walker.

So if you guys would sit in the first row there. We have Susan, Ed, Noreen, Susan, and Rodney.

MS. GORDON: Good afternoon, Chairman Lerner and members of the Task Force. Thank you for the opportunity to testify.

My name is Susan Hayes-Gordon. Susan, S-u-s-a-n; Hayes, H-a-y-e-s; Gordon, G-o-r-d-o-n. I'm the Chief Public Policy Officer at Children's Memorial

Hospital. I'm here on behalf of Patrick Magoon, who is our president and CEO to provide the highlights of his testimony which have been submitted in full.

Children's Memorial Hospital is the only freestanding, full-service, pediatric acute care hospital in Illinois. Since our founding in 1882, we have been dedicated to serving all children regardless of their family's financial circumstance.

We are the single largest provider of pediatric Medicaid inpatient and outpatient services in Illinois, and because of the breadth of depth of services we offer, we have the privilege of serving children from every single legislative district in the state. Last year we cared for 102,000 children from throughout the state providing 9,300 admissions, 362,000 outpatient visits, and 53,000 ER visits. Five percent of the ER visits were for children who were uninsured which equates to about a little more than 2,600 children. Many of these children are undocumented.

In 2004, our hospital offered $27.5 million in uncompensated care including Medicaid as part of the total $99.9 million that Children's dedicated to programs and services that benefit the community including community clinics, child advocacy, family support and interpretation services, medical research, and other programs for which we are not reimbursed. The charity care amounts include free or discounted care and access of cost over reimbursement for Medicaid which amounted to 24.5 million in 2004.

We help patients without insurance to find coverage through Medicaid, Family Care, and Kid Care, and for those families that don't qualify for public assistance, we often waive fees, offer discounts, work out payment plans, and so on. Medicaid is a critical safety net, and we rely on it and so do the families of our nation and our state. Congress and the successive administrations have worked hard to ensure that lower income children have access to health insurance and Medicaid provides that.

The National Association of Children's Hospitals whose board Patrick Magoon serves as chair of, developed some recommendations. We have submitted them to this Task Force in full for your consideration.

And just in a nutshell, the three things that the National Association is recommending is that all children who are eligible for Medicaid be enrolled, and secondly, that we have to ensure that the services are available to all children regardless of their income level, and to do that hospitals and physicians must have payments that are predictable and sufficient to meet those costs of services. And third, the federal government is making substantial investment in the development of quality measures for hospitals through Medicare which serves the elderly. There is no such investment for children, and we urge the federal government to make a comparable investment in child health quality measurement to ensure Medicaid has both program

accountability and the data needed for quality and performance based measured.

In closing, I would like to say that Children's Memorial supports efforts and policies that would ensure all children have the health coverage they need and access to appropriate care that they require. This is why Children's was among the very first to endorse the All Kids Program, and we look forward to working on that as it is -- as it rolls out.

As you all review the many proposals you will receive in the coming months, I urge you to help ensure that the solutions do not come in the form of greater burden on hospitals that are already shouldering a significant responsibility in the care to the uninsured. Providing health care to those who lack insurance or adequate insurance is a societal responsibility, not a hospital only responsibility. And all of us: hospitals, health care workers, union, business, government need to work together to craft reasonable plans, and we look forward to

doing that.

Thank you very much.

CHAIRMAN LERNER: Thank you, Susan.

We've been joined by another member of our Task Force, Ken Robbins. Thanks, Ken.

The second speaker is Ed Roberts. Mr. Roberts?

MR. ROBERTS: My name is Edward Roberts, R-o-b-e-r-t-s. I live in Schiller Park, Illinois.

As a private citizen, when I look at this, I think some of our problems in health care and a couple of these are buzz words: accessibility, affordability, administrative costs of delivery, and overall costs.

Regarding accessibility to deny insurance to someone because companies have a choice to insure only the healthy to me is strange. That's to say the least. There are stronger terms which might be attached at this practice, but we'll stick with strange. I would hope your commission recommends we

join the five other states where people purchasing health insurance cannot be charged higher premiums or be denied coverage because they are not healthy, because they have preexisting conditions. This could mean having one standard-type policy with basic coverage: perhaps generic drugs, limited testing, et cetera.

Eventually it is the people who pay for medical costs either through their own dollars via insurance premiums or pay directly to a provider as care is given or through lower wages as employers pay a portion of their wage costs with the cost of insurance premiums or via taxes.

Government today pays about 45 percent of all medical costs. I'm not telling you people anything you don't know, I'm just giving it as I see it.

Recognizing that it's the people that pay for health care, I hope your commission will explore pre-tax withholding from all wages to cover the majority of health care costs. Employers who currently pay for

part or all of the insurance premiums could switch these costs into gross pay and then make the appropriate health insurance deduction. This deduction hopefully will be a flat percent of gross earnings. Probably 10 to 15 percent. So even the working poor will pay but in smaller amounts as their situation would dictate.

A few years ago I read that our administrative costs gobbled up 25 percent of all health care costs. The rest of the world used 12 percent of health care cost for administration.

Please consider a standard basic no fringe insurance policy which I touched on earlier. We currently have a paperwork joke with so many companies each offering a variety of polices. There could also be standard optional packages to cover things not included in the basic polices. This is kind of patterned after Medicare today. I would hope these optional offerings would be very limited.

A central data bank for

medical history could be mandated by you allowing certain professionals to have access to an individual's medical information. I think the insurance industry already has this. Let's get it out into the fresh air to save some redundancy of cost as people use different providers.

Litigation is one factor pushing administrative costs. One small suggestion, once the FDA approves a drug, the developing company should be immune from lawsuits. I believe the State has recently done some work in this litigation area, more attention is needed.

In closing, I hope you find a wisdom to come up with a plan that the Savianos and the Harmons could pass. Thank you.

CHAIRMAN LERNER: Thank you very much, Mr. Roberts.

Noreen Boyd.

MS. BAID: Thank you very much, Dr. Lerner. It's Noreen, N-o-r-e-e-n, Baid, B-a-i-d.

I am the Director of Communications of Government Relations for Advocate Illinois Masonic Medical Center, and I'm honored to testify before you this evening, and we're honored to serve the people of Illinois' Fifth Congressional District and the neighboring districts as well.

We are part of Advocate Health Care which is the largest health care system in the state. I commend the members of the -- of the Adequate Health Care Task Force for hosting this hearing to listen to our views on these issues and how we could provide access to quality health care for the people of Illinois.

Advocate Illinois Masonic Medical Center in partnership with Advocate Health Care, our corporate parent, has long been concerned about the crisis of the uninsured and underinsured. We support efforts to find reasonable and workable solutions to the uninsured crisis.

We're a not-for-profit faith based provider with a mission to serve the

health needs of individuals, families, and communities. Illinois Masonic, like other Advocate Hospitals throughout Chicagoland, is committed to the health care for people in our communities regardless of their ability to pay. We proudly offer one of the most comprehensive charity care programs in the nation. Advocate offers discounts to patients with incomes up to 400 percent of the federal poverty level. Financial counselors meet with each inpatient to review their insurance benefits and coverage and for those who may need assistance with their bills, we offer to patients, so that they know about our charity care program and how it's available to them. Additionally, as part of the charity care application process, we work with patients to determine whether they are eligible for Medicaid and Kid Care to provide ongoing health care coverage. The benefits that Illinois Masonic provides to our community are well beyond charity care for helping our patients obtain financial assistance.

In accordance with the

Illinois Community Benefit Act, Advocate filed its first community benefit report at the end of last June. We provided as a system over $240 million in community benefit programs and services in the year 2004. For example, Illinois Masonic runs one of Illinois' busiest trauma centers. In 2004 we saw 1300 trauma patients come through our level I center. Operating a level I trauma center is extremely expensive and many of our costs go unreimbursed. Additionally, Illinois Masonic is the largest community-based teaching hospital in Chicago training hundreds of medical students, residents, and fellows each year. Across the Advocate system we spend more than $30 million each year on medical education as part of the benefit we provide to the community.

Illinois Masonic faces challenges of other urban hospitals. We are always trying to do more with the same amount of resources. Advocate Health Care System is fortunate in that through rigorous financial management we do have a little positive

operating margin. At Advocate the dollars that our margin provides are all reinvested into the organization. We're able to acquire the newest medical technology and update our -- update our physical plans and perhaps most importantly these dollars now allow Advocate to keep the doors open and invest in Illinois Masonic and our other two city hospitals which all three together post a $2.5 million operating loss every month.

At Advocate we believe everyone living in America deserves access to affordable health care. We recognize that Illinois and the nation face a daunting problem that can't be solved quickly or easily. Certainly, the Governor's All Kids Program is a large step in the right direction. Thus we ask the Task Force to carefully and properly consider the many proposals that will be presented over the next coming months. Whatever this solution the Task Force considers we respectfully ask the Task Force members to recognize that placing a greater burden on hospitals will not solve the

uninsured crisis and will only damage perhaps permanently the health care system in our -- and our patients in our communities that have come dependent upon us.

Hospitals alone cannot solve the crisis. The partnership and commitment of everyone is necessary to find a workable solution. Those of us at Advocate Illinois Masonic Medical Center along with the rest of the Advocate system stand ready to assist the Task Force in meeting this challenge.

Thank you.

CHAIRMAN LERNER: Thank you very much, and I apologize for mispronouncing your name.

MS. BAID: That's all right. It happens all of the time.

CHAIRMAN LERNER: Susan Swider.

MS. SWIDER: Susan, S-u-s-a-n, Swider, S-w-i-d-e-r. I am a public health nurse for 25 years. I'm on faculty at the College of Nursing at Rush University Medical Center, but I'm here today as a private citizen who lives in this congressional

district. In addition to my public health background, I'm also on the board of Erie Family Health Center for over a dozen years, and I understand you heard at a previous hearing from one of our fellow board members. Erie provides care to underserved and uninsured populations. We're funded by -- in part by the federal government to do so. Our patient population has gone from 28 -- 19,000 to 28,000 in the past three years which says something about the numbers of people that have become uninsured and look for that type of health care. So I bring that as my -- part of my perspective to this hearing and want to extend my appreciation to you for this hearing both for the important subject of health that's so crucial to all of us and for the process of bringing people's voices to the table, which I think is vital to our citizenry as a whole.

By now I'm sure you've heard over the course of these hearings from a variety of people talking about the problem of access to care, and Dr. Lerner started out

with a summary of that. I'm sure you all are very aware of this and don't need me to repeat it. I do just want to say in case it hasn't been brought out earlier, that the World Health Organization, which looks at these issues across global -- across our -- across the world, has a series of indicators that they measure countries on, and they include things like per capita spending on health care, infant mortality, numbers of people properly -- children properly immunized, proper access to clean water, live expectancy, and you know that the U.S. isn't even in the top ten amongst all of those countries. I believe the last ranking I saw was 37th. Considering that we are number one with how much we spend, I would suggest that the Task Force look more broadly at this issue.

While I agree that access is crucial and absolutely needs to be a piece of -- important piece of what we do, we obviously need to do some systemic things because even with access we seem to be addressing the wrong things or not

prioritizing properly so that countries with much lower expenditures of health care are able to get better global outcomes. So I think we need to make sure we tie whatever we do to global outcomes as well as numbers of people served.

I wanted to just suggest a couple of solutions that you might consider in your looking at all kinds of opportunities and options, and these are global. I'm an academic, I can help to think big picture. There are some things that I think other people have done that might be useful to look at if you haven't already considered them. One is the recently enacted main legislation which is a universal access system with pooled insured for uninsured and people who need to be self-insured. It's very new. I know they had some difficulties with implementation, but I think it's a model that's worth looking at.

The second idea I would like to recommend is citizen involvement in allocation decisions, and I would provide a model for this being Organ (sic), which has

been doing this for about 20 years, and in the eighties and nineties did a series of public discussions throughout the state to look at what they should be funding in health care with public money. And actually the results of the discussions were used as apart of legislation. It was not without controversy. It never is, but it was a very important public debate and basis for legislation that the public could get behind and could have a say in what was going to impact them. They have continued to do this. They just published a report last year where they do massive town hall meetings around values and health. What is it that we think we ought to be funding for one another and supporting for one another.

Along the lines of consumer and citizen participation I would also like to point out the model of the healthy communities healthy cities, another WHO program that's been also used widely in this country where you bring people together from across different sectors that really all should be

interested in health. So people in education, people in the business sector, who put in so much of the tax dollars. People in social service organizations and people in health care to try to determine what communities can do fairly low cost and effectively. A lot of the initiatives have been things like helmet safety for bicycling kids, seat belts and things like that. A lot of those preventive initiatives are very cost effective and have lots of outcomes and have very positive outcomes for the health of the public.

And lastly -- Actually, just along the healthy communities piece, we had the Ambulatory Care Council for a while in Chicago and Cook County. I'm not sure it always worked up to potential. I think it had -- It's dissolved within the last year. I think that was the beginnings of a structure of bringing people together to talk about what communities can do to improve their health.

And lastly, I would suggest that we look at how we're allocating resources overall. Nationally I believe the figure

that's often quoted is 99 percent of our health care dollars go to curative services and 1 percent to prevention. We have really good outcome data to say that if we shifted that we would have a lot more -- We would have much more cost effective solutions and might truly impact those global outcomes. So I would like to see the Task Force consider recommendations around shifting more funding towards preventive services which you can have a big bang for the buck with those.

Thank you.

MS. DAVIS: I have a question for her.

CHAIRMAN LERNER: Sure.

MS. DAVIS: Can you give us a recommendation on nursing as we move forward with this new system?

MS. SWIDER: Oh, Margaret, you don't have enough hours in the day.

MS. DAVIS: Give me a couple of things.

MS. SWIDER: A huge investment in staff nursing and baccalaureate education in

staff nursing. We've done really well in advanced practice. I think advanced practice nurses are doing great things. We always need more, but I think the variety of things have been done at the federal level and variety of states in terms of loan repayment for people going into studying nursing, in terms of faculty development and loan repayment, in terms of coordinating schools so that you can make it relatively effortless for students to pursue education in nursing. Those would be my first suggestions. We have to get more teachers and more people into the field.

We've been having great success at Rush. I'll put in a personal plug with our advanced accelerated baccalaureate program. There are people coming after they've had a degree in something else and they do like an incredibly intensive year. We get the brightest most committed folks that way, and I know Loyola has a program like that too to be fair. Things like that.

CHAIRMAN LERNER: James?

MR. DUFFETT: How would you suggest

always the battle that exists between doctors and nurses, nurses and other medical personnel, how should we be viewing that in terms of how to maximize the utilization of the health professionals that we do have here and to be sure that those individuals are qualified to be able to take on more responsibilities? Any suggestions on how to open up that Pandora's box and deal with that issue?

MS. SWIDER: You guys ask the big questions. You know a lot of suggestions about that. I think we've actually -- My personal view is we've done a pretty good job with licensure and protection. I don't know that I feel like that's been a big problem. I mean, medicine may feel differently. Other disciplines may feel differently. One of our personal things that we've been spending a lot of time at Rush that I have a lot of faith in is much more interdisciplinary education so that people are starting to be educated together from very early times. At Rush we have a large community service program that

requires -- it doesn't require, it's voluntary. Students from across our disciplines go in and provide services at a variety of home shelters and clinics and schools on a regular basis and are learning incredible amounts about what our people do. You know, nurses, nursing students, and medical students didn't have a clue what speech pathologists did for example, and you know, if they start to learn to work and play together in their early years, I think they'll be much more effective in working in teams later on.

In terms of some of the other disciplines, when you say that about protection, I've worked extensively with community health workers, and a lot of times you hear oh, they're going to take nurses' jobs. I think as long as we can kind of keep some type of team system so that you don't have a lay health worker who do marvelous things in practicing independently, but you have them practicing as part of a team where they work with the nurse back at the office or

the clinic, and that they have -- so that the services are in the best interest of the community or the client and there's checks and balances built in.

I mean, those would be kind of off the top of my head ones.

CHAIRMAN LERNER: If I could kind of summarize just part of it. If they do something about the access problem and now 1.8 million people now have a greater degree of freedom for access in the system, demand for services will go up of any sort curative, preventive, long-term care, et cetera. We continue to have a supply problem with the health care staffing in this country, and what has been suggested as a result of this triangular discussion was the delivery systems under which we would be able to deliver the services that the population needs, needs to be explored as well. So not only having the right supply of physicians, nurses, and other health professionals and care professionals but the model under which you deliver those services needs to be explored.

Rush has a long history as it turns out of not only developing tremendous advanced practice nurses but encouraging nurses and doctors to join practice together and therefore extending the practice in the community.

So one of the things I hope the Task Force will consider are some of the off shoots of these conversations later.

Thank you very much, Susan.

MS. SWIDER: Thank you.

CHAIRMAN LERNER: Mr. Rodney Walker.

MR. WALKER: Good afternoon. My name is Rodney Walker. First name Rodney, R-o-d-n-e-y; last name Walker, W-a-l-k-e-r. I'm a practice rep for Access Community Health Network. We are the largest community health network center in the nation. We operate in 43 health centers in Cook County and in DuPage County serving approximately 200,000 low-income residents. About 70,000 of those patients are uninsured.

I come before the Task Force

today just to offer two solutions: One, at Access we are starting to work with specialty care services having our specialty care providers also work with our community health centers. That way the patient can get comprehensive services without making multiple trips. So we have specialty care services in our community health centers.

Secondly, we have a program where we're working with the University of Chicago Hospital and their emergency room. And what we're doing there is we're working in the emergency rooms who take those uninsured patients, unassigned patients, and assign them to community health centers that we operate reducing the uninsured cost to the hospital. We're now doing that in University of Chicago Hospital and we will be starting to do that at Mt. Sinai Hospital, the hospital that we partnership with.

In conclusion, I just want to say that the Task Force, I believe, is doing a great job, and we ask that you consider community health centers as part of the

solution to any health care system.

Thank you for your time.

CHAIRMAN LERNER: Thank you, Mr. Walker.

We have another person that would like to speak before us, Johnny Hap.

MR. HAP: My name is Johnny Hap, J-o-h-n-n-y, H-a-p. Thank you, Chairman Lerner. It's an honor to be here. I am a candidate for U.S. Congress here in the Fifth District, and I am an uninsured American.

I commend the Task Force for their work, and I understand this is an Illinois State issue, but I wanted to take a moment first of all to listen as a candidate, that's the most important thing that I can do here. I wanted to express my personal opinions and talk about legislation at the federal level.

I believe we need and we deserve as a human right, universal health care for all U.S. citizens. This can be achieved and paid for through a single-payer system publicly funded and privately

administered. We're already spending enough money to provide this service, we're just not receiving it. Why not, because we're wasting precious dollars on private, profit-driven insurance companies. We pay through premiums for the big salaries of executives. We also pay for the millions of dollars spent by insurance companies on political campaigns, and we pay yet millions more for the lobbyists that insurance companies have in Washington. It's a system designed by and for big insurance companies. It's time for the citizens and the medical establishment to take back control of the system.

A 2004 study by public citizen and Harvard Medical School calculated that bureaucratic waste in health care during the year 2003 was $400 billion. That's bureaucratic waste. According to the study a national health insurance plan could save an estimated $286 billion annually just on paperwork.

I just want to highlight a plan put forward physicians working group for

single payer national health insurance. It's based on four basic principals: 1) access to comprehensive health care is a human right and is the responsibility of society through its government to assure this right; 2) the right to choose and change ones physician is fundamental patient autonomy. Patients should be free to seek care from any licensed health care professional; 3) pursuit of corporate, profit, and personal fortune have no place in care giving and provide enormous waste. The U.S., as I mentioned, already spends enough to provide comprehensive health care to all Americans with no increase in total costs; 4) in a democracy the public should set overall health policies. Personal medical decisions should be made by patients with their care givers, not by corporate business or government bureaucrats.

There's a current resolution in the House of Representatives. It's put forth by Representative Kassovitch of Ohio and John Connor of Michigan. It's called HR676, United States National Insurance Act. It has

62 cosponsors, and let it be known that the current incumbent of the Fifth District is not one of those cosponsors. As a representative of Congress, I would proudly sign on as a cosponsor to HR676. We cannot wait any longer. Our country is in a health care crisis. We have 40 million citizens without insurance, and as mentioned 1.8 million citizens here, in Illinois, without insurance. The time to act is long overdue.

Thank you.

MR. ROBBINS: Can I ask a question?

CHAIRMAN LERNER: Ken?

MR. ROBBINS: Given your -- Sir, given your focus on a national solution and our task to come up with a state recommendation, should we conclude that you think it is better for there to be a national solution than to attempt a single-payer system at the state level?

MR. HAP: I certainly think at the moment it's very important to continue to work with the Task Force because who knows how long the U.S. government is going to stall

implementing a program. So your work right now is very important, but in the end, end all be all, I would say it's most definitely a federal priority to provide a standard health care service for every U.S. citizen across the board.

MR. ROBBINS: Well, would you recommend to us that we support a single state level single-payer system?

MR. HAP: I think it should be worked for -- continued to be worked for at the moment. Once established at the federal level, the state would be relieved of that burden.

CHAIRMAN LERNER: I think Ken's asking you the opposite side of that question. Is the focus -- Would you recommend for the Task Force that we focus on a single-payer structure for the State of Illinois while whatever happens at the federal level happens?

MR. HAP: Yes.

CHAIRMAN LERNER: Is that what you're suggesting?

MR. HAP: Most definitely.

CHAIRMAN LERNER: Thank you, very much.

DR. YOUNG: I don't want to exploit your presence as a candidate, but tell this Task Force what you sense and your constituents, feel about the health care question.

MR. HAP: Well, it would be difficult for me to generalize everyone in the entire district.

DR. YOUNG: I just want your feeling.

MR. HAP: The persons that I talked to are in favor of a national health care program, and I know, Dr. Young, that you are a supporter of the physician working group for single payer national health insurance.

CHAIRMAN LERNER: Any other questions?

Thank you very much, Mr. Hap.

MR. HAP: Thank you for your time.

MS. POWERS: Representative Saviano wanted to say a few words.

CHAIRMAN LERNER: I see his name on this list.

REPRESENTATIVE SAVIANO: Thank you, very much. I wasn't prepared to speak, but I heard --

CHAIRMAN LERNER: Would you state your name and spell it.

REPRESENTATIVE SAVIANO: My name is Skip Saviano, S-a-v-i-a-n-o. I'm the State Representative from the 77th District.

CHAIRMAN LERNER: Thank you.

REPRESENTATIVE SAVIANO: Just a couple -- Just a couple of points that kind of rang a bell. I have been representative of this area for 16 years now. Four years as a township supervisor and I'm in my 14th year in the legislature, and I grew up here too so I'm pretty familiar with this district as well as my own district.

I have been the chairman of the licensing committee in Illinois House. I'm going into my 12th year both under republican and democratic administrations in the House.

The one thing that I have encountered over the years, and this is just a small part of the big magnitude of the issue that you're addressing, is when people come to testify in front of my committee to give certain health care providers more authority and more authority to duties which are usually things that are good, we always have to balance access to care, quality of care. There's no reason why -- And this is one concern I have. When they come in and say well, this will improve the access to care in our inner city areas or down state, well, if I can't protect the quality of care in those areas to the standards that we're used to, people like us who have health insurance, I don't want to create that scenario. So that's an ongoing debate in my committee, and my committee always takes that into consideration.

I was the one that sponsored a bill to license APRNS here in the state. We're the last state in the nation to do that. It wasn't an easy task to take on the

medical society at that point, but after a couple of years we were able to let the issue evolve and put certain safeguards into the working relationship between doctors and nurses that gave a comfort level not only to us legislatures, but also I think to people throughout the health care industry and the public, itself. So I would just ask that you keep that in mind. You know, I have midwives testify in front of me every year with their issue, and I mean, in a perfect world I guess that would work out, but we have advanced practice nurse midwives who are -- The safeguards are built into that process. And your -- You certainly probably heard a lot already, and you're going to hear more, but this is a -- I mean, I've been chairman of this committee for 12 years. So every time I think I've heard everything, I hear something else.

So I just want to offer you services of myself and my colleagues if you need to access our experiences, we would be happy to help you out since we kind of put you

in this mess. But we really do commend you for this job, and again, thank you for being here.

CHAIRMAN LERNER: Any questions for Representative Saviano?

MS. DAVIS: I got an email from Senator Rutherford about the use of the nursing fund to be incorporated in the general revenue fund. Have you heard any feedback on that?

REPRESENTATIVE SAVIANO: Well, you kind you have brought up two different -- You kind of brought two issues to light. Number one you also hit on the shortage of health care delivery personnel, people, and especially nurses. I pretty much sponsored, as Kenny would tell you, quite a bit of nursing bills over the last five or six years and took -- to try to improve at least the perception that the acute nurse care is the place to be. Our average age of a registered nurse today in the state is around 45 or 46 years old. We certainly want to lower that average age.

The issue that Margaret brought up pertains to the hard economic times that we've experienced here, in Illinois, and as a result we've experienced fund sweeps. And back in ninety -- I want to say '94, '95 I passed a bill which created dedicated funds for each of the individual licensures in the state. And the reason for that was for us to keep track of how much was in each fund, which is funded by licensure fees, and how much resources we could dedicate to that profession in monitoring, investigations, and things like that. Well, I think the previous governor maybe his last term and ever since there has been fund sweeps which they take excess money out of those dedicated funds and put them in general revenue which obviously I'm not really happy about, considering I have to oversee all of these licensures. I have daily calls whether they're doctors, nurses, real estate people, cosmetologists saying they haven't seen an investigator in their area in five years. As a matter of fact, just for example, the real estate division only has one

investigator for over 100,000 real estate agents in the state. So those are things that obviously we're going to have address in the future, and if we are going to increase the amount of people eligible for health care to keep the quality of care that we would expect, we're going to have to make sure we fund those funds to make sure there's people out there looking over people's shoulders.

CHAIRMAN LERNER: Dr. Young?

DR. YOUNG: I want to thank you for the substantive material you shared with us in your role. And since you raised it, I would like to inquire, I'm referring to the nurse midwives and the freestanding burden they service for low-risk mothers, which of course the state has yet to license. Are we getting any closer to joining the rest of human race on that one?

THE WITNESS: Well, I'm not sure. Would that come under the health facilities planning board? They're the ones that would authorize that.

MS. DAVIS: Yeah, I think so.

REPRESENTATIVE SAVIANO: I certainly would be happy to take a look at that, but I think that Health Facilities Planning Board probably is the place that would make that final decision.

CHAIRMAN LERNER: Thank you very much.

REPRESENTATIVE SAVIANO: Thank you.

CHAIRMAN LERNER: Thank you for bringing up a great point that not only making sure that we credential people and license them appropriately, but we have the right people to support that licensure credentialing process. Thank you.

Are there any other individuals who wish to provide testimony before the Task Force?

Did you sign in?

MS. BYRNE: I didn't sign in that's what I'm asking.

CHAIRMAN LERNER: I'll let you do it this time. We'll sign you in on the way out.

Please state your name and

spell it for us.

MS. BYRNE: My name is Alice Byrne. I'm a resident of Franklin Park. I'm also a member of the Campaign for Better Health Care and League of Women Voters of Elmhurst has been extremely interested in this project, and they have a chairperson for their district. She attends the campaign meetings regularly. I'm sure Jim remembers Carol Lanberg (phonetic).

CHAIRMAN LERNER: How do you spell your last name?

MS. BYRNE: B-y-r-n-e. My biggest efforts are with mental health. I didn't hear anything this morning or this afternoon about mental health. I must say that our local elected politicians have been very generous with their time listening to our problems and standing up with us, and I would like to get a chance to talk to the nurse for Rush because I'm also a nurse. I'm retired, of course, documentary, but still very active.

The other -- I won't go into all this mental health thing because you never

stop, but the other issue that I'm very concerned about is the care that supposedly is available to low-income immigrants, legal immigrants, even new citizens who are unable to feel their way through the bureaucracy. For many years -- I retired in '87 from my regular job, and I've been doing this ever since, working with that level of people. I wish that the Task Force would try to see what can be done about maybe ombudsman for these people, community -- For instance, at the township office could they have somebody as a resource to listen to these people so they know what to do. The people -- One case I have been with for eight years, and we've gotten this girl a lot of things because her mother just works so hard, but her mother has no place to go to ask about what she needs to know. She can't interpret the N-400 from the citizenship and immigration service. She can't read -- She can talk English to me, but she can't interpret things. These people would pay for this. They're working. She works weekends and takes care of an invalid.

She would pay if there was somebody she could go to.

I do it voluntarily, but there's going to be a day when I'm not going to do this anymore. You know, I'm getting there, and there are lots of people in that group. I would like if the Task Force will consider how to help the low -- some of them are poverty and some of them are not poverty. They're just unable to get through the bureaucracy. My best thought is maybe an ombudsman or like I said a little office in a community. I'll bet they could get volunteers if there would be space provided. It's a big, big issue, and then there won't be in the emergency rooms, costing so much in the emergency rooms, and some of them can't even get there.

Thank you very much.

CHAIRMAN LERNER: Thank you very much, Ms. Byrne. Actually old ideas come back over and over again, and in the old days we used to talk about patient advocates all of the time. You have reminded us even by

creating access to the system that we don't help people who are part of special populations, and I mean that broadly, special populations. If we don't help them navigate through the system then the curative and preventive aspects of what we're trying to accomplish won't get accomplished.

Thank you very much.

CHAIRMAN LERNER: Any other individuals at the moment?

Let me suggest then we take --

MR. SHOOK: Hi.

CHAIRMAN LERNER: Please.

MR. SHOOK: I'm the tech here, so I'm being real unprofessional.

CHAIRMAN LERNER: Did you sign in?

MR. SHOOK: My name is a Ron Shook, S-h-o-o-k. I just want to tell a little personal story. I'm not sure how it fits in. Actually, I do have an inkling.

I grew up on a farm. I've always been very independent. I worked as a freelance person all of my life. Paid for my

own medical insurance for 30 years, probably more than that, probably close to 35. Two years ago, just about exactly two years ago, I got to the point where I just couldn't take the premiums. It was either that or stop driving my car. I couldn't do my job, so I had to drop it, and of course, you know, that's when things hit. I had a blood clot in my leg earlier in the year, and now, you know, I'm virtually uninsurable. The hospital worked with me. Fortunately, I had the first good year in about eight years after all that recession and changes in my industry, but everything good that came out of this year went to the hospital.

It really makes me angry that I paid for insurance for 30 years and I don't think they ever -- I ever got a dime out of it, and yet because I couldn't for a couple of years, I'm completely on the outs.

Someone mentioned earlier that, you know, there's only five states in the union where the patient pool is completely statewide. And if there's one thing you could

do for this state it's to go in that direction. I mean, it just grinds me that insurance companies won't insure everyone. They'll only insure people that they can make a fortune off of.

That's all I've got to say.

CHAIRMAN LERNER: Thank you. You told a very appropriate story for our Task Force. Thank you very much.

The feel went away from community rating to experience rating. That's exactly what ended up happening, and that will be one of the topics that we'll address as part of our Task Force deliberations.

Okay. Now, let's take a ten-minute break and come back together. We'll get back together about quarter after 5:00.

Thank you.

(A short break was taken.)

CHAIRMAN LERNER: On behalf of the Task Force, I call the meeting adjourned.

Thank you.

(Which were all the

proceedings had.)

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

I, DEBORAH R. SANTI, Certified Shorthand Reporter and Notary Public in and for the County of Cook, State of Illinois, do hereby certify that on the 4th day of January, 2006, that I reported in shorthand the proceedings had at the foregoing hearing

I also certify that the foregoing is a true and correct transcript of all my shorthand notes so taken as aforesaid and contains all of the proceedings had.

Witness my official signature and seal as Notary Public, in and for the County of Cook, State of Illinois, on the 18th day of January, 2006.

DEBORAH R. SANTI, CSR
CSR # 084-004107