

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

9TH CONGRESSIONAL DISTRICT PUBLIC HEARING
OF THE ADEQUATE HEALTH CARE TASK FORCE
UNDER THE HEALTH CARE JUSTICE ACT

Wednesday, January 18, 2006
4:00 p.m.

OAKTON COMMUNITY CENTER
4701 OAKTON STREET
SKOKIE, ILLINOIS 60076

REPORTED BY:
PATRICIA L. ERICKSON
ILLINOIS CSR NO. 084-001616

1 A P P E A R A N C E S :

2

 ADEQUATE HEALTH CARE TASK FORCE PANEL:

3

 DR. WAYNE M. LERNER, presiding as Chairman

4

 MR. MICHAEL GELDER

5

 MS. MARGARET DAVIS

6

 DR. QUENTIN D. YOUNG

7

 MR. JAMES A. DUFFETT

8

 DR. CRAIG A. BACKS

9

 MS. TRACEY PRINTEN

10

 MS. CATHERINE BRESLER

11

12

13

14

15

16

17

18

19

20

21

22

23

24

1 DR. LERNER: If I could ask
2 everybody to grab a seat, and we'll get
3 started. We're just about out of time.

4 I would like to remind
5 everyone as we get started that the
6 proceedings are being transcribed; and
7 therefore, I would ask anyone whose making
8 commentary to use the microphone and to speak
9 clearly so that we can get a full record of
10 what goes on here today.

11 My name is Wayne Lerner. I'm
12 the President and Chief Executive Officer of
13 the Rehabilitation Institute of Chicago, and I
14 also have the honor to chair the Adequate
15 Health Care Task Force.

16 And I would ask the members of
17 my committee who are up here today to
18 introduce themselves. Michael?

19 MR. GELDER: I'm Michael Gelder
20 with the Illinois Department on Aging and also
21 a trustee in Skokie, so I welcome you to our
22 fine village. Glad you're here.

23 MS. DAVIS: Hi. I'm Margaret
24 Davis. I'm a nurse by training, and I work

1 with the Health Care Consortium of Illinois.

2 DR. YOUNG: I'm Quentin Young. I'm
3 a physician in Chicago, Hyde Park to be exact;
4 and I'm the national coordinator of Physicians
5 for a National Health Program.

6 MR. DUFFETT: I'm Jim Duffett. I'm
7 the executive director of the Campaign for
8 Better Health Care. The campaign is the
9 State's largest grass-roots health care
10 coalition.

11 DR. BACKS: Craig Backs, president
12 of the Illinois State Medical Society. I
13 practice internal medicine in Springfield.

14 MS. PRINTEN: I'm Tracey Printen.
15 I'm an associate in the Health Policy Research
16 and Advocacy Division at the Illinois State
17 Medical Society.

18 DR. LERNER: I know we have a
19 couple of other individuals here whom I'd like
20 to introduce. And if I miss some people, just
21 ask Ashley back there to give me your names;
22 and we'll introduce you.

23 Eric Miller representing
24 Elizabeth Colson. Thank you very much.

1 Jan Fowler from the Illinois
2 Department of Health Services, Office of
3 Family Health.

4 One of my colleagues, Dr.
5 Bruce Campbell, CEO, Lutheran General
6 Hospital.

7 MR. CAMPBELL: Thank you.

8 DR. LERNER: Did I miss anybody?
9 The president's not here, and the mayor's not
10 here.

11 I'd like to thank the Village
12 of Skokie for allowing us to utilize their
13 wonderful facilities.

14 I would like to make some
15 introductory comments before we get started:
16 Good afternoon and welcome to the 9th
17 Congressional District Public Hearing of the
18 Advocate Health Care Task Force which was
19 established under the Health Care Justice
20 Act.

21 It has been well demonstrated
22 that a person's ability to access the health
23 care system influences his or her treatment,
24 the outcomes that they achieve, and their

1 health and functional status.

2 Access to health care is most
3 affected by the ability of those seeking care
4 to afford the services that they need.
5 Therefore, the uninsured, the working poor,
6 racial and ethnic minorities, undocumented
7 immigrants, and special populations in
8 Illinois are least likely to be able to afford
9 to pay out of pocket for many health care
10 services.

11 Many citizens of Illinois lack
12 access to the health care system because they
13 lack health insurance. On any given day, 1.8
14 million Illinoisans are without health
15 insurance. That's about one in seven.

16 Additionally, a growing number
17 of Illinoisans are underinsured; and the
18 consumer's share of the cost of health
19 insurance is growing.

20 While Illinois has many
21 safety-net providers, including public and
22 private clinics, public hospitals, and a
23 tremendous amount of charity care administered
24 by private hospitals that attempt to narrow

1 the gap between the insured and the uninsured,
2 many uninsured Illinoisans lack access to a
3 usual source of preventive and comprehensive
4 care.

5 The Health Care Justice Act,
6 signed into law by the governor in August,
7 2004, encourages the State of Illinois to
8 implement a health care plan that provides
9 access to a full range of preventive, acute,
10 and long-term health care services and
11 maintains and improves the quality of health
12 care services offered to Illinois residents.

13 The Act created the Adequate
14 Health Care Task Force which has undertaken
15 the task of developing this access plan. 29
16 members of the Task Force were appointed by
17 the governor, the president of the senate, the
18 minority leader of the senate, the speaker of
19 the house, and the minority leader of the
20 house.

21 As part of its work, the Task
22 Force will be holding at least one public
23 hearing in each congressional district to seek
24 the input from the public regarding the access

1 plan; and, in fact, we are not going to have
2 19. I think we're going to have 21 public
3 hearings across the State of Illinois to make
4 sure that we're crosscutting the state and
5 getting everyone a chance to provide input,
6 and that's why we're here today.

7 On behalf of the Task Force
8 and the Illinois Department of Public Health,
9 I'd like to thank each of you for coming out
10 this afternoon to take part in this important
11 process.

12 Now, before we get started, a
13 couple of housekeeping items: First, my
14 biggest request for those of you with any type
15 of electronic devices, PDAs, BlackBerries,
16 Treos, telephones, pagers, -- pacemakers are
17 not included -- please turn them off or put
18 them on vibrate. It would be nice to be able
19 to run the meeting without having too many
20 interruptions. We will take periodic breaks
21 so that you can report back in.

22 Second, if you haven't already
23 done so, please sign in at the table located
24 at the back of the room. This will help the

1 members of the Task Force and the department
2 track the number of people who attend this
3 hearing.

4 There are also handouts
5 available at the table that provide more
6 information about the Health Care Justice Act
7 and the Adequate Health Care Task Force public
8 hearing.

9 Should you wish to testify, be
10 sure to sign up at the table located at the
11 back of the room. Individuals will be called
12 to testify in the order in which they signed
13 up.

14 And if you brought written
15 testimony to submit, you also may do so at
16 that same table.

17 We will begin the hearing by
18 calling up the first five speakers. Please
19 sit where you will be instructed, which is
20 here in this front row, in the order in which
21 you are called so that we can really pay
22 attention to everything you're saying, make
23 sure we coordinate that.

24 Before you testify, -- and

1 please do so at the microphone -- you should
2 please be sure to say and spell your first and
3 last names for the court reporter.

4 And, finally, please be
5 reminded that oral testimony will be limited
6 to three minutes; and we've got our famous
7 timekeeper right here to my left, and we'll be
8 watching him.

9 Again, we're looking for an
10 interchange. Members of the Task Force in the
11 past have asked questions or they have not,
12 and it really is up to everybody's own
13 interests.

14 So with that as the
15 background, let me get started. The first
16 five individuals, if you would come up and
17 take your seats: Sydney Bild, Beryl Clemens,
18 Michael Brennan, Holly Berman, and Marie or
19 Margaret Schaps.

20 MS. SCHAPS: Margie.

21 DR. LERNER: Margie. I'd get it
22 eventually. Thank you very much. Mr. Bild?

23 MR. BILD: Thank you very much, Dr.
24 Lerner.

1 My name is Sydney Bild.

2 That's S-y-d-n-e-y, last name B-i-l-d.

3 I have been so bold as to
4 title my remarks as follows: Universal Health
5 Care for Illinois: The Real Thing. That's
6 because that's my opinion. As the old
7 spiritual says, everyone talking about heaven
8 ain't going there.

9 And the concept of universal
10 health care means different things to
11 different folks. To the market-based health
12 insurance companies, universal health care is
13 just another way to get windfall profits
14 through well-established health care rationing
15 techniques which are standard in the health
16 insurance and HMO industry.

17 True government-assured
18 universal health care was first introduced in
19 the Congress in 1948 as the National Health
20 Insurance Act, the Murray-Wagner-Dingell Bill,
21 endorsed by the Truman administration. It was
22 rejected by the Congress, but today it is
23 recognized that reformation of health care is
24 long overdue.

1 The nation is in a health care
2 crisis acknowledged by all. We must have a
3 critique of our health care system because
4 form dictates function.

5 All in need of health care
6 must have the same timely access to services
7 with maximum ease. There must be adequate
8 numbers of qualified practitioners throughout
9 the State to establish adequate ratios of
10 service to patients in all areas of the
11 State.

12 A modern health system
13 includes accountability and the addressing of
14 complaints on a timely basis. How well health
15 insurance systems are working can be
16 objectively measured by real-time attention to
17 parameters such as infant mortality, life
18 expectancy, adherence to standards of care, et
19 cetera.

20 The World Health Organization
21 report 2000 gave the United States a ranking
22 of 37 in its evaluation of health care systems
23 of member states. France was ranked number
24 one. That's the book (indicating).

1 commercial market.

2 The hallmark of U.S. health
3 care is not its world-class excellence but its
4 world-class costs. The key to affordable
5 access to health care is affordable health
6 insurance.

7 Medicare has demonstrated how
8 it is possible to pay and provide stewardship
9 for senior health care. The 2 percent
10 administrative costs of Medicare stands in
11 sharp contrast to the for-profit sector's cost
12 of 15 to 35 percent.

13 Sometimes called single-payer,
14 government-assured health insurance is the key
15 to a fair and affordable system. The
16 unfairness of for-profit health care systems
17 can be clearly seen by examining data on the
18 percentage of household income which is spent
19 on health care. A figure of spending --

20 DR. LERNER: Mr. Bild, Mr. Bild, if
21 I could ask you to -- if you have a written
22 commentary, we'd be glad to take it.

23 And if you want to wait and
24 see if there are --

1 MR. BILD: Well, I just have a few
2 more.

3 DR. LERNER: We're well over the
4 time already, and it's not really fair to
5 other people; so if you can hang loose, we can
6 -- I would like to move on to our next
7 speaker. Thank you.

8 DR. LERNER: Miss Clemens?

9 MS. CLEMENS: Thank you, Dr.
10 Lerner. My name is Beryl Clemens.

11 And if only we had the Health
12 Care Justice Act twenty years ago, I would
13 have had a completely different life than the
14 one I'm leading now.

15 When I was 57 years old, my
16 husband passed away. He had an insurance
17 policy for me, but the company went bankrupt
18 when I was 58 years old.

19 I was stuck without any
20 insurance because of the ridiculously
21 expensive cost for my age group. I had to
22 wait until I was 65 to be covered by Medicare
23 and get Blue Cross and Blue Shield.

24 In the intervening years, I

1 was very fortunate to be able to maintain my
2 good health and not have any accidents; but I
3 could never explain how nervous and upset I
4 was all of the time thinking about what would
5 happen to me if I became sick or injured.

6 It was a living nightmare. I
7 worried about my health at all times. I
8 guarded myself against all illness as best I
9 could. I had a car that I didn't use much
10 because I was afraid of accidents.

11 I was president of a Veterans
12 of Foreign Wars Ladies Auxiliary for three
13 years, and I spent my time in the office
14 looking for speakers who would speak on
15 universal health care.

16 I just had a horrible
17 existence in those seven years. I was
18 unhappy, I was scared, I was a different
19 person completely.

20 Thank God that I was in pretty
21 good health and I lived a healthy lifestyle.
22 I made it until I was 65.

23 I would be very pleased if we
24 were able to pass a comprehensive health care

1 bill so that no one else in Illinois would
2 have to go through the torture that I went
3 through those seven years. Thank you.

4 (Enter Catherine Bresler.)

5 DR. LERNER: Thank you very much.
6 By the way, before we go on, we have another
7 member of our Task Force joining us, Catherine
8 Bresler. Thank you, Catherine.

9 DR. LERNER: Mr. Brennan?

10 MR. BRENNAN: Thank you all for
11 your continuing concern about this really
12 important issue. You know, if this room
13 reflected the concern of the people of
14 Illinois for what you're doing, there would be
15 standing room only.

16 I want to remind you of what
17 the Bernadin Amendment got, what the votes
18 were. Back in 1998, November 3rd, in Cook
19 County when the vote was for a constitutional
20 amendment -- for the Bernadin Amendment --
21 that we would have health care for everybody
22 in this State, the vote was yes, 708,750, no,
23 141,508.

24 And what about downstate, you

1 might ask, and the suburbs? Yes, 92,394, no,
2 38,350.

3 So I want to thank you for
4 your responding to what is a statewide and
5 nationwide scandal and for your constructive
6 efforts, and I want to also thank you for what
7 you're doing is going to be a life-and-death
8 difference.

9 I don't know how many of you
10 are familiar with this book. It's called Care
11 Without Coverage: Too Little, Too Late from
12 the Institute of Medicine.

13 If you go in this book, you'll
14 find that people aged 25 to 64 in this state
15 who die every year in this country for lack of
16 health insurance number 18,000. That means
17 that as we sit here today in Illinois, someone
18 in this state is dying because they don't have
19 health care.

20 I'd like to stress we're
21 talking about health care, not necessarily
22 health insurance. Do you remember that
23 headline back about ten years ago in the
24 Chicago Tribune, "Medicine Aches with HMO

1 Fever"?

2 Remember the story of Wanda
3 Peake? She was the lady -- she thought she
4 had health insurance. Her leg got diseased.
5 She went to her doctor. Her doctor went to
6 the HMO. The HMO said, "Well, our policy says
7 we cut it off because that's the cheapest
8 thing."

9 So some of us think we're
10 covered, but how many of us know whether there
11 lurk in our policies some phrase like the one
12 that was going to cut off Wanda Peake's leg?

13 So I really encourage you to
14 think of a policy that's going to guarantee
15 not just insurance but coverage. How do you
16 do that?

17 Again, a reminder of something
18 a lot of you know. Remember the GAO, the
19 United States -- I think it was called
20 Government Accountability Office. Back in
21 1991, they put out a study. Let me quote from
22 Page 71 very briefly, and then I will
23 conclude: "The Canadian experience clearly
24 demonstrates that it is possible to move to

1 universal access without any major effects on
2 the net costs of health care.

3 Indeed, the short-term
4 administrative savings alone are more than
5 adequate to cover any reasonable cost estimate
6 of extending health care to everyone."

7 So I want to thank you for
8 your consideration of these important ideas, I
9 believe; and I want to thank you for what
10 you're going to do to make sure that never
11 again will anyone in the State of Illinois die
12 for lack of health care. Thank you.

13 DR. LERNER: Thank you Mr. Brennan.
14 Miss Berman?

15 MS. BERMAN: My name is Holly
16 Berman, H-o-l-l-y B-e-r-m-a-n.

17 I'm the president of the
18 League of Women Voters of Wilmette. Wilmette
19 is partially in the 9th district and partially
20 in the 10th district.

21 The League has a national
22 position on health care based on a study done
23 a number of years ago. The position supports
24 affordable, accessible, quality health care

1 for all citizens financed throughout general
2 taxes, commonly known as a single-payer
3 approach.

4 We'd like to see that on a
5 national level. If we can't get it at a
6 national level right now, we're happy to
7 advocate for a state-level approach.

8 Everyone agrees the current
9 health care system's a big mess. It's costly,
10 it's inefficient with wide variances in levels
11 of care.

12 I happen to have an M.B.A.
13 from the University of Chicago; and what
14 disturbs as much as anything else is not only
15 does it have all those horrible
16 characteristics, but it creates all kinds of
17 unhealthy distortions in our economy including
18 the fact that GM can't be profitable because
19 of health care costs and workers that are not
20 free to change employers.

21 I've known many people who
22 have not been able to change jobs or not been
23 able to work for a small employer because they
24 needed their health care. That kind of

1 distortion in our economy can't be good for
2 anybody, and I think it's largely bad for the
3 State of Illinois.

4 So how can the State make a
5 difference?

6 I would congratulate the State
7 for the actions they've taken now. My mother
8 has a drug cost of over \$1,000 a month, and
9 Circuit Breaker and Senior Care has made a big
10 difference for her.

11 But beyond providing Medicaid
12 and those kinds of services, I think the State
13 can take some measures even short of universal
14 health care without spending a great deal of
15 money.

16 Some of those would be to
17 provide more information and incentives to
18 increase efficiency and quality of care; to
19 require insurers operating in the State to
20 limit restrictions on things like pre-existing
21 conditions; and to create more options for
22 coverage of the 15 percent of the State that's
23 uninsured.

24 Infection rates and medical

1 error rates in hospitals are incredibly high,
2 unacceptably high. I believe that improved
3 information technology would increase
4 efficiency and decrease errors.

5 Perhaps a combination of
6 publishing data about current infection and
7 error rates combined with some financial
8 incentives would push hospitals into taking
9 action and make these changes. Using the
10 State's power to require reporting on these
11 issues and to publicize data could be a
12 powerful inducement to change.

13 Small employers are engines of
14 economic growth, and the State should
15 encourage these types of businesses. However,
16 their ability to hire good employees or to
17 keep them is hindered by the high costs of
18 providing health insurance benefits.

19 This is a major reason why
20 only 59 percent of smaller employers offer
21 coverage, and the number gets smaller over
22 time.

23 Some states have attempted
24 innovative programs to provide coverage to

1 employees of small businesses and the
2 self-employed. I'm not sure if you're aware
3 of the approach in Maine which is called
4 Dirigo; but it attempts to expand coverage for
5 self-employed and small business employers
6 while controlling costs, and it seems to have
7 potential application here in Illinois.

8 If we see this correctly as an
9 investment in economic growth rather than just
10 an unacceptable expansion of government
11 spending, we might be encouraged to try an
12 innovative experiment.

13 There's precedent for state
14 innovation preceding national government
15 action, -- Social Security started with states
16 -- and I'd encourage your committee to
17 recommend some bold ideas.

18 Factors the League would like
19 to see in your plan include: risk-sharing
20 among a large group; fairness to all income
21 levels; leveraging group purchasing power;
22 aiming for comprehensive, quality coverage;
23 measures that would contain health care costs;
24 portability of coverage with continuity of

1 care and some measure of choice. Thank you.

2 DR. LERNER: Thank you, Miss
3 Berman.

4 I would encourage any
5 individuals who have prepared remarks like
6 this, that in addition to our ability to take
7 and view a transcript, if you have copies and
8 you can leave it with us, that would be great
9 because you're providing us with wonderful
10 information, starting with Mr. Bild, if we can
11 get our hands on it; and we can make sure that
12 that's available to the Task Force members.

13 Thank you very much. Miss
14 Schaps?

15 MS. SCHAPS: I'm Margie Schaps,
16 M-a-r-g-i-e S-c-h-a-p-s.

17 I'm the executive director of
18 the Health and Medicine Policy Research Group
19 in Chicago and a resident of the 9th
20 congressional district.

21 For 25 years, Health and
22 Medicine has served as an independent,
23 nonprofit center that does research and policy
24 analysis and advocacy on behalf of the

1 development of a just and equitable health
2 system for all in Illinois.

3 Our group has come to believe
4 that the only way to solve the problem of the
5 millions of uninsured and millions more
6 underinsured in Illinois and across the
7 country is to develop a single-payer,
8 government-financed system, improving the
9 experience of the highly successful
10 single-payer system for the elderly --
11 Medicare.

12 If we do not promote this real
13 reform, we are destined to continue to put
14 forth incremental efforts that have
15 historically failed and, in fact, increased
16 cost, decreased access, and decreased
17 quality.

18 In 1990, 10.1 percent of
19 Illinois's population was uninsured. By 2005,
20 this has grown to 14.4 percent or 1.8 million
21 people in the State, this despite all the
22 incremental efforts like KidCare, Medicaid
23 expansions, and family care that have been put
24 in place.

1 At the same time, we see the
2 employer-based system of health insurance
3 rapidly imploding. Employees are facing ever
4 larger copays, deductibles, and exclusions.
5 Half of the bankruptcies -- 2 million annually
6 -- in the United States were attributable to
7 illness or unpaid medical bills.

8 The current link between
9 coverage and employment means that insurance
10 often evaporates when it's needed the most,
11 when illness is so severe that the
12 breadwinners are unable to work.

13 The COBRA law has failed to
14 address this program because the premiums for
15 continued coverage are unaffordable.

16 No one is happy with the
17 current system. Despite spending at least
18 twice as much per capita as any other country,
19 we have 45 million uninsured people, 30
20 million underinsured, and everyone watching
21 costs go up and access down.

22 Even people who think they
23 have good coverage are often stunned when they
24 need it and it isn't there for them.

1 Expensive, high-tech care is available to some
2 but even basic and preventive care unavailable
3 to many.

4 Our national health indicator
5 ranks us the best of the third-world countries
6 rather than the industrialized democracies
7 with government-sponsored insurance.

8 We spend over 20 percent in
9 administrative costs in our private insurance
10 programs as compared with about 3 percent in
11 our Medicare system.

12 More than half of our health
13 dollars are already tax supported, and the new
14 taxes needed would be offset by decreased
15 insurance premiums and out-of-pocket
16 expenses.

17 Illinois is at a crossroads,
18 and this committee has the power to recommend
19 which road will be taken. We can promote the
20 incremental reforms that we know won't work in
21 the long run, or we can choose what every
22 other industrialized nation in the world has
23 chosen: a variation of single-payer,
24 government-funded health system.

1 You have the opportunity to be
2 leaders in real health care reform that will
3 give everyone in our state access to
4 affordable, high-quality, and accessible
5 health care.

6 This shouldn't be a difficult
7 choice. The public and the physicians are
8 with you. They're increasingly frustrated
9 with the system.

10 Almost two-thirds of Americans
11 indicate they prefer a universal system
12 administered by the government as opposed to
13 the current employer-based system, and a
14 Washington Post poll reports 62 percent of
15 Americans indicated they prefer a universal
16 system administered by the government.

17 According to the Annals of
18 Internal Medicine, nearly 60 percent of
19 academic physicians support a single-payer
20 system.

21 We all know the system is
22 broken. I ask you, please, to do the right
23 thing: recommend a single-payer,
24 government-financed health system. Anything

1 short of that will guarantee a perpetuation of
2 a growing number of uninsured, growing
3 inefficiencies, and public and private
4 dissatisfaction. Thank you.

5 DR. LERNER: Thank you very much.
6 I'd like to thank Mr. Bild and Miss Clemens
7 and Mr. Brennan and Miss Berman and Miss
8 Schaps.

9 And now we have the second
10 group of speakers, so if I could ask them to
11 come forward and take their seats up front:
12 Mark Pelletier, Joseph Johnson, Adam
13 Scheffler, Robert Burkhart, and Georgia
14 Evans.

15 While we're getting organized,
16 Ashley -- where's Ashley -- could you stand
17 up. Anybody that's got anything to submit, --
18 that's Ashley Walter -- if you would please
19 give it to her either after you're done giving
20 your commentary or if you're not going to make
21 oral testimony beforehand. We'd really
22 appreciate it. Mr. Pelletier?

23 MR. PELLETIER: Good afternoon.

24 DR. LERNER: Working with the

1 microphone does not count against your time.

2 It will add to your time.

3 MR. PELLETIER: Good afternoon.

4 Thank you. I'm Mark Pelletier, M-a-r-k
5 P-e-l-l-e-t-i-e-r. I'm the interim chief
6 executive officer for St. Francis Hospital in
7 Evanston.

8 First of all, I would like to
9 commend the Adequate Health Care Task Force on
10 all of the hard work that has gone into
11 gathering the views, comments, opinions, and
12 concerns on the critical issue of providing
13 access to quality health care for all the
14 people of Illinois. Your efforts are greatly
15 appreciated.

16 The Illinois hospital
17 community supported the Health Care Justice
18 Act which established this Task Force.
19 Hospitals continue to be strong advocates of
20 efforts to find reasonable and workable
21 solutions to the uninsured crisis.

22 I am here today to make a
23 specific request of your Task Force: Please
24 make recommendations that do not rest solely

1 on hospitals, hospitals who are already
2 financially challenged and providing a great
3 many uncompensated community benefits.

4 Hospitals alone cannot solve
5 this health care crisis. A multifaceted,
6 public-private approach is required.

7 I'd like to provide you with
8 some background information on Saint Francis
9 Hospital and the roll that we play in helping
10 address the problems of the poor and uninsured
11 and serving our community's needs.

12 Saint Francis Hospital is a
13 member of Resurrection Health Care, Chicago's
14 largest Catholic health care system, whose
15 mission is to provide compassionate,
16 family-centered care that improves the health
17 and well-being of everyone in the community,
18 especially the poor and disenfranchised.

19 At Saint Francis, we have
20 always been concerned about the crisis of the
21 uninsured and underinsured because of the
22 large percentage of our patient population in
23 these two categories.

24 Saint Francis Hospital, like

1 hospitals all over the State, is committed to
2 serving the health care needs of all the
3 people in its service area regardless of their
4 ability to pay or their insurance or
5 citizenship status.

6 We treat patients from every
7 segment of society, 24 hours a day, 7 days a
8 week, 365 days a year. Our patients depend on
9 us. They turn to us in times of crisis. They
10 want and need us to be there for them, and we
11 are.

12 Saint Francis Hospital and all
13 Illinois hospitals are truly the health care
14 safety net for the underinsured population.

15 Being the health care safety
16 net for Illinois' uninsured and underinsured
17 population puts tremendous strain on Illinois
18 hospitals. Each year, Illinois hospitals
19 provide over \$1 billion of free health care.

20 In 2005, Saint Francis
21 Hospital provided \$19.7 million of free health
22 care. Over the three-year period from 2002
23 through 2004, Saint Francis Hospital provided
24 over \$63 million in free care.

1 Each year, Saint Francis
2 Hospital sees an average of 33,600 patients in
3 its emergency room. Many of these patients
4 use our emergency room as their primary health
5 care provider.

6 Our clinic, the Saint Francis
7 Hospital Community Health Center, serves
8 approximately 15,000 poor and uninsured
9 patients each year, the majority of who are
10 mothers and their children. None of these
11 patients pay the full cost of their care.

12 Saint Francis Hospital, as are
13 all Illinois hospitals, is truly a valuable
14 health care resource to the community it
15 serves.

16 Saint Francis is doing
17 extraordinary work in its community every day;
18 but its ability to continue to perform this
19 vital role is being threatened because of
20 financial pressures, being squeezed between
21 sourcing costs -- many of them beyond our
22 control -- and declining revenues.

23 Today, two out of every three
24 hospitals in Illinois lose money taking care

1 of patients; and more than one in three
2 hospitals in Illinois have negative operating
3 margins.

4 In fiscal year 2005, Saint
5 Francis Hospital had only a \$1.4 million
6 operating profit or 1 percent of revenues.
7 For fiscal years 2002 through 2004, Saint
8 Francis Hospital lost over \$4 million from
9 operations alone.

10 In spite of financial
11 challenges, Saint Francis Hospital continues
12 to provide quality, lifesaving care to
13 patients and to meet the needs of its
14 community every day. In 2005, almost 60
15 million of community benefit services were
16 provided.

17 In conclusion, Saint Francis
18 is doing everything it can to serve the
19 uninsured and underinsured in its local
20 community under extremely difficult
21 circumstances -- low reimburse coupled with
22 high operating costs. Expecting hospitals to
23 finance or underwrite health care for the
24 uninsured is an impossible expectation.

1 We support any effort to find
2 reasonable and workable solutions to the
3 uninsured crisis, not an easy task. Finding
4 alternative sources to finance health care
5 coverage for the uninsured and underinsured is
6 a vital importance to hospitals, our patients,
7 and our communities. Universal health care
8 coverage is a goal that we all embrace and
9 support.

10 I urge the Task Force to
11 carefully and thoughtfully consider the review
12 of the many proposals that you will be
13 presented, some of which could have unintended
14 consequences that may worsen the problem.
15 Placing a greater burden on hospitals is not
16 going to solve the uninsured crisis and will
17 only damage the health care system that
18 patients and communities have come to depend
19 on.

20 All of us need to work
21 together -- hospitals, health care workers,
22 insurance companies, businesses, and
23 government -- to find reasonable solutions to
24 this problem.

1 I thank you for providing us
2 the opportunity to comment on this issue and
3 express our appreciation of your work and all
4 the hours of time and energy that have gone
5 into this final report. Thank you.

6 DR. LERNER: Thank you, Mr.
7 Pelletier. Mr. Johnson?

8 MR. JOHNSON: My name is Joseph
9 Johnson, J-o-s-e-p-h J-o-h-n-s-o-n. I'm the
10 pastor at Epworth United Methodist Church in
11 Chicago, 5253 North Kenmore Avenue.

12 I'm coming to speak as a
13 clergyperson -- a person of faith -- living in
14 the State of Illinois and particularly speak
15 from a United Methodist perspective in
16 advocating for just a health care system; and
17 that's based on our belief that every person
18 living in Illinois is a child of God and is
19 deserving, therefore, of health care.

20 I'd like to share seven points
21 about a just health system in a just society.

22 The first is basic health
23 services that are accessible and affordable in
24 each geographic and cultural setting;

1 second, an environment that
2 promotes health;
3 third, active involvement of
4 the patient in the formulation of health care
5 activities that meet local needs and
6 priorities, which is part of what we're doing
7 today;
8 receive compassionate and
9 skilled care;
10 a health care system sensitive
11 to cultural needs and medical and ethical
12 critique;
13 and, seven, access to funding
14 sources, where necessary, for basic health
15 services.
16 I just turned 35 on January
17 1st. I've been in the ministry for seven
18 years; and over those seven years, I've seen
19 the health care premiums increase
20 astronomically. As a 35-year-old
21 professional, I'm not sure that I'll have
22 health insurance in ten years.
23 Another one of my clergy is
24 here, and his wife administers our health

1 benefits program; and he possibly might speak
2 about that.

3 But I'm very concerned about
4 it even just from my own self as a
5 professional, and so I encourage you to work
6 toward a single-payer system.

7 As a church, we believe a
8 for-profit health insurance system can never
9 be ethical because profits will always win
10 over a person's needs to have health care, and
11 so I just ask you to move forward on a
12 single-payer system.

13 And I know that you don't have
14 much influence over the national budget, but a
15 revenue source for that would be taking money
16 from armament to go for health care.

17 So thank you for your time.

18 MS. DAVIS: What were numbers five
19 and six?

20 MR. JOHNSON: What did you say?

21 MS. DAVIS: What were numbers five
22 and six?

23 MR. JOHNSON: Five was to receive
24 compassionate and skilled care, and six was a

1 health care system sensitive to cultural needs
2 and medical/ethical critique.

3 That doesn't happen to some
4 degree now. Physicians are not able to
5 critique it. Their hands are tied like the
6 rest of us. So thank you for asking.

7 DR. LERNER: I would ask you again
8 to make sure that --

9 MR. JOHNSON: I have twenty copies
10 for all of you.

11 This is taken from our book of
12 resolutions, so this is actually an
13 international document as well as just
14 national.

15 DR. LERNER: We appreciate the
16 intensity of your feeling. And if we can do
17 something in Illinois, that would be a great
18 step to doing something nationally; but we
19 haven't been called by Washington yet.

20 MR. JOHNSON: Okay. Thank you so
21 much.

22 DR. LERNER: Thank you, Mr.
23 Johnson. Mr. Scheffler?

24 MR. SCHEFFLER: Good afternoon. My

1 name is Adam Scheffler, and that's A-d-a-m
2 S-c-h-e-f-f-l-e-r.

3 Thank you for the opportunity
4 to testify today. I'm grateful to the Task
5 Force for the work that you're doing.

6 I want to say, first of all,
7 that I live in the 9th congressional district.
8 That's why I chose this particular hearing.

9 I am a licensed social worker,
10 and I work in private practice as a health
11 policy analyst and journalist; so I'm
12 self-employed. I'm speaking for myself only.

13 I'm going to discuss two
14 points briefly: a little bit about my
15 personal experience with health insurance
16 coverage in the State of Illinois and,
17 secondly, some thoughts about the goals to
18 maintain and improve the quality that are
19 contained in the legislation directives to
20 this Task Force.

21 First, my personal experience:
22 The last time I had employer-based health
23 insurance coverage was by Blue Cross-Blue
24 Shield of Illinois.

1 I was able to continue that
2 coverage once I left that organization under
3 COBRA, as has already been mentioned, at a
4 higher rate; so it was difficult.

5 Then I switched to some
6 association-based coverage through the
7 National Writers Union. The first plan,
8 however, quickly was -- went into receivership
9 because it was being defrauded in, I believe,
10 the State of Arizona or New Mexico.

11 We were able to get coverage
12 by Aetna but only for a year before Aetna
13 refused to cover our members; then UniCare for
14 the next year until they refused to cover us.
15 So at that point, I was out of luck.

16 I applied to Blue Cross-Blue
17 Shield for individual coverage; was turned
18 down.

19 Then, I found out about -- at
20 the same time, I found out about ICHIP Plan
21 which I'm sure you're familiar with in your
22 deliberations; and I'm a member of that plan.
23 It's a great plan.

24 Again, I have Blue Cross --

1 I'm happy to report -- of Illinois. However,
2 the cost is near astronomical. Only through
3 the help of family members am I able to
4 continue paying these premiums.

5 So just as an aside, I would
6 say make sure in the transition that whatever
7 you're recommending that you make some
8 recommendations about adding a lot of money to
9 the ICHIP Plan because it's a great plan and
10 deserves support, at least for now.

11 My experience is not typical.
12 Like the previous gentleman, I'm
13 self-employed. Well, he's not self-employed.
14 I'm a professional, and I worry about my
15 ability to get coverage.

16 I do work that allows me to
17 have some more information than the average
18 person in the State about what's going on in
19 the health care system, but even I cannot be
20 sure of having affordable coverage.

21 So I don't want to repeat any
22 more about that or what other people said; but
23 I want to switch just very briefly to the part
24 about ensuring, maintaining, and improving

1 quality health care in the State of Illinois.

2 I'm not sure how seriously
3 this part of your mandate is going to be
4 attended to because I only have heard about it
5 talked about recently at one of your other
6 meetings; but the question about expanding
7 access, of course, we want everybody to have
8 access. But the question I have is: Access
9 to what?

10 And the IDPH report that was
11 already cited plus a whole raft of other IDPH
12 reports about the quality of care and the
13 safety or lack of safety in the health care
14 system leads us to believe that even with
15 universal access, there are a whole other
16 range of questions that need to be dealt with
17 and can be dealt with possibly more easily
18 under a government-funded system; but not
19 necessarily unless there's an affirmative
20 effort made to use the power of purchasing, as
21 was mentioned before, to really regulate the
22 quality of care in ways that will not impose
23 on the prerogatives of medical professionals
24 but will actually support them to do the job

1 presently, health care spending accounts for
2 16 percent of our gross domestic product,
3 which is a record high. The health care cost
4 in '04 was nearly 8 percent above the previous
5 year, which means it doubled over the past ten
6 years.

7 And although there has been
8 some coming together of the gap between blacks
9 and whites, it's increased between Hispanics
10 and whites, and it's increased between the
11 rich and the poor.

12 Are we surprised? Probably
13 not. Are we upset? I hope so.

14 Are we willing to do
15 anything? Time will tell.

16 I'm sure that you've been
17 hearing numerous stories about people who do
18 not have access to health care. As a pastor,
19 I've heard many. Some are members of my
20 congregation who have lost the benefit of
21 fully- or partially-covered health insurance
22 from their employers.

23 It's driven health care to
24 some persons to be an unaffordable luxury.

1 Some persons are not getting operations that
2 would correct problems; some are not
3 medicating issues as blood pressure; some are
4 not getting -- some are getting teeth pulled
5 instead of root canals; some are not taking
6 advantage of smoking cessation measures.

7 Why? Because of costs.
8 Often, uninsured persons avoid addressing
9 medical issues until they become extreme and
10 then are forced to seek hospital emergency
11 rooms which not only crowd out real
12 emergencies but cost far more dollars than if
13 the person would have gone to a doctor's
14 office in the first place.

15 There's no doubt we need a
16 universal plan affordable to all because our
17 systems are sick and in need of healing.

18 Why should we take action?
19 Should we even care?

20 As a person of faith, this is
21 a moral issue. I'm a United Methodist pastor.
22 Our denomination has a stance of justice for
23 all persons, especially the neediest. It's
24 based on the life and teachings of Jesus who

1 frequently crossed the boundaries of his day
2 to offer care to persons neglected.

3 Our denomination's founder,
4 Englishman John Wesley, was deeply concerned
5 about health care. He, himself, provided
6 health care services to the poor at no cost in
7 London. He also emphasized preventive care.

8 In our denomination's Social
9 Principles, which is in addition to which
10 Pastor Johnson had referred, there's a section
11 that says, "Health care is a basic human
12 right. It's unjust to construct or perpetuate
13 barriers for physical or mental wholeness or
14 full participation in the community.

15 We encourage individuals to
16 pursue a healthy lifestyle and affirm the
17 importance of preventive health care,
18 education, environmental and occupational
19 safety.

20 We also recognize the role of
21 government in ensuring that each individual
22 has access to the elements necessary to good
23 care."

24 I applaud all of you and the

1 Health Care Justice Act. It's a positive and
2 needed step.

3 I endorse the principles that
4 health care be accessible, affordable with
5 quality, and containing costs. It must be
6 comprehensive not only in addressing illness
7 but in supporting preventive medicine as well
8 as promoting healthy lifestyles and wellness.

9 We have a moral obligation to
10 transform health care from a privilege which
11 it is now for many people to be a right that
12 it should be for everyone. Thank you.

13 DR. LERNER: Thank you, Mr.
14 Burkhart. Miss Evans?

15 MS. EVANS: Good afternoon. My
16 name is Georgia Evans.

17 I'm a lifetime resident, give
18 or take college and how the lines were drawn
19 for the 9th Congressional District, first
20 growing up in Park Ridge and now 25 years in
21 Rogers Park.

22 Given how the lines are drawn
23 with insurance, I have either been insured,
24 underinsured, or uninsured.

1 I lost my job on June 16th,
2 the day that insurance was to be offered.
3 This was not casual; it was calculated. I had
4 been making inquiries since January as to when
5 the policy would be offered.

6 I was given a stipend when I
7 came on to pay for \$175 of \$469 of a COBRA
8 policy. The rest of the fourteen-member
9 company who were professional as opposed to
10 support staff, with the exception of two other
11 support staff in New York, were given a
12 50-percent stipend to pay for their health
13 care costs.

14 My health insurance went
15 away. I needed continuous coverage. I went
16 to Cook County and waited eleven hours to go
17 in through the emergency room with everyone
18 else who was there as the working poor.

19 There was not one catastrophic
20 incident in the four hours I was in the
21 general waiting room. I was there in a silk
22 suit, as were other people waiting for health
23 care.

24 I had been diagnosed with a

1 potential heart attack from four negative EKGs
2 during a cholesterol study. I hope you'll
3 consider in your adequate health care that
4 people need to be responsible for their own
5 health; and continuously smoking, drinking
6 sugared drinks, becoming obese, and then
7 throwing themselves into the health care
8 system or suing McDonald's is not being
9 responsible.

10 So when I had no other
11 alternative, I, being a taxpayer, went to Cook
12 County for my care after paying \$200 for an
13 outside cardiologist who said, when I had
14 insurance, not exhibiting symptoms, I would
15 then need a doppler EKG.

16 And calling around for various
17 hospitals, this was going to cost me several
18 thousand dollars; so I opted for Cook County
19 which said I must go through the emergency
20 room to get in. That was a seven-hour
21 experience.

22 Then you go -- that was
23 November. It took until July -- November was
24 when I had my fourth negative EKG, April is

1 when I went through the emergency room, July
2 is when I had the doppler; and it would have
3 taken until October to have it read.

4 So unless you are persistent
5 and articulate, it is almost impossible to
6 negotiate the system; and this is something
7 else that needs to be considered.

8 I went for all my primary
9 health care this summer, being unemployed, to
10 Cook County. There was a woman next to me in
11 mammography that spoke no language that could
12 be deciphered by any of the staff despite the
13 fact they should have been entitled to an
14 interpreter. So who knows what kind of care
15 she would have received?

16 I don't represent anyone,
17 although I feel I have been documented in the
18 cartoon in today's Washington Post. I am at
19 the beginning of the continuum that a previous
20 citizen has outlined her fear of seven years.

21 I'm trying to take care of
22 myself. I forgo other pleasures, except good
23 dark chocolate, with things that are good, or
24 an occasional red wine; so I am taking care of

1 myself mentally and physically.

2 But many people just get
3 absolutely discouraged and frustrated and are
4 without means and then forgo the other care
5 that's been discussed. It is a huge problem,
6 but I think preventative care needs to be a
7 big part of it and obviously all the other
8 statistics that have been previously cited
9 about fairness and not putting all the burdens
10 on hospitals.

11 Thank you for listening.

12 DR. LERNER: Should we keep going,
13 or do you want to take a break?

14 MS. DAVIS: Did you ever get the
15 care that you were looking for?

16 MS. EVANS: The doppler EKG, yes.

17 MS. DAVIS: Did they ever interpret
18 it, and did you ever get follow-up?

19 MS. EVANS: I went to my ward
20 committeeman who happened to work in the Cook
21 County system to find out what doctor might be
22 able to see me in less than two months because
23 it would have been almost a calendar year from
24 November to October.

1 So I showed up at seven in the
2 morning, presented myself to the doctor he
3 suggested. She suggested that perhaps a call
4 from him would have been appropriate.

5 I said I wasn't looking to
6 jump in line in front of anyone except I
7 wanted to see someone before October; and if I
8 could sit and wait, she could see me that
9 day.

10 I said, you don't need to see
11 me. You need to push a button on the computer
12 to read the results of the EKG -- of the
13 doppler EKG.

14 I had an ischemic heart attack
15 which was considered extremely minor. I'm
16 always go to show up with negative EKGs the
17 rest of my natural life; and I have to now
18 advise the health care community of this so I
19 don't have unnecessary, expensive tests.

20 But if I hadn't been extremely
21 aggressive and stand up to the system, I would
22 have waited. I still wouldn't -- well, I
23 would have had it in October, I guess. So
24 thank you.

1 DR. LERNER: Any other questions?

2 (No response.)

3 DR. LERNER: Before we go to the
4 next set of speakers, there's a couple of
5 other people I think I'd like to introduce and
6 also may want to introduce themselves.

7 Is Jim Jordan from the
8 Division of Insurance here?

9 (No response.)

10 DR. LERNER: I thought he was going
11 to be here.

12 Also, I see one of our
13 founding members of the Task Force who I just
14 noticed is going to speak, one of the founding
15 steering committee members, Robyn Gabel.

16 Why don't you stand up and
17 just be recognized. Thank you.

18 DR. LERNER: We also have the
19 chairman of the Illinois Hospital Association
20 and one of the senior executives at the
21 Evanston Northwestern Healthcare Corporation,
22 Ray Grady. Thanks, Ray, for coming.

23 I know that there are several
24 members of legislative staff who are here.

1 Would you stand up and just be recognized
2 right now and introduce yourselves, please.

3 MS. COMBS: I'm Leslie Combs from
4 Congresswoman Schakowsky's office.

5 MS. BANERJI: I'm Anita Banerji
6 from Jeffrey Schoenberg's office.

7 MS. RAVENNA: I'm Joan Ravenna from
8 state representative Lou Lang's office.

9 DR. LERNER: Thank you very much.
10 Periodically, I'll stop the hearing to see if
11 there are other people whom the rest of you
12 want to get to know as we go through this
13 public hearing process.

14 I'd like to thank the five
15 speakers for their input. We really
16 appreciate it.

17 And now I'd like to call up
18 front Wendy Mathewson, Robyn Gabel, Leslie
19 Combs, Amy Laiken, and Anita Banerji. And if
20 I mispronounced anybody's names, I'll
21 apologize now.

22 Wendy Mathewson?

23 MS. MATHEWSON: Good evening. I'm
24 Reverend Wendy Mathewson, W-e-n-d-y

1 M-a-t-h-e-w-s-o-n.

2 I'm a presbyterian minister at
3 Northminister Presbyterian church in Evanston,
4 Illinois; and I'm a resident in West Rogers
5 Park.

6 This week as we celebrated
7 Martin Luther King, Jr. Day, I came across
8 this quote attributed to him: "Of all forms
9 of inequality, injustice in health care is the
10 most shocking and inhumane."

11 And as I became a little more
12 familiar with the state of health care in
13 Illinois, I was shocked at the number and
14 percentage of people in our communities that
15 lack insurance. A third of our people have no
16 access to insurance and what's unjust about
17 this shocking figure is that it's
18 disproportionately ethnic minorities and other
19 disadvantaged people who our society
20 marginalizes.

21 And, as a person of faith, I
22 want to say something about values. I think
23 that we should be judged by the way that we
24 treat the most marginalized among us and the

1 poor, the stranger. These are the people that
2 our hospitality, our care for them, reflects
3 on us and our morality and our values.

4 The Prophet Jeremiah asked his
5 people, "Is there no balm in Gilead? Is there
6 no physician there?" "Why then," he said,
7 "has the health of my poor people not been
8 restored?"

9 And if we were to ask
10 ourselves the same questions, we do have
11 balms, we have medicines, we have physicians.
12 We have more resources than any other country
13 in the world; and, yet, the health of our
14 people has not been restored.

15 And I would like to ask you,
16 as you make recommendations to the General
17 Assembly, to be courageous in standing up for
18 values that place not only equality on all
19 people, including marginal people, but also
20 that don't leave people on their own.

21 There are some biblical
22 medical anthropologists who believe that in
23 the time that the gospels were written -- the
24 stories of Jesus -- that illness was not only

1 viewed as a disease, as a problem in your
2 system, your biological system; illness was
3 viewed as isolation in the community.

4 And when we leave people who
5 are struggling with diseases on their own, it
6 increases their sense of illness. It is not
7 right. We should be coming together not only
8 in equality but in connectedness with each
9 other.

10 I really appreciate the
11 opportunity to share my views with you. Thank
12 you for the time.

13 DR. LERNER: Thank you, Wendy.
14 Robyn Gabel, good to see you.

15 MS. GABEL: Good to see you, too.
16 Wow, it's kind to hard to follow that. That
17 was very nice.

18 My name is Robyn Gabel,
19 R-o-b-y-n G-a-b-e-l. And I'm a board member
20 of the Campaign for Better Health Care and a
21 voter in the 9th Congressional District, which
22 is why I am here today.

23 I would like to thank all the
24 members of the Task Force for your time and

1 with recommendations and plans; but our
2 governors in the past have not really been
3 that open to the results. And I feel that
4 this time, we somebody that's ready to hear
5 what we have to say; and I hope that you can
6 come up with a plan that he can then approve.

7 MS. DAVIS: Did he mention us?

8 MS. GABEL: Did he mention the
9 Adequate Health Care Task Force? Not in the
10 time that I heard. I didn't hear the entire
11 speech.

12 MS. CLEMENS: He did not mention
13 you at all, and I was very surprised about
14 it.

15 He mentioned KidCare,
16 children's health care, and returning
17 veterans. That's all.

18 DR. LERNER: What Miss Clemens
19 said, just so everybody can hear, was that
20 from her recollection, the governor did not
21 mention the Task Force but did mention KidCare
22 and other related programs. Thank you.

23 MS. GABEL: I think he's waiting to
24 see the results of the Task Force before he

1 talks too much about it.

2 So I am just here to hammer
3 home the four main things that I would like
4 you all to consider in this next period.

5 And I did see on the back of
6 one sheet that President Jones still didn't
7 appoint somebody to the Task Force, even
8 though they tell me they did; so maybe I can
9 talk to him again, and maybe I'll be back with
10 you after May.

11 So, first, we ask that the
12 Task Force recommendations ensure that health
13 care is accessible; and I know a lot of people
14 have talked about accessible and what it
15 means, and I think we've had some great
16 examples of health care being inaccessible to
17 people who lose their jobs.

18 We ask for health care without
19 barriers that is comprehensive; and I think
20 when we look at what kind of health care
21 insurance or coverage we want to look at, we
22 need to include primary, specialty care,
23 dental, vision, behavioral health, in-home
24 care, and long-term care.

1 And we want to make sure that
2 it provides continuity of coverage from
3 outpatient to hospitalization. We have some
4 health care programs that just cover
5 hospitalizations, some that just cover
6 outpatient. We need to look at a program that
7 actually covers both.

8 The second point is to make
9 sure that health care is affordable. When we
10 look at affordable, we want it to be looked at
11 in a broader sense. It needs to be affordable
12 to individuals, to families, but also to
13 businesses and to taxpayers; and I think we
14 should take a broad approach to looking at
15 affordable.

16 Also, the providers who are in
17 the system have to be paid in a timely manner;
18 or we won't have any providers in Illinois.
19 And as we know, in deliveries and ob-gyn,
20 providers are already leaving the state in
21 droves. As the saying goes, southern Illinois
22 is a great place to live; but you can't be
23 born there. Everybody's born in Kentucky or
24 Paducah, right?

1 your attention; and again, I really do
2 appreciate your commitment to the Health Care
3 Justice Act and to the Adequate Health Care
4 Task Force.

5 DR. LERNER: Thank you, Robyn.
6 Leslie Combs?

7 MS. COMBS: Hi. Thank you. My
8 name is Leslie Combs, L-e-s-l-i-e C-o-m-b-s.

9 And I'm the district director
10 for Congresswoman Jan Schakowsky who would be
11 with you here today if she weren't in
12 Washington trying to come up with some
13 positive strategies for the democrats, so I'm
14 going to be reading her testimony.

15 I want to begin by thanking
16 you and the members of the Adequate Health
17 Care Task Force for holding this public
18 hearing today, for your commitment to
19 providing access to affordable, quality, and
20 comprehensive health care to all residents of
21 Illinois.

22 With the development of
23 prescription drug purchasing pools and
24 Governor Blagojevich's commitment to

1 protecting low-income seniors and persons with
2 disabilities during Medicare's prescription
3 drug transition, Illinois is being recognized
4 as a leader in this fight.

5 Today's hearing is a
6 recognition that we can and must do even
7 more. I believe that implementation of the
8 Health Care Justice Act will help us achieve
9 the mission that Cardinal Joseph Bernadin so
10 eloquently challenged us to undertake when he
11 told us that health care is an essential
12 safeguard of human life and dignity, and there
13 is an obligation for society to ensure that
14 every person be able to realize this right.

15 We are all aware of the
16 problems facing us in Illinois and around the
17 country. Our health care system is falling
18 apart faster than we can patch it together.

19 While nearly 1.8 million
20 Illinoisans were uninsured in 2004, twice as
21 many lacked coverage for some or all of the
22 last two years, indicating that many of our
23 friends, neighbors, and family members fell in
24 and out of coverage.

1 This is a particular problem
2 since half of all Americans are estimated to
3 live with chronic health conditions from
4 asthma to diabetes that require ongoing
5 medical care.

6 Eliminating the insecurity and
7 discontinuity present in health care should be
8 a goal of the Adequate Health Care Task Force.
9 The demand for action is evident.

10 As we heard earlier, the
11 Institute of Medicine has estimated that
12 18,000 Americans die each year because they
13 were uninsured and unable to obtain care.
14 Uninsured Americans are nearly eight times
15 more likely to skip health care because they
16 cannot afford it.

17 We must act but not by handing
18 the uninsured an insurance card that still
19 leaves them with gaping holes in access to
20 care.

21 Over half of all medical
22 bankruptcies in the U.S. are the result of
23 medical bills, and the majority of those cases
24 involve the insured. The uninsured may be

1 drowning, but the answer is not to put them on
2 a sinking ship.

3 In thinking about the goals of
4 the Health Care Justice Act, I think about
5 constituents I have heard from and their
6 health care needs, many here today: a young
7 woman whose insurance doesn't cover the cost
8 of caring for her breast cancer; an older
9 woman who lacks comprehensive back-ups in
10 mental health services; a family facing
11 bankruptcy because even with insurance, they
12 couldn't afford their out-of-pocket costs for
13 a catastrophic illness; a man who can only
14 afford a high-deductible policy and doesn't
15 have the resources to get preventive care and
16 cancer screenings. They, too, are looking at
17 us for help.

18 The Health Care Justice Act
19 requires that we look at the problems facing
20 not just the uninsured but the problems
21 created throughout our health care system. It
22 gives us the opportunity in Illinois to look
23 for bold and comprehensive solutions; and by
24 setting timetables for action, makes it clear

1 that we do not have time for anyone's debate,
2 but we must act now to make a change.

3 As a member of the US House of
4 Representatives, I'm unfortunately spending
5 most of my time trying to tread water
6 preventing cuts in Medicaid and trying to
7 maintain funding for the State children's
8 health insurance program.

9 Many of my colleagues and I
10 are also trying to push for bolder, more
11 comprehensive approaches. We have adopted a
12 number of principles that I believe are
13 equally important for this Task Force.

14 We must focus on providing
15 access to medical care, not insurance. Health
16 coverage must be comprehensive. In Washington
17 and some states around the country, arguments
18 are being made that we can only help the
19 uninsured by taking away some of the benefits.

20 Health care must be affordable
21 to individuals and families, to businesses and
22 farmers, and taxpayers. Our financial health
23 care system is like a giant game of hot potato
24 with each player trying to shift costs to

1 someone else: businesses to workers, the
2 federal government to state and local
3 governments, providers with uncompensated
4 costs to patients with insurance.

5 We must look at ways to lower
6 costs for everyone instead of cost shifting to
7 someone else. This means that we need to look
8 for cost effective ways to spend our
9 health-care dollars.

10 We should look for ways to
11 reduce administrative costs, unnecessary
12 bureaucracy, and marketing expenses that do
13 nothing to improve health care quality or
14 access, including improved insurance
15 regulation to make sure that premium dollars
16 are spent on health care.

17 Economies of scale work.
18 Group coverage is cheaper than individual
19 policies, discounts are deeper if negotiated
20 on behalf of many rather than a fewer.

21 Proposals by Healthy Illinois,
22 which would create a statewide, comprehensive
23 health insurance pool for the uninsured,
24 self-employed, and small businesses and

1 municipalities, would result in lower costs
2 and better access than assistance for the
3 purchase of individual policies.

4 Public accountability is also
5 key. I agree with economist Paul Krugman who
6 wrote, "In health care, the private sector is
7 often bloated and bureaucratic. The United
8 States has the most privatized, competitive
9 health care system in the world. It also has,
10 by far, the highest costs and worst results."

11 For that reason, I support a
12 Medicare-for-all approach that would provide
13 public financing and private delivery of
14 health care; but even if private insurance is
15 part of your final recommendations, there must
16 be clear rules and oversight mechanisms in
17 place.

18 And, finally, we must look at
19 the health care system not just from the
20 consumer perspective but also from the
21 provider side. As often as I hear from
22 patients, I hear from doctors, nurses, social
23 workers, and other professionals who are
24 concerned about their ability to act in their

1 patients' interests, staffing levels, and the
2 level and timeliness of payments.

3 A critical component of
4 ensuring access to quality care should be the
5 ensured availability of adequate numbers of
6 qualified providers.

7 In 2000, I worked with the
8 State of Illinois to secure a Health Resources
9 and Services Administration state planning
10 grant for universal health care.

11 In the six years since then,
12 Illinois has taken important steps to expand
13 coverage but has not reached the goal of that
14 initiative.

15 I hope that six years from
16 now, if not sooner, we will be able to point
17 to the Health Care Justice Act as the catalyst
18 that not only spurred a debate but that
19 brought us universal access to comprehensive,
20 affordable, and quality care.

21 I look forward to working with
22 you and Governor Blagojevich. Thank you so
23 much.

24 MS. DAVIS: Leslie, could you

1 please tell your congresswoman that we are
2 very appreciative of her supporting the
3 Conyers bill.

4 MS. COMBS: I absolutely will pass
5 that on to the congresswoman. Thank you.

6 MR. GELDER: Are you -- you're
7 organizing a hearing on the Medicare drug
8 benefit?

9 MS. COMBS: We are. Word travels
10 fast.

11 We are organizing a hearing on
12 the Medicare Prescription Drug Benefit, and we
13 have tentatively scheduled it for February
14 10th at ten o'clock at the Metcalf Federal
15 Building; but it's tentative, so I don't have
16 anything solid on that.

17 As soon as we've solidified
18 it, we will get the word out as best we can.

19 MS. DAVIS: Notify Ashley, and
20 she'll get it out to us.

21 MS. COMBS: I sure will.

22 DR. LERNER: Any other questions?

23 MS. PRINTEN: We couldn't hear what
24 Margaret said. Supportive of what?

1 MS. DAVIS: Congressman Conyers'
2 bill.

3 DR. LERNER: So when -- just to
4 clarify it, when Margaret said "we," it was
5 not the literal "we" to her.

6 MS. DAVIS: Thank you.

7 DR. LERNER: Just to keep the -- it
8 was singular "we." It was this "we" right
9 here.

10 The transcript will note that
11 I was pointing to the two individuals to my
12 right. That's not to exclude other people who
13 want to be included in the collective "we."
14 You can get there later.

15 But the Task Force has to
16 remain objective, of course. Thank you very
17 much. Amy?

18 MS. LAIKEN: Hi. My name is Amy
19 Laiken, A-m-y L-a-i-k-e-n.

20 I'd like to talk a little
21 about some of the experiences that I had while
22 I was working. I've been retired for three
23 years.

24 I was an administrative

1 hearing officer for eleven years for the
2 Department of Public Aid and the Department of
3 Human Services. As such, I conducted hearings
4 on the appeals of applicants for, and
5 recipients of, the various types of public
6 assistance provided by the State.

7 Beginning in approximately
8 1990, the only way a person could qualify for
9 medical assistance if he or she were under 65
10 with no dependent children would be to meet
11 Social Security guidelines for disability.

12 Many such people who could not
13 afford health care but desperately needed it
14 would apply for Medicaid with the State.

15 If the Security Administration
16 had previously found that the person was not
17 disabled, the State of Illinois would then do
18 an independent assessment.

19 If the Department of Human
20 Services determined that the individual was
21 not disabled, it denied his or her application
22 for medical assistance whether or not he or
23 she met the financial guidelines.

24 If the person filed an appeal,

1 he or she was entitled to a fair hearing,
2 which is where I came in. It was my job to
3 examine the written medical evidence as well
4 as to elicit testimony as tot he appellant's
5 educational level, work history, and physical
6 complaints.

7 After adjourning the hearing,
8 it was my responsibility to review the
9 testimony and objective medical evidence to
10 assess whether the appellant met the Social
11 Security guidelines for disability, which we
12 also used to make the determination.

13 It is important to note that
14 the definition of disability that we used was
15 a legal one rather than a medical one.

16 In other words, an appellant
17 who suffered from an illness that made it
18 virtually impossible to work in the real world
19 would not be considered disabled unless he or
20 she fell into one of the categories in the
21 six-step process.

22 Moreover, a person who was
23 seriously ill but managed to engage in
24 employment that paid more than a certain

1 amount would not be eligible even if
2 uninsured.

3 Most people who appeared
4 before me were not engaged in substantial
5 gainful employment, nor did they have an
6 impairment that was expected to be severe for
7 at least twelve continuous months or that was
8 expected to result in death; nor did their
9 medical evidence contain specific findings
10 that were listed in the guidelines that would
11 warrant a determination of disability without
12 further evaluation.

13 I was therefore required to
14 determine the residual functional capacity of
15 most people who appeared before me. This
16 entailed reviewing a detailed history of the
17 person's educational and work backgrounds and,
18 taking into account his or her age, comparing
19 it with a grid established by the Social
20 Security Administration.

21 Most people appearing before
22 me simply did not meet the definition of
23 disabled according to the guidelines. For
24 example, 47-year-old with limited education

1 who suffered from severe but no end-organ
2 damage would not be considered disabled if he
3 or she had performed semiskilled work.

4 A 57-year-old high school
5 graduate who suffered from cancer that had not
6 metastasized would not be disabled if he or
7 she had previously performed skilled or
8 unskilled work.

9 In other words, most people
10 who appeared before me were denied medical
11 assistance in spite of their need for health
12 care to manage serious chronic conditions or
13 their need for follow-up care for an acute
14 condition.

15 Most people who need emergency
16 care or treatment for an acute condition can
17 usually get it. If they are uninsured,
18 however, someone pays in the long run. Either
19 the local hospital provides so-called charity
20 care, or they are treated at a public hospital
21 at public expense.

22 For chronic conditions,
23 though, many people who can't afford regular
24 health care wind up getting it eventually when

1 their legs are amputated or they have to go on
2 dialysis.

3 As The New York Times series
4 on diabetes pointed out recently, a \$150 to a
5 podiatrist might help prevent foot infections.
6 In our State, a diabetic might not qualify for
7 medical assistance unless he or she meets the
8 Social Security guidelines.

9 However, if that person could
10 not afford to see the podiatrist and later
11 needs an amputation, he or she might then meet
12 the guidelines; and the State might pay as
13 much as \$30,000.

14 To not provide medical care
15 for those who need it is not only morally but
16 economically indefensible.

17 As Jesse Jackson might say, we
18 need to spend more for preventive and
19 maintenance care at the front-end so that we
20 might spend less for catastrophic care at the
21 back end. We need one comprehensive system;
22 everyone in, nobody out.

23 Thanks for your attention and
24 your commitment.

1 DR. LERNER: Thank you very much.
2 Which also calls into question what happens
3 with those individuals who don't get medical
4 assistance but theoretically could work but
5 nobody wants to employ them because they're
6 afraid of being able to take care of people
7 with those kinds of impairments or their lack
8 of medical costs.

9 We will take a break for a
10 moment.

11 (Short break taken.)

12 DR. LERNER: If I could call us
13 back in to order, please. Anita?

14 I would also like to remind
15 people to turn their phones off.

16 Also, if you have any interest
17 in the Health Care Justice Act or the Adequate
18 Health Care Task Force, there are handouts for
19 you in the back of the room. Anita?

20 MS. BANERJI: Good afternoon. My
21 name is Anita Banerji, A-n-i-t-a
22 B-a-n-e-r-j-i.

23 I am the chief legislature
24 aide for Senator Jeff Schoenberg, and I'm here

1 this afternoon to testify on his behalf. He
2 regrets he can't be here to be at the hearing
3 in person, as he's in Springfield for the
4 legislative session.

5 He would like to relay the
6 following comments and observations on the
7 State's health care needs: First and
8 foremost, we must remain true to the
9 importance of upholding health care access and
10 quality service to all residents of Illinois.

11 In doing so, we must continue
12 to ensure that adequate resources are
13 continually allocated to funding health care.

14 For that reason, I am proud to
15 be the chief architect of two hospital
16 assessment plans which will bring nearly \$2.3
17 billion in new federal Medicaid funding to
18 Illinois.

19 The two plans represent an
20 essential infusion for financing health care
21 in Illinois and represent an important
22 mechanism that provides for the numerous
23 hospital services that are rendered to
24 thousands of patients in our state each year.

1 As a Senate Appropriations
2 Chairman, I know all too well how important it
3 is to continue to help generate funds for
4 health care here in our community.

5 And it is important,
6 particularly, to note that during this time,
7 while many states across the country have cut
8 back on health care and human services to
9 balance their budgets in slow economic times,
10 Illinois, in fact, has expanded its health
11 care coverage.

12 According to a report just
13 released by the respected Kaiser Family
14 Foundation, in some cases the planned cuts to
15 health care coverage have been quite large
16 such as in Tennessee, Oregon, Mississippi, and
17 Missouri which, when fully implemented, will
18 virtually eliminate Medicaid coverage for more
19 than half a million people.

20 That said, without innovative
21 funding proposals for health care in Illinois,
22 hospitals and other health care and human
23 service providers would not be able to
24 confront the growing Medicaid caseloads or

1 provide for people's individual health care
2 needs, let alone expand statewide programs
3 such as the All Kids program passed by the
4 General Assembly and signed into law last
5 fall.

6 In addition to continuing our
7 commitment to generating more resources for
8 publicly funding health care, I also believe
9 it is equally vital for us to provide
10 alternatives to the health care services for
11 those lower- and lower-middle-income residents
12 who are ineligible for Medicaid to meet their
13 primary care needs.

14 More specifically, it is well
15 documented that emergency room care is the
16 most expensive form of treatment.

17 Groundbreaking, yet
18 common-sense programs like Access to Care
19 which seeks to reach those who have just
20 enough income to put them out of eligibility
21 for public health insurance could be a viable
22 alternative for people who work but do not
23 have health care insurance through their
24 employment.

1 Access to Care is a unique
2 public/private partnership that makes primary
3 health care and the ancillary pharmacy,
4 laboratory, and radiology services available.

5 The program provides diagnosis
6 and treatment to individuals and families for
7 a small copayment per visit per visit,
8 procedure, prescription medication.

9 By adopting a resourceful
10 administrative approach that relies heavily on
11 economics of scale, Access to Care minimizes
12 the cost of health care services while seeking
13 to provide access to health care services that
14 would otherwise be unavailable.

15 Thank you again for allowing
16 me to share my thoughts with you. I look
17 forward to continuing our work together as we
18 confront these serious challenges facing our
19 families and neighbors.

20 DR. LERNER: Are there any
21 questions for Senator Schoenberg's office?

22 MS. DAVIS: I was wondering: Is
23 the \$2 billion in the form of a bill, or is
24 this just being discussed?

1 MS. BANERJI: I believe it's
2 already in the bill. It's for \$2.3 billion in
3 new federal Medicaid funding.

4 DR. LERNER: Maybe I can comment on
5 it since I was the past Chairman of the Board
6 of the Illinois Hospital Association that
7 worked with Senator Schoenberg on this.

8 It's very critical; and we
9 want to thank him for his leadership and
10 Congresswoman Schakowsky's support -- the
11 Illinois delegation's support -- because we
12 need everybody's support to pass this.

13 Illinois is 46th out of 50
14 states in the public aid funding for hospital
15 and other provider care. As Mr. Pelletier was
16 talking about it and as reflected by
17 everyone's comments, one in seven members of
18 the State of Illinois are uninsured or
19 underinsured.

20 Another one in seven are on
21 Medicaid, so there's a substantial population
22 that don't have access to continuous
23 comprehensive care in the way that many of us
24 do.

1 Through efforts like Senator
2 Schoenberg's here in the State of Illinois,
3 supported by the governor and the Illinois
4 delegation, we hope to ramp up the public aid
5 funding if it's finally approved by CMS -- by
6 the Medicare agency -- in Washington; and it's
7 currently sitting in Washington.

8 It's my understanding that we,
9 through the Illinois Hospital Association,
10 have addressed the concerns that CMS had put
11 forth; and the clock is back running with the
12 ball in their court. And we hope to hear
13 about it within the next ninety days or so, as
14 I recall.

15 So this is a great example of
16 a partnership between government, the provider
17 community, and the people receiving the care
18 because if we get it, then we can continue to
19 offer the services we need and continue to
20 meet the needs of the community.

21 Sorry to take so much time,
22 but I needed to clarify that. Other
23 questions?

24 (No response.)

1 DR. LERNER: Thank you very much.
2 We have two more speakers. If I could have
3 them come forward: Margaret Stapleton and
4 Joan Ravenna.

5 MS. STAPLETON: Good afternoon. My
6 name is Margaret Stapleton. That's
7 M-a-r-g-a-r-e-t, last name Stapleton,
8 S-t-a-p-l-e-t-o-n.

9 I could best introduce myself
10 as a groupie of the Health Care Justice Act,
11 which I will explain later.

12 I'm an attorney with the
13 Sargent Shriver National Center on Poverty
14 Law, and I'm a resident of this district.

15 DR. LERNER: If you could just speak
16 into the microphone.

17 MS. STAPLETON: The Sargent Shriver
18 National Center on Poverty Law has supported
19 for many years the passage of the Health Care
20 Justice Act.

21 We are, frankly, supporters of
22 anything that moves more people in Illinois
23 into coverage, with some reservations, I
24 suppose. We supported All Kids, we supported

1 family care expansion, we supported Medicaid
2 expansion. We're very interested in
3 supporting the Healthy Illinois Plan.

4 But I'm not going to speak
5 today as an attorney with the Sargent Shriver
6 National Center on Poverty Law. I believe that
7 we will have an opportunity to address you at
8 your Task Force meetings as opposed to the
9 hearings about more technical things.

10 I want to today just speak
11 very briefly as a resident of this district.
12 I've lived here for twenty years. Before
13 that, I lived in East Saint Louis. Before
14 that, I lived in Cairo, Illinois, working as a
15 lawyer both in East Saint Louis and Cairo.
16 Before that, I lived on the south side of
17 Chicago and went to school.

18 But, anyway, today I'm
19 speaking as a resident of this district. Now,
20 I wander around the district. I have a dog.
21 I go to the park, I go to the beach, I go to
22 the grocery store, I go to church, I go to the
23 library.

24 I know a lot of people, and

1 people know that I know a little bit about
2 health care or about Medicaid or something; so
3 people talk to me whose names I don't even
4 know. I know they have a dog named Daisy, or
5 I know that they have a kid that plays in the
6 park behind us.

7 And everybody that speaks to
8 me about this has somebody in their circle of
9 the people they love that doesn't have health
10 insurance, that can't get health care. It's
11 their brother that lost his job, it's their
12 adult son, it's the woman who cares for their
13 mother whom they love like a family member.

14 And so what I want to tell you
15 is that the people -- you've reached critical
16 mass the same way a school district wants to
17 have a lot of kids in the school district so
18 when a referendum comes up, there'll be enough
19 people who care about the kids to vote for the
20 referendum.

21 In this district -- and
22 probably throughout the State -- everybody
23 knows somebody who needs your help. Everybody
24 cares about somebody in a really intense way:

1 about that nephew or about the caregiver or
2 about themselves and their kids.

3 So I think there are three
4 messages. People want care for everybody.
5 People are surprised, frankly, when they find
6 out that lower-income people don't have
7 coverage. You just heard a description of how
8 hard it is to get coverage as a disabled
9 person in Illinois.

10 People think if you're poor in
11 Illinois, you get access to care through
12 Medicaid. You just heard a very comprehensive
13 description of how that just is not so.

14 And, finally, my message is
15 simply that I think that the people are with
16 you. I think the people of Illinois want
17 everybody to be covered, and it's up to you to
18 figure out how to do that.

19 And good luck, and we'll help
20 you as much as you can; but you have critical
21 mass. Whether it's based on ethics or
22 religion or need or whatever you want to call
23 it, the people of Illinois, I think, want
24 universal health care for everybody and will

1 support you in your best efforts.

2 Finally, thank you so much for
3 your long hours of work, your long hours of
4 travel, for all the attention and careful
5 thought you're giving to this.

6 And I'm on my last line, which
7 was supposed to be my opening line, which is
8 that I once had to speak after Studs Terkel at
9 a funeral. It was the worst experience of my
10 life. This was, in some ways, the second
11 worst experience of my life. You've heard
12 from tremendously articulate people today.
13 I'm really proud to be a resident of this
14 district. Thank you, and thank you all.

15 MS. DAVIS: I know that you have
16 been very much involved in the passage of All
17 Kids, and you're looking at this as being a
18 mecca for the children; but what safeguards
19 are there in there for the providers in terms
20 of getting them paid in timely fashion?

21 MS. STAPLETON: Here's a
22 complicated answer. I apologize to this.
23 And, first, I don't want to claim credit where
24 credit is not due. We're big supporters of

1 All Kids, but the All Kids proposal came very
2 much out of the governor's office and Barry
3 Maram of the Department of Family Services.
4 We wish we'd suggested it. We didn't suggest
5 it, but we think it's a great idea.

6 But answering your question is
7 that independent of All Kids, Illinois --
8 Governor Blagojevich and Director Maram of the
9 Department of Healthcare and Family Services
10 signed a consent decree in the federal courts
11 over the summer. I think the case was called
12 Memisovski vs. Maram.

13 The Shriver Center, Health &
14 Disability Advocates, and a private law firm
15 had litigated that case against the State for
16 ten years. Governor Blagojevich chose to
17 finally settle it.

18 It's doubling and, in some
19 cases, more than doubling the rates that are
20 being paid to providers under any of the
21 Medicaid programs for children.

22 And it's also putting many of
23 those providers in specific classes of
24 pediatricians and some others. One provides

1 office services to children on a thirty-day
2 payment schedule.

3 So the Memisovski decree,
4 which we would be glad to discuss with you at
5 great length -- or even at a much shorter
6 length -- in one of your Task Force meetings,
7 has sort of set -- I'm waffling here -- could
8 be considered one of the foundations on which
9 the governor felt confident going forward with
10 All Kids.

11 People tell me that
12 pediatricians from out of state are now
13 calling Illinois, calling the Department of
14 Health Care and Family Services, asking how
15 they can set up practices here; so there will
16 be enough pediatricians possibly, possibly in
17 Illinois.

18 The payment schedules have
19 become much more realistic. They're the same
20 packets submitted to Medicare, and there's a
21 faster payment schedule.

22 So I think the foundations for
23 this being successful for the All Kids program
24 working are very, very strong, combined with

1 the idea of every child having a medical home,
2 a doctor that they see more than once, keeping
3 them -- getting them the kind of preventive
4 care and the kind of treatment that they need
5 which will keep them out of emergency rooms,
6 which we all know are very expensive.

7 So there are lots of very
8 thoughtful foundations there. I hope that
9 answers your question.

10 DR. LERNER: Any other questions of
11 Margaret who has been diligent in attending
12 every one of our meetings. We appreciate
13 that.

14 MS. STAPLETON: Well, I think what
15 you're doing is really, really important; and
16 I think you're going to win. You're going to
17 get it. Thank you.

18 DR. LERNER: Thank you.

19 MS. STAPLETON: As we say in the
20 law, thank you for your time.

21 DR. LERNER: Let the record show
22 that the chair nor any of the task force
23 members did not call her a groupie. She
24 called herself a groupie.

1 I also want to note before we
2 call Ms. Ravenna that -- two things. If
3 there's anybody else that wants to speak, give
4 oral testimony, we certainly have time. The
5 deal is that we've agreed to go to six
6 o'clock; so if there's no one signed up,
7 we're just going to adjourn until the clock
8 reaches the six o'clock time.

9 If there's a whole slew of
10 people who want to talk, we will go beyond six
11 o'clock; so, really, it's to meet the needs of
12 the people who have decided to come and visit
13 with us at the public hearing.

14 The other thing is when you're
15 thinking about the Health Care Justice Act and
16 the Adequate Health Care Task Force, I hope
17 you'll step back and think about what we've
18 represented today. This has been an
19 overwhelming public hearing compared to the
20 ones I've been to because it's really covered
21 a lot of ground. There's been tremendous
22 attendance.

23 Health care in Illinois, for
24 sure, -- forget about nationally -- is a

1 patchwork quilt; and if people think that
2 we're going to create a revolution of change
3 all at one time, it's a challenge that is
4 daunting.

5 How we put it all together
6 will be part of the deliberation of the Task
7 Force, and what models we use to get from here
8 to some outcome that we all could agree to
9 will be an interesting path to traverse.

10 But as you listen to it,
11 you've already heard about twenty different
12 programs discussed this afternoon; and you
13 need to keep that in mind. Ms. Ravenna?

14 MS. RAVENNA: Hi, everybody.
15 Please bear with me for the spontaneity. I do
16 not have a prepared presentation from
17 Representative Lang. So I will speak both as
18 a constituent of this area and as state Rep.
19 Lou Lang's director who has worked with and on
20 health-related issues in many circumstances in
21 the community, mental health included, -- that
22 specialty -- a professional in the background
23 of mental health.

24 I am the daughter and

1 granddaughter of physicians who worked for and
2 did exercise their practice as part of the
3 universal health care system in Italy and
4 again here. My dad was at the VA and at U of
5 I.

6 So I grew up in a world where
7 health care was a science and an art, not a
8 business; and it was those two things first.

9 It was a calling, it was a
10 service, it was a way of connecting to people
11 and keeping those people in need connected to
12 a community and a larger whole that was
13 caring.

14 And as you all know, our
15 current society system, federal and state
16 government are a patchwork at best, a social
17 safety net that has more holes than it does
18 catch people.

19 And while there were more than
20 I can name, innumerable cases cited of people
21 falling through those cracks, some whose
22 assets may be three dollars over the minimum
23 for public aid and so on and so forth, even
24 those people are not getting the kind of care

1 that our country can afford and is spending on
2 other -- in other directions related to the
3 health care system.

4 It's my understanding -- and
5 my data may be a little bit out of date --
6 that our health care system is using at least
7 16 percent of our economy and that we have an
8 enormous number of people who are not on the
9 rolls of any of the numbers of the data that
10 is available.

11 We know that as Joe Q. Public
12 walks down the street on any given day, if he
13 doesn't have an insurance card that is
14 sufficient for the nearest emergency room and
15 he has an emergency, he may not get care.

16 If he's in -- if he's
17 fortunate enough to be in Cook County, he may
18 be transported to Cook County Hospital; and if
19 he is seen in time, he may get the care he
20 needs.

21 But there are many more in
22 between those; and I know you all know, and I
23 know you're all working hard on it.

24 I think my point in going

1 through this -- you're hearing something you
2 all know -- is that I don't think everybody
3 knows; and I think that a major part of your
4 accomplishing what needs to be done and what I
5 have absolute faith and conviction will
6 ultimately be done in terms of providing
7 everyone with health care -- unfortunately
8 mandated at the federal level, sort of dumped
9 on the State. Excuse my using loose speech.

10 But that's what's happened.
11 And dumped on the county and everywhere else,
12 that will take and has as a system the
13 compassion and the commitment and connection
14 to the community and the people.

15 So as this trickles down,
16 what's happened is people really don't know.
17 For example, the malpractice legislation that
18 was passed in Springfield this past year, I
19 can't remember the name of the bill. Lou
20 argued very effectively against it based on
21 data, based on information.

22 In fact, if it weren't for the
23 insurance companies' involvement in the
24 process, the physicians who supposedly had

1 been exiled from southern Illinois in terms of
2 providing specialties to other states would
3 not have been.

4 Further, we have to look at
5 the populations and how many specialists a
6 rural area can support and what a
7 subspecialist does and what kind of medicine
8 that area actually needs.

9 So there's an enormous amount
10 of information that is not getting out there;
11 so I guess I'm making a request that somehow
12 in the process of an overwhelming job that you
13 have taken on, you provide public education,
14 work with the media more effectively, get
15 their ear, and see if we can really garnish
16 public support so that your job can be
17 facilitated. Thank you.

18 DR. LERNER: Thank you. And would
19 you also again express our appreciation to
20 Representative Lang for supporting this issue.

21 Margaret, do you have a
22 question?

23 MS. DAVIS: How do you spell her
24 name?

1 DR. LERNER: R-a-v-e-n-n-a.

2 MS. RAVENNA: Right.

3 DR. LERNER: Ravenna. Is there any
4 one else?

5 (No response.)

6 DR. LERNER: All right. Mr.
7 Barnes?

8 MR. BARNES: My name is Gary
9 Barnes, B-a-r-n-e-s. And I wanted to go last
10 because I'm from out of district; but, also, I
11 want to address things that are at the tail
12 end of the process.

13 I think you're facing some
14 deadlines, and I want to address you on
15 exactly how you're going to go about doing
16 what all of us want you to do; not exactly
17 perhaps but in three minutes.

18 The first point I want to make
19 is that I think the State has to have the
20 authority and you have to ask the State to
21 take the authority to bring these two groups
22 -- this group of profiteers over here and
23 this big lump of unaffordability over here --
24 and bring them together. I think the State

1 has to do this.

2 Secondly, although there are
3 plenty of people who argue that there's plenty
4 of money in there already, it's just a
5 question of redirecting it to show that the
6 state is serious, I think the State should
7 find a way to pump some additional money into
8 the system.

9 After all, we are running a
10 huge deficit as it is; and that, in my
11 opinion, should involve a constitutional
12 amendment which at least you should have in
13 mind as a Plan B for how you're going to do it
14 if it takes more money.

15 Of course, I'm thinking of
16 Article 9. But, also, there is an economic
17 development argument that can be made here;
18 and this can be construed as seed money.

19 And the third point I want to
20 make is that there are plenty of people around
21 who could cast universal health care as a
22 special interest. To us that's absurd, but
23 there are plenty of people around here who are
24 going to try to do that.

1 And I watched the tax swap
2 that tried to go through the legislature this
3 past spring for more funding for poor school
4 districts without a constitutional amendment,
5 and I think you all saw what happened to them;
6 and I could not understand why they didn't
7 want as allies in this process, shall we say,
8 the health care reform group or people who
9 were interested in lowering university
10 tuitions or something, why they didn't make an
11 attempt to avoid being cast as a special
12 interest.

13 Okay. So those are pretty
14 much my three points. Thank you.

15 DR. LERNER: Thank you, Mr.
16 Barnes. Any questions of Mr. Barnes?

17 Any other people, anybody else
18 sign up to provide oral testimony?

19 (No response.)

20 DR. LERNER: We will adjourn until
21 either we have another speaker or until six
22 o'clock arrives. Thank you very much.

23 (Short break taken.)

24 DR. LERNER: All right. If I could

1 have the next set of speakers come forward.

2 I'd like Martha Holstein and Rhona Jacobs.

3 The hearing is called back to
4 order. Ms. Holstein, thank you very much.

5 MS. HOLSTEIN: Thank you. And,
6 again, our apologies for being so last-minute.
7 Between a conference call and going the wrong
8 way on Oakton, that's what happened; so thank
9 you for your attention.

10 I'm presenting testimony on
11 behalf of the Center for Long-Term Care Reform
12 of the Health and Medicine Policy Research
13 Group.

14 As we all know, America's a
15 long way from having a just health care
16 system. If it did, we would not be here
17 tonight.

18 As far as we are from the
19 system for acute care systems in which money
20 or status or geography or even type of illness
21 does not influence the type and extent of care
22 we received, we are even further from it when
23 it comes to long-term care services.

24 Yet, a just health care system

1 would require that the dependency needs of
2 people who suffer from long-term chronic
3 conditions with occasional or frequent
4 exacerbations be recognized as equal to the
5 needs of individuals who require care for
6 acute conditions only.

7 Each demands broad
8 risk-sharing, affordability, reliability,
9 high-quality in access and administration.

10 Today, long-term care, with
11 the important exception of care for people in
12 very low incomes, tends to be viewed as a
13 private rather than a public problem.

14 Hence, as currently functions,
15 it places the burden of costs and care on
16 those who already are the most vulnerable,
17 individuals who have chronic conditions that
18 limit their ability to carry out the
19 activities of daily life.

20 The majority of these people
21 are women. While women live longer than men,
22 they also suffer from more chronic conditions;
23 and since then outlive their husbands, often
24 by many years, -- sorry, men -- when they need

1 care, they must rely on family members, again
2 most often woman who are on paid assistance.

3 The long-term care system thus
4 rests on the shoulders and backs of women
5 whose paid and largely unpaid labor allow
6 everyone else to go about their business.

7 Without broad risk-sharing
8 with the healthy and the ill in a common risk
9 pool and generous funding, we cannot begin to
10 address these fundamental inequities.

11 We must not be like the
12 legislator who, during debates about Medicare,
13 in opposing the inclusion of long-term care
14 services and Medicaid, wondered aloud, "Who
15 would not want to have their beds made and
16 their meals prepared," as if he ever did
17 either.

18 We also know something that he
19 didn't know. People do not come out of the
20 proverbial woodwork when services are
21 available. They really do try to manage on
22 their own and continue to do what they always
23 have done, and that is to help one another.

24 Based on these observations,

1 the Health and Medicine Policy Research Group
2 makes the following recommendations: The cost
3 of providing care for people who are limited
4 in their day-to-day activities as a result of
5 chronic conditions ought to be shared broadly.
6 It ought not differ from the costs in
7 providing people who do bypass surgery or
8 other acute medical care.

9 Two, an adequate, long-term
10 health care system will assure that resources
11 are available to effectively link the chronic
12 long-term-care system with the acute system;
13 that is, well-supported discharge planning
14 that is continuous from the time a person
15 enters the hospital to when he or she leaves
16 it, well-designed and accurate medical records
17 that move with the person, reimbursement
18 categories that see a single spell of illness
19 as one that includes transitional care.

20 Three, while a continuing
21 problem, it needs always to be reiterated.
22 Mental health services should be available and
23 on par with physical health services.

24 Treatable depression and other

1 common conditions can exacerbate physical
2 symptoms and seriously affect one's quality of
3 life. This problem is as significant and
4 maybe more so when one is old as when one is
5 young.

6 Follow-up care at the
7 community ought to be available to assure that
8 patients, families, and other caregivers have
9 the education and the support that they need
10 to provide the care that is needed. Such care
11 would shorten linkages between the social
12 services and the medical care system.

13 Next, a just health care
14 system would reward frontline care providers
15 for people with long-term care needs with
16 adequate pay, health benefits, and support and
17 respect for the work that they do.

18 At a minimum, this system
19 would cover out-of-hospital costs for medical
20 goods and services that are necessary when
21 families provide care.

22 Although a universal long-term
23 care benefit is preferable, a statewide system
24 of support for long-term care services can be

1 designed in a way that incorporates
2 income-related contributions that include
3 large numbers of the middle class.

4 The strategy would take
5 advantage of an individual's willingness to
6 contribute to his or her own care while also
7 strengthening the State-based system.

8 Next, because long-term care
9 services take place largely in the community,
10 a just system must go beyond medical care to
11 assure that affordable options for housing and
12 services are available so that genuine choice
13 become a possibility.

14 And, last, the system should
15 develop an ongoing informational campaign to
16 build awareness of the long-term-care benefit.

17 We thank you for the
18 opportunity to present this testimony and
19 would be pleased to work on legislative
20 initiatives that advance the proposed agenda
21 for including long-term care in a just health
22 care system.

23 DR. LERNER: Thank you, Miss
24 Holstein. Questions, Margaret?

1 MS. DAVIS: One of the issues that
2 I've been kicking at Mike about is the issue
3 of respite care for caregivers.

4 Long-term care in the home is
5 akin to daycare twenty years ago. It's
6 fragmented. It's not enough time to allow a
7 working woman to work.

8 What's your thoughts on that?

9 MS. HOLSTEIN: Oh, well, I agree a
10 hundred percent.

11 I don't know how far we should
12 be going in this testimony about providing
13 respite care, but I think one of the issues is
14 unpaid family caregivers. Again, my emphasis
15 is on women. Even though men are getting
16 better, it's still largely a woman's
17 responsibility for reasons that they earn less
18 money, women are expected to provide this kind
19 of care.

20 But I think a comprehensive
21 response to really make women who give care
22 equal to those who don't give care is a very
23 serious need and could involve financing the
24 out-of-pocket expenses.

1 But respite would be one of
2 the critical dimensions. I think respite is
3 very significant, but respite is a way of
4 helping people cope with an inequitable
5 system.

6 The important factor in
7 addition to respite is to make the system more
8 equitable so it's not only women who provide
9 the care and it's not only women who have to
10 quit work, work less, suffer future losses and
11 Social Security benefits and pension benefits.

12 So respite should be the
13 ground floor of helping people to cope with an
14 inequitable system. I'd like to see the
15 system become more equitable so we don't have
16 to cope so much with it. So, yes, yes, it's
17 very important.

18 DR. LERNER: Catherine, do you have
19 a question?

20 MS. BRESLER: No.

21 DR. LERNER: Let me ask you just a
22 point of clarification since you've been one
23 of the few talking ostensibly about long-term
24 care.

1 My interpretation of your
2 comments is that you aren't really focusing on
3 a level of care or an institution or an
4 organization.

5 You are calling our attention
6 to the conditions that surround long-term care
7 and asking us to think broadly about how
8 people with chronic conditions of various
9 sorts -- medical, physical, et cetera -- fit
10 into the overall system that we're trying make
11 some recommendations about; is that fair?

12 MS. HOLSTEIN: Precisely,
13 precisely. Right now, long-term care is sort
14 of, to the extent that there is a system, --
15 and Mike knows the inequitable problems in the
16 system that now exist.

17 But it ought to be part of a
18 whole health care system which is one of the
19 reasons we're stressing so much the link
20 between chronic and acute care.

21 We often just says here's
22 chronic care, and here's acute care; and the
23 bridges between the two are inadequate.

24 DR. LERNER: And the problem,

1 especially with the public and actually in the
2 provider world, when people think about
3 long-term care, they think about nursing
4 homes; and that's not what we're talking
5 about.

6 We're talking about acute
7 conditions -- chronic conditions -- could be
8 cared for in hospitals, nursing homes,
9 communities, homes, et cetera. That's the
10 interpretation.

11 MS. HOLSTEIN: Right. And one of
12 the things that we're concerned about is that
13 people who have chronic conditions and are
14 part of the community care program that Mike
15 is so involved with, that's basically
16 considered a kind of social network of
17 services; but people wouldn't be in it if they
18 didn't have chronic impairments.

19 So, somehow, we have to be
20 aware of what happens to people when they make
21 unnecessary ER visits or hospitalizations; so
22 we'd like to make long-term care part of the
23 system which was debated in 1960 during the
24 discussions about Medicare.

1 That's why I quoted this
2 infamous legislator who said, "Who wouldn't
3 want their beds made or meals prepared," as if
4 people would deliberately take advantage of
5 the system when I think that the evidence is
6 real clear they don't.

7 DR. LERNER: Jim?

8 MR. DUFFETT: Either to Martha or
9 to Mike, now, I know there's that Task Force
10 that you guys are working on in terms of
11 long-term care.

12 Do you have a specific time
13 line on when those recommendations are going
14 to be ready because we -- as a Task Force
15 member, I would love to be able to see them as
16 we talk about how we're going to be looking at
17 the multitude of different ideas to be able to
18 come up with a plan for the General Assembly
19 that will provide access to everyone not only
20 getting a card but to have access.

21 But our law talks about
22 long-term care, and so I may have mentioned
23 this to you a long time ago. I'm actually
24 looking to you guys to help me and hopefully

1 help the rest of the Task Force to be able to
2 handle that issue.

3 And I wonder what your guys
4 time line is on that.

5 MR. GELDER: The committee that
6 you're referring to is the Older Adult
7 Services Advisory Committee which was
8 established by the Older Adults Services Act
9 of two years ago.

10 And we have a report due to
11 the General Assembly this month outlining our
12 first year's progress, and that will have a
13 set of specific recommendations of immediate
14 short-term things which could be done -- need
15 to be done, should be done.

16 It's vetted by a 31-member
17 committee representing all the various
18 stakeholders including seniors themselves and
19 AARP and advocacy organizations on their
20 behalf.

21 So that should be ready within
22 the next week or so, and we will be continuing
23 -- there's a work plan of future longer-range
24 projects that are -- that the committee is

1 pursuing in the area of nursing home
2 conversion, developing a financing scheme, and
3 things that will take longer to figure out
4 financing for that need to be part of a
5 long-term care system. So that's the answer
6 to that.

7 I would also comment I think
8 in terms of the chairman's observations that I
9 think I also heard from this testimony that
10 aside from the particular services of the
11 long-term-care component that we've been
12 focusing on the committee, there is just a
13 general context within which we recommend or
14 look at the issue of affordable, accessible
15 health care; and that they've offered some
16 important perspective, I think, on how we look
17 at the broader picture separate and apart from
18 the particular services that might be covered.

19 MS. HOLSTEIN: I just want to say
20 one very quick thing. Without assessing how
21 it works, Germany decided in 1996, -- I think
22 it was in '96 -- voted unanimously to approve
23 long-term care in their overall health plan
24 because how could we treat long-term care

1 differently than we treat anything else
2 without knowing or describing how it's
3 working; and that's what I think we'd like to
4 see.

5 DR. LERNER: And I would just again
6 suggest that we've been reminded by dozens of
7 speakers formally and informally, we've got to
8 clarify what we mean by terms because my guess
9 is if you talk to the public about long-term
10 care, they've got a certain vision in their
11 mind; and you're talking about a much broader
12 concept here, so that will be part of it.

13 And, Mike, maybe when you guys
14 are ready, you could work with the Adequate
15 Health Care Task Force and let us know what it
16 is that you developed.

17 MR. GELDER: Sure. I'd be happy to
18 come to one of the Task Force meetings.

19 DR. LERNER: We have Rhona Jacobs.

20 MS. JACOBS: Hi. I don't know if
21 you can hear me with this.

22 My name is Rhona, R-h-o-n-a,
23 Jacobs, J-a-c-o-b-s. I'm a registered nurse.
24 I'm a member of this congressional district.

1 I was talking with Margaret
2 and finally decided to stand up and say
3 something.

4 I understand there's two
5 nurses on the Health Care Task Force, and
6 there were a few here in the audience.

7 I just think it's important
8 that people know how important a universal
9 health care system is. I grew up with two
10 parents who were ill. They both had rheumatic
11 fever and somehow managed to meet each other
12 and have me and my brother, so we grew up with
13 illness in the house.

14 And about the age of three or
15 four, I decided I wanted to be a nurse because
16 they helped people. Many years later, I
17 became a nurse. First, I was a lab tech; so
18 I've worked in these different areas of health
19 care.

20 And it can't begin to be
21 emphasized how much health care for everyone
22 is needed. It's just so necessary.

23 For my father, we schemed; and
24 we found ways to get him some of the best

1 health care when he didn't have money to pay
2 for it. How many people got surgery -- open
3 heart surgery -- in 1969 at Rush without money
4 to pay for it? Somehow, it got worked out. I
5 don't know. And he had this kind of luck for
6 the rest of his life, which was about another
7 ten years.

8 So this is a real important
9 issue for me. I've worked at free clinics
10 providing health care to people for free which
11 I think is important, but we have to provide
12 it for everyone. Everyone has to know that
13 they can get health care.

14 They shouldn't have to go to
15 Cook County Hospital and sit there for eleven
16 hours, twelve hours until they're seen. They
17 shouldn't have to have a special doctor that
18 they know at Cook County who's going to get
19 them in, which also happens.

20 My grandmother was a patient
21 there. They had her in the halls. This was
22 like 1936. My father and his brothers went in
23 and got her out, okay? This is not stuff that
24 should be going on.

1 I don't know what else to
2 say. I worked at U of I, I took care of women
3 who were pregnant. They were high-risk women.
4 They had their babies, or they were waiting to
5 have their babies.

6 What I saw was incredible.
7 They were one-issue patients. They were there
8 to have their baby. If their tooth was
9 hurting, which is important when you're
10 pregnant, we should know this because of
11 complications that can come about, they
12 wouldn't tell you.

13 If they had bad headaches,
14 which we also needed to know because it might
15 mean their blood pressure was up, they
16 wouldn't tell you. If their big toe was
17 hurting, they wouldn't tell you.

18 We had to educate them to do
19 that; but they were used to going to doctors
20 and just discussing what the problem for the
21 day was, not their whole general health care.

22 Many of them never have had a
23 visit with a doctor that discusses from head
24 to toe what's going on with them. This is

1 what is needed.

2 You were talking about respite
3 care; and I've since left the hospital because
4 after a certain age, we get a little too old
5 to move beds and push patients around;
6 although I guess the average age of a floor
7 nurse is 49. I'm a little bit older than that. My
8 friends were all leaving. We can retire.

9 I now work in a school with
10 children who are disabled. I wonder if I was
11 their mother's nurse. They have many
12 different disabilities; so for me, it's coming
13 the full circle.

14 And I have talked with some
15 people about the parents getting respite care
16 for themselves with the children that they
17 have to take care of, just another issue.

18 The other thing and final
19 thing I'll bring up is a good friend of mine
20 is a nurse at Swedish Hospital in Washington,
21 Seattle. She's a recovery room nurse.

22 They just voted -- and they're
23 members of SEIU. They're no longer members of
24 the State Nurse Association. They got out of

1 that a few years ago, so now they're SEIU; and
2 part of their membership is also housekeepers,
3 kitchen workers, a lot of different people.

4 They just were voting whether
5 to strike or not. One of the big issues was
6 they were going to take away their free health
7 care insurance. I said, "You get what?" And
8 I tried to be real nice about it. She said,
9 "Well, they're going to take away our health
10 care insurance." I said, "What do you mean?"
11 Well, we get free health care insurance.

12 And I said very nicely, "How
13 many hospitals in the State of Washington do
14 you think get free health care insurance?"
15 And then she said, no, I know that we're
16 privileged, that this is special; but we can't
17 let them take it away because if they do,
18 while the nurses and some of us may be able to
19 pay for this, the kitchen workers will not.
20 And the people who are lower on the pay scale
21 won't be able to pay for it.

22 As it is, they get free health
23 care. They pay for their children or
24 dependents. I guess that's the same.

1 Luckily, they won; and they
2 continue to get their free health care.
3 What's going to happen in the future I'm not
4 certain, but they did win that part. And
5 that's all I want to say.

6 DR. LERNER: Thank you very much.
7 We have one other individual who signed up,
8 Ms. Sheforgen.

9 MS. SHEFORGEN: Very good.

10 DR. LERNER: I'm trying.

11 MS. SHEFORGEN: And you're doing a
12 good job. Thank you very much.

13 And, first of all, thank you
14 to everybody on the Task Force for being here
15 this evening. We appreciate that.

16 My name is Joan Sheforgen.
17 I'm the chief executive officer of Prime Care
18 Community Health. This is a
19 federally-qualified health care system that
20 serves the northwest side of Chicago.

21 DR. LERNER: Do me a favor. Just
22 spell your name for the record.

23 MS. SHEFORGEN: J-o-a-n
24 S-h-e-f-o-r-g-e-n.

1 DR. LERNER: Okay.

2 MS. SHEFORGEN: We serve
3 predominantly the area of Humboldt Park. We
4 are the only community health center in West
5 Humboldt Park, West Town, Wicker Park,
6 Bucktown, Logan Square, and Hermosa.

7 And I think that everything
8 that you are hearing as you come to these
9 hearings was brought home to us very loudly
10 and clearly during the last three weeks.

11 We just by happenstance had
12 somebody from Telemundo call us the week after
13 Christmas and came out and did a little piece
14 for their community-health feature that they
15 have every Tuesday at the five o'clock and ten
16 o'clock news.

17 And so they did really just a
18 one-minute piece; and it talked about the
19 services of a community health center and, in
20 particular, about the sliding fee schedule or
21 financial assistance program that we all
22 offer, which offers a discount of our services
23 to those patients who qualify based on their
24 income level compared to the poverty level put

1 out by the federal government.

2 And most of us have a minimum
3 payment; so if they qualify a hundred percent
4 discount, for example, our minimum payment is
5 \$10. And as the income goes up, the discount
6 goes down; but the minimum payments goes from
7 \$10 to \$50.

8 We have had in three weeks 392
9 calls. They are still coming in at the rate
10 of 24 calls per day. Sometimes, it's a little
11 bit more than that. In the beginning, it was
12 24 calls per every two minutes in the first
13 week.

14 And every one of these
15 individuals are looking for health care. They
16 have no health insurance. For the most part,
17 I would say -- and I've talked to most of them
18 because we administratively are a smaller
19 organization. Our front desk would not have
20 been able to keep up with the calls. So I
21 gave my number; and I'm bilingual, and so I
22 was able to talk with almost all of these
23 individuals.

24 And then our financial

1 counselor is calling each of them back and
2 making appointments so we can offer them our
3 financial assistance program and get them into
4 health care.

5 These, however, are
6 individuals who are working. All of them,
7 except for a very small minority, are
8 documented. They are all Hispanic. I think
9 we maybe had one call that was not Hispanic.

10 They are coming from all parts
11 of the Chicagoland area. The calls are coming
12 predominantly from, I would say, the areas
13 that we service; but we have also had calls
14 from West Chicago, from Waukegan, from
15 Indiana. I think you name it, we've had
16 almost every suburb, especially the western
17 suburbs.

18 And where there are other
19 federally-qualified community health centers
20 closer than us, I'm also acting as a referral
21 service to that they don't have to come all
22 the way to the city.

23 However, these individuals --
24 many of them are sick. They're very sick. We

1 have brought in those individuals very quickly
2 who needed immediate health care. Some of
3 them we've had to send over to the emergency
4 room to be hospitalized.

5 One gentleman was a taxi
6 driver. He came from West Chicago. He
7 couldn't work anymore, he was so ill.

8 But these are working
9 individuals. They are paying taxes, they are
10 supporting their communities, they are
11 supporting their families, they're supporting
12 their children.

13 And they are asking for
14 nothing more than health care so they can keep
15 working, so they can be a supportive member of
16 their community.

17 So we would ask, as a
18 community health center system, that the Task
19 Force continue to reach out to your other
20 colleagues as these hearings continue and
21 remind them, because there are many more
22 members who have been assigned to this Task
23 Force, of really their moral and their ethical
24 duty to support you as you come to these

1 hearings; and that we would very much like to
2 see more of the Task Force members represented
3 at the hearings.

4 We ask that the
5 recommendations that the Task Force makes
6 ensure that health care is accessible to all
7 who live in Illinois.

8 We ask for health care without
9 barriers; that is, health care that is
10 comprehensive, primary and specialty care,
11 dental, vision, behavioral health, in-home
12 care, long-term care; health care that
13 encourages more collaboration among all
14 providers in the health care system -- public,
15 nonprofit, and private -- to provide the
16 continuity of coverage and care; health care
17 that provides the consumer the right to choose
18 a provider; health care for all, those with
19 special needs.

20 I can tell you I took today a
21 call from a mother who was tremendously
22 distraught. She has a special-needs child.
23 The child is learning disabled. She did not
24 know -- the child is nineteen years old. She

1 didn't understand nor did she have much help
2 in navigating the school system in Chicago.

3 This child -- there are laws,
4 there are resources to link this mother to;
5 but the mother was unaware of the resources,
6 so we clearly have to do a much better job in
7 publicizing what is out there.

8 We ask that those living in
9 urban or rural areas have access and those who
10 are unserved and underserved; in other words,
11 everybody in and nobody out.

12 We ask that the Task Force
13 recommendations ensure that health care for
14 Illinois is affordable and that the system
15 ensures timely payments to all providers in
16 order to guarantee continued access to
17 providers.

18 We also -- I can cut this down
19 very quickly. We also know that this is a
20 monumental task for the Task Force members to
21 figure out how we're going to finance this.

22 We ask that the Task Force
23 recommendations ensure quality of services.
24 We recommend the adoption of the Healthy

1 People standards 2010 as well as the joint
2 commission standards as the criteria to be met
3 by all providers in the health care system.

4 We ask that the Task Force
5 recommendations ensure that health care for
6 Illinois is cost efficient, spending the
7 maximum amount of dollars on direct patient
8 care.

9 And, lastly, we ask that the
10 Task Force, which is comprised of members who
11 have chosen a career of service, to embrace
12 this challenge, to put politics aside, and to
13 bring health care justice to all in Illinois.

14 Thank you very much for your
15 time.

16 DR. LERNER: Thank you very much.
17 I guess with that applause, that should end
18 it.

19 Are there any other speakers
20 to register?

21 (No response.)

22 DR. LERNER: Hearing none, I
23 declare the hearing closed.

24 Thank you very much for your

1 time and your attention. Thank you very much.

2 (Which were all the proceedings had.)

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

1 STATE OF ILLINOIS)

2) SS.

3 COUNTY OF COOK)

4

5

6

7

I, PATRICIA L. ERICKSON,

8

Certified Shorthand Reporter and Notary Public

9

in and for the County of Cook, State of

10

Illinois, do hereby certify that on the 18th

11

day of January, 2006, the said proceedings was

12

taken before me, reported stenographically and

13

was thereafter reduced to typewriting under my

14

direction.

15

The said proceedings was taken

16

at the time and place aforesaid, and there

17

were present persons and parties as previously

18

set forth.

19

I further certify that the

20

foregoing Pages 3 through 131, inclusive, is a

21

true, accurate, and complete record of the

22

proceedings so taken as aforesaid.

23

I further certify that I am

24

not counsel for nor in any way related to any

1 of the parties to this proceeding, nor am I in
2 any way interested in the outcome thereof.

3

4

5

6

7

PATRICIA L. ERICKSON, CSR

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

