HEALTH CARE JUSTICE ACT

PUBLIC HEARING

SPRINGFIELD

Howlett Building Auditorium

Tuesday, February 28, 2006

Reported by

Rhonda K. O'Neal, RPR

DR. YOUNG: Good afternoon and welcome to the Springfield public hearing of the Adequate Health Care Task Force under the Health Care Justice Act. It has been well demonstrated that a person's ability to access the health care system influences his or her treatment, outcomes, and health status. Access to health care is most affected by the ability of those seeking care to afford the services that they need.

Therefore, the insured, working poor, racial and ethnic minorities, and undocumented immigrants in Illinois are least likely to be able to afford to pay out of pocket for many health care services. Many Illinoisans lack access to the health care system because they lack health insurance. Additionally, a growing number of Illinoisans are underinsured, and the consumer's share of the cost of health insurance is growing.

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

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preventative and comprehensive care.

The Health Care Justice Act, signed into law by the Governor in August 2004, encourages the state of Illinois to implement a health care plan that provides access to a full range of preventive, acute, and long-term health care services and maintains and improves the quality of health care services offered to Illinois residents. The Act creates the Adequate Health Care Task Force which has undertaken the task of developing this access plan.

The 29 members of the task force were appointed the Governor, the President of the Senate, the Minority Leader of the Senate, the Speaker of the House, and the Minority Leader of the House. As part of its work, the task force will be holding at least one public hearing in each congressional district to seek input from the public regarding the access plan, which is why we are all here this afternoon.

On behalf of the Adequate Health Care Task Force and the Illinois Department of Public Health, I would like to thank each of you for coming out this afternoon to take part in this

important process. I would also like to thank the Secretary of the State's office for sharing their space with us this afternoon.

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

Second, should you wish to testify, please be sure to sign up at the table near the entrance of this room. Individuals will be called to testify in the order in which they sign up. If you brought written testimony to submit, you may also do so at this table. We will begin the hearing by calling up the first five speakers. Please sit where you are instructed, in the order in which you are called.

Before you testify, please be sure to say and spell your first and last names for the court

reporter. Please be reminded that oral testimony will be limited to three minutes in order to take everybody's testimony.

MS. DAVIS: Hi. Margaret Davis, Health Care Consortium of Illinois.

MR. SCHUBERT: Ralph Schubert with the Illinois Department of Human Services.

MR. DUFFETT: Jim Duffett, Campaign for Better Health Care.

MR. MOORE: Jim Moore, (inaudible) Health Care Peoria.

MR. CARVALHO: David Carvalho, Illinois Department of Public Health.

MR. DOOLING: Terry Dooling.

MS. DAKER: Jan Daker.

MR. SMITH: I'm Greg Smith with Group Marketing Services in Lincoln, Illinois.

MR. MURPHY: Mike Murphy with Wellpoint.

DR. YOUNG: That does it. Okay. I will now, we have--here's the situation. The first row here there's a set of reserved seats for speakers, and there's a mic there. I'll call the first people to sign up, ask you to take your seats, and as you complete your testimony, hand the mic to your next

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person.

MS. SCHULTZ: My name is Cathy Schultz. Cathy, C-a-t-h-y. Schultz, S-c-h-u-l-t-z. I'm speaking tonight with regard to our concerns about accessibility and affordability of health care. I am reading now an e-mail that I got from a friend of mine at church because I overheard her say, my kids--and her kids are in their 20s--have no health insurance where they work. So I wrote her, and I said, well, what are you concerned about. So this is her letter.

Actually at present, D--that's her husband--and I are paying for insurance for both kids because they don't have the money themselves. Joanna works as a waitress, no benefits, and she's teaching voice. She, Joanna graduated last summer with her bachelor's in music. We hate the idea of their not being covered. So she has a COBRA from D's former employment plan at Argonne Labs. He retired a few years ago back there but was still able to get this for her. It costs $365 a month.

Mark--this is this lady's son--has a policy that we were able to get after he grew too old for the COBRA which is HMO coverage but with

no medications. Mark has been an asthmatic since year five and is overweight to obese. When I called about insurance coverage, his weight and asthma disqualified him from getting a policy. So we got him the one we could, no questions asked, that was available after the COBRA coverage. It too is $360 a month.

As we each retire in 18 months, that's a pretty big chunk to keep paying for them. Of course, we wish they had full-time benefit-paying jobs. Mark is going to school at COD and working at a restaurant averaging $8 an hour. They are very careful only to let cooks work under 40 hours so they avoid benefits. Joanna works at Moon Dance Diner and hopes for benefits after six months there, but the medical coverage was evidently marginal.

So our kids are the fortunate ones with parents who have income to keep them covered for the time being until a job with good coverage develops. But it's fascinating to run into kids from their classes who don't have these opportunities. (Inaudible) our kids would not have coverage.

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I'm really concerned about families. A friend of mine who teaches about 35 music students and is a music director at a church, and her husband works at Osco just for the medical benefits. He was a writer in advertising but he was laid off, and he has a master's degree. I feel very strongly about our current medical system.

When I was a speech therapist in Boston, I worked with World Health Organization at a free clinic on Saturdays. I hope you will keep me posted on efforts, et cetera. You're welcome to use any of this information. I will never forget my mother's terror in her dying years over Medicaid. Thank you.

DR. YOUNG: Thank you very much. Our next speaker is two speakers. David Anderson and Bishop Warren Freiheit.

MR. ANDERSON: Thank you very much, members of the task force. I'm the Reverend David Anderson, D-a-v-i-d, A-n-d-e-r-s-o-n, and I'm executive director of the Illinois Conference of Churches, a statewide ecumenical body whose members represent 31 jurisdictions of 15 denominations representing

Protestant, Catholic Orthodox, Christian traditions.

Today the conference is involved in trying to increase access to health care. I have asked one of our religious leaders to bring testimony today. I'm pleased to introduce to you Bishop Warren Freiheit, who is the Bishop of Central Southern Illinois (inaudible) of the Evangelical Lutheran Church of America.

BISHOP: Thank you for the opportunity to speak today. With the help of notes, you may experience one of the great miracles of our day, a bishop who limits his remarks to three minutes. We do feel health care security in Illinois is the first moral issue facing American people, given approximately 45 million people without health insurance in our country.

In Illinois it's our experience that there are 3.5 million among whom 84 percent are working families. And of those, the Latinos, the African-Americans seem to be the largest percentage who are uninsured. Health care costs continue to outpace the rate of inflation, prescription drug costs continue to escalate.

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Employers who provide health care benefits are on the brink of extinction.

Businesses are continuing to struggle to increase the--or because of increased labor costs, to try to compete to pay for the medical care of the people's become much more difficult. For nonprofit organizations and churches that I represent, the spike in health care benefit costs are alarming. People's greatest fears continue to be the terror that if a medical illness will strike them or a member of the family it could suddenly push them over the edge to poverty.

For lower-income families who do not qualify for Medicaid and Families First, life is like a lottery accompanied by the fear of being struck down by a catastrophic illness. When families live paycheck to paycheck, health care all too often becomes a luxury. Too many people in our own United States today frankly cannot afford to be sick nor can they afford to take time from work to go see a doctor. An illness becomes a terrifying situation.

Since its 1999 meeting, the Illinois Conference of Churches has worked to increase

access to health care, believing it to be a basic human right. In its public policy declaration of universal health care, the church has said health care should not be a commodity bought and sold in the marketplace where the needs of the privileged are fully met while the needs of the poor are oftentimes ignored.

The liberating truth is that access to health care is the greatest safeguard against the terror of poverty. Thus, the Illinois Conference of Churches applauds the passage of the Health Care Justice Act, and we also pray to see the day when health care will securely become a bedrock of values that we share together as we show love for our neighbors. Everyone in and nobody out. Thank you very much.

DR. YOUNG: I will take a moment to introduce Representative William Delgado. Will you please (inaudible).

REPRESENTATIVE DELGADO: Thank you, Chairman. I just want to thank all of you for all your hard work here today testifying. I am chief sponsor of the legislation in the House of Representatives looking forward to carrying legislation, making

sure that we are covering the entire state.

I am going out to Harrisburg and Chicago to make sure that we're able to get our there and do the right thing for all Illinoisans, and I applaud all the efforts and all the hard work. And keep in mind that we all need to make sure that everybody's in, make sure nobody's left out.

MR. BROEKER: My name is Gerard Broeker. G-e-r-a-r-d, B-r-o-e-k-e-r. I'm the executive director of the Statewide Independent Living Council of Illinois based here in Springfield. The current health care crisis affects me and my family in several ways. First, as an employee of a small not-for-profit corporation, I am enrolled in a small group plan. The plan does cover my medical insurance 100 percent for medical and dental. We do not have vision insurance, but that is a luxury I can survive without for now.

My company cannot afford to cover any of my wife's premiums, so those come out of my pocket. In order to cover her, I have over $618 a month deducted from my paycheck. In total, this is over $7400 per year of my income which is spent solely on insurance premiums. This is a large

expense for any family to incur.

Second, as a person with a significant physical disability, I rely upon personal care assistance to help me with activities of daily living such as bathing and dressing. In Illinois, personal assistants paid through the Department of Human Services home services program currently earn $7.85 per hour and do not have health or worker's compensation benefits. The fact that these benefits are nonexistent makes keeping qualified workers extremely difficult, especially when they can receive better wages and receive benefits working in a fast food restaurant.

Third, my wife and two stepchildren have all been diagnosed with psychiatric health problems. They are all covered by group insurance plans, but those plans limit the number of visits they can make for outpatient psychiatric and psychological consultation. When the maximum number of visits is reached, which has already occurred for my stepdaughter, my family has two choices. One, pay the visits out of our own pocket, or two, stop receiving the necessary psychiatric care.

We have chosen to pay out of pocket for my stepdaughter, but this is an expense of over $5,000 per year. Many families cannot afford this expense, and even though our cost is split with her father, I'm not sure my family can continue to pay our portion much longer. It will definitely be an unbearable burden when my wife and stepson reach their maximum visit limit.

In addition, prescription drugs are a heavy expense for my family. Our group insurance plans cover the majority of the costs, but the copayments still run close to $250 a month. Added together, copayments for prescriptions alone are another $3,000 per year. This is an expense which we can't afford to not pay. All the prescriptions that we have enable my family to continue to function as normally as possible.

In total, when doctor visits as well as medical supplies are added to the expense of my family base, we spend nearly $20,000 per year on medical costs. This is a heavy financial burden on any middle class family. Unfortunately, the burden on my family is not unique. I know many working families who are under similar or even

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heavier financial constraints due to health care costs.

The big question is what to do about easing the burden. I have two suggestions which I believe are readily achievable. The first is to expand the health benefits for workers with disabilities program to include all uninsured workers regardless of whether or not they have a disability and whether or not they could be covered by a spouse's group insurance plan.

The second is to develop a single-payer system which either supplements or encompasses the current employer-provided insurance system. I'm not unrealistic. I recognize that neither of these plans could be implemented with the current financial constraints the state is under. How would the state pay for such a plan? The only way I see would be a tax increase.

I'm not a huge advocate of an income tax increase unless I see that it will benefit a majority of the people. In the case of controlling the financial burden that health care causes for families in Illinois, I'm a strong proponent of paying more tax money to help the

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state accomplish this vital goal. Thank you.

DR. YOUNG: Thank you. Some other members of the task force have joined us. Representative Coulson and Dr. Backs. Dr. Backs is president of the Illinois State Medical Society, and Representative Coulson represents her district. Also we note the presence of Dr. (inaudible), the Illinois Senator. If you want to say a word to us, we'll be happy to listen.

SENATOR: I'm here to listen.

MS. VEGA: Good afternoon. I'm Susan Vega. S-u-s-a-n, V-e-g-a. I work at Alivio Medical Center. We're a federal-qualified health center in Chicago's community serving 10 southwest side communities in Chicago. I wanted to--this is the third time I've come before the committee, and I want to thank the task force members and the representatives for being here and listening to our concerns.

Today what I'd like to talk about is what our experience has been, what my experience has been in the government dabbling in private companies running health care programs. I've been working on Medicare and other related issues for

the past six years, and the experiences we've had with Medicare Part C, the HMOs, the PPOs, and the private fee-for-service plans has not been stellar.

But nothing has been the disaster that the part D plans have been. First of all, there are 20--no--43 plans in the state of Illinois. Pharmacists don't understand them, the beneficiaries don't understand them, the families of beneficiaries don't understand them, and the experts both inside and outside government barely understand them.

The private insurance companies are providing little or no customer service. You call for service, the phone rings and rings and rings. You call at 2:00 in the afternoon, 5:00 in the afternoon, 6, 8, doesn't matter; nobody's answering the phone. There are pharmaceutical benefits managers with no experience providing insurance now providing insurance under part D, and they're not governed by the rules of the Department of Insurance because they're insurance companies.

There's no standards, there's no

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predictability. And once again, this is all done in the name of people making profit. Health care is not a commodity; it's a right. And we should not sacrifice quality and access for the sake of profits. Thank you very much.

DR. YOUNG: Shuman Mitra, please. Dr. Mitra?

DR. MITRA: Yes. My name is Shuman, S-h-u-m-a-n, Mitra, M-i-t-r-a. I'm a physician, and I've practiced in Springfield, Illinois for over 25 years. I'm a member and vice president of the Sangamon County Medical Society. However, the views that I'm going to express tonight are solely my own and in no way reflect the views of the medical society.

In the three minutes that I have, I'd just briefly like to touch upon two subjects. One is access to medical care. Access to medical care. We have known this for years and years and years. It's nothing new. It's amazing in a country like ours this issue has not been really addressed. There has been a lot of patchwork, we have community health clinics, this clinic, that clinic to take care of so-called poor and indigent patients.

Then we have Medicaid. Medicaid in my opinion's a disgrace. Medicaid automatically demeans people who can't pay. They don't have insurance. They go to the emergency room for their care, wait there for hours and hours to be treated, and they get a patchwork. The acute emergency's taken care of, they go home to get sick again. I think we can do better.

I think the Medicare should be replaced by an insurance system like Medicare where all patients can be treated the same way. There will not be a two-tiered system. I think we have enough resources to take care of our three and a half (inaudible) that are not insured and probably many more who are underinsured.

The second point I want to make is the cost of medical care. All these years I have been fortunate to be a provider. Until recently with a family illness I have become a consumer as well. And that's what I do see. One of my relatives broke her bone in the wrist. Was not a big deal. Went to the hospital, had surgery, stayed overnight, was discharged next day. Our bill was $12,000. This did not include the physician

payment at all.

A CAT scan now costs $6,500 in Springfield, probably double in Chicago. I don't think anybody asks, is this the real cost? What's the difference between cost and charge and how it is paid for? I think the powers should investigate and see how we can control costs. Having the third-party payment system, the insurance company pays. Their only job is to increase your premium, and then they don't pay it all, so you are left with a large bill.

I care for a large number of elderly patients, indigent patients. They're very proud people. They won't tell you that they don't have medications that they can buy because they're so expensive. So I emphasize again that there should be a way to investigate what is the real cost.

I also want to mention at this time that only about 22 percent of the full medical cost is because of the doctors. About 34 percent of the cost is the administration, and a large amount of the cost is medical malpractice. So the large portion of the cost is the hospital and the clinics and the way the system is run. So I think

there's a lot of opportunity to contain costs in various sectors. Thank you.

DR. YOUNG: Thank you. The next person I'd like to come forward is the Reverend Jennifer Kottler.

REVEREND KOTTLER: Thank you, members of the committee. My name is Jennifer Kottler. I'm the deputy director of Protestants for a Common Good. The book of Isaiah says: If you offer your food to the hungry (inaudible) of the afflicted, then your light shall rise in the darkness and be like a new day. The Lord will guide you continually and satisfy your needs in (inaudible) and make your bones strong. And you shall be like a water garden that the spring of water as well and never fail.

Health care is a moral imperative. We can no longer treat health care as a commodity to be purchased. It is a right. It is a right that needs to be available to all of our citizens. As a pastor, I have seen people with inadequate and nonexistent health care coverage. These ones are the afflicted in our society.

Previously I was a special educator. I

saw families with children with physical and neurological disabilities, many with acquired disabilities like traumatic brain injury, and I saw the toll that the medical expenses played on these families. These are the afflicted in our society. And as such, as a society we will be judged on our ability to ensure that health care is available to all of our citizens.

We are the only civilized society, the only first-world country in the world that does not insure that all its citizens have health care. Health savings accounts are a great idea but only if you're wealthy enough to have money to put into them. They are not a solution. We need a system that provides holistic health care that leads to healthier citizens including preventive and reproductive health care and provides for all of our families.

All in, nobody out. Some would say that we can't afford to provide health care for all. And I firmly say we can't afford to do anything less. Thank you.

DR. YOUNG: Next is Connie Schroeder, Kim Richter, Larry Greenfield, Pearlie Green.

MS. SCHROEDER: Connie Schroeder. C-o-n-n-i-e, S-c-h-r-o-e-d-e-r. I'm president and CEO of Illini Community Hospital in Pittsfield, Illinois. Illini is located in Pike County. We're the only hospital in our county of about 17,000 people. According to the 2000 census and the 2006 Report on Illinois Poverty, 19.2 percent of our population is over 65 and 12.4 percent of our total population and 17.7 percent of our 18 and under population are below the poverty line.

The average wage per job is 22,500, and the median household income is 31,000. Our land mass of Pike County is 830 square miles. We have about 21 people per square mile. Agriculture is our major industry. In other words, we are more rural, we are older, and we are poorer than the state overall. These characteristics make adequacy and access to health care a priority for us.

Illini understands that we have a responsibility in helping our community have adequate health care services and access to those services. Over the past several years we have attempted to improve adequacy by bringing dialysis

services, oncology services, rural health clinic, prenatal services, mobile MRI, new diagnostic technology in our radiology laboratory and respiratory department, and new treatment technology in surgery, rehabilitation and pharmacy to all our community.

We are trying to address access by treating all the patients who seek services from us. We are the only health care provider in our whole county that are open on evenings and weekends. We truly are the safety net. Additionally we have policies and practices for charity care and for payment plans. We have a financial counselor who helps people with Medicare, Medicaid, Kid Care, and Family Care applications. We have Senior Health Insurance Program volunteers to assist people with Medicare.

We donated an entire building for the use of our county ambulance service to reduce their operating expenses. We provide health care screenings and health education to our community. And we are working with the community coalition to address communitywide health care priorities. We really do take our responsibility seriously.

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In fiscal year 2005 and so far this year, we have a negative margin. As a critical access hospital, we do receive cost reimbursement from Medicare and a percent of charges from insurance companies. But we received nearly 500,000 less than it cost us to care for our Medicaid population. And our charity care was around 50,000, but our bad debt was over 450,000 of which about 230,000 should be considered care. And we've seen our Medicaid and our Public Aid population go up.

So you may be asking, what's my point? My point is that as the issue of adequacy and access to care are being addressed, please don't place the burden just on hospitals to solve this problem. It won't help our problems. It will, in fact, make it worse. Our hospitals, for one, cannot continue to see reduced reimbursements and increased mandates and expectations that increase financial burdens on us. This issue must be solved by all of us together, all of us working together.

Hospitals, other health-related businesses, workers, businesses in general, agencies and government. We need to work together

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to solve this problem. I thank you for your time, and I commend you for the work that you're doing here for all of us for adequate access to health care. Thank you.

DR. YOUNG: Thank you very much.

Kim Richter.

MS. RICHTER: My name is Kim Richter. K-i-m, R-i-c-h-t-e-r. In February 2004 I once again become a member of the Gap. The Gap is a group of people who go uninsured because they are not eligible for Medicaid or Medicare coverage and are not able to purchase affordable private insurance because of pre-existing conditions. I am one of the 3,597,000 people, one of three or 31.5 percent, in Illinois under the age of 65 who at some point in two-year period have gone without health insurance, and the number continues to rise.

The following is a brief synopsis of my personal situation. At age 15 in 1975, I became ill with a disease called dermatamyositis. This is an autoimmune disease that affects both the skin and muscles, and thankfully, at that time my parents had health insurance. Otherwise they

would have sure been wiped out by all the medical bills adding on to the stress of having a child with a severe medical condition.

At age 24 I moved out into an apartment and qualified for Medicaid. At age 28 with the assistance from Office of Rehabilitation Services, I was able to find employment with a company that offered health insurance. So from 1987 to 1995, all of my medical needs were met until in February 1995 the company closed.

From February 1995 to April 1997 I again went without insurance. The small business I worked for full time did not offer it. I was ineligible for Medicaid due to their income restrictions, so the local hospital and doctors I saw then worked out a payment plan. But I saw as little of them as possible because I wanted to avoid further medical bills.

In April 1997 I took a full-time position with an employer that did offer health insurance. I was covered till February 2004 when I lost my job and also my health care coverage. So today here I am at age 46, and I once again find myself among the ranks of the uninsured as one of those

individuals who fall between the cracks into the Gap.

I work part time as a substitute teacher, which does not offer health insurance. My husband and I currently have assets over both Medicaid and health benefits for workers with disabilities. I began receiving Social Security Disability in August 2004 but have not met the two-year waiting period to qualify for Medicare.

Illinois currently provides two good programs that have begun to meet the health care crisis, one of them being the Health Benefits for Workers with Disabilities and the All Kids programs. But I would love to see Illinois become a forerunner and offer a statewide health care program where people could access services based on a sliding scale fee that everyone could choose to participate in.

With health care costs soaring for insurance providers and the state, it just makes sense to work together to create not a free program but one that is affordable for everyone. And I, just speaking for my friends and myself, when you're a member of the Gap, it's not--it's

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like somebody mentioned earlier. It's like playing Russian roulette or gambling because you never know when a major illness is going to set you back. And I really appreciate the opportunity to testify.

MR. GREENFIELD: I'm Larry Greenfield. L-a-r-r-y, G-r-e-e-n-f-i-e-l-d, the executive minister of the American Baptist Churches of Metropolitan Chicago, an association of culturally, economically, socially, and racially diverse congregations working together to give honor to God by trying to love the world in which we are placed like God loves that world. That is, not in some warm and fuzzy way but passionately and compassionately, caring for those who need that care the most. Those, that is to say, who suffer from human injustice.

I need to say that we are grateful to the General Assembly and the governor of this state for being civic partners in our quest for justice, for health care by enacting the Health Care Justice Act of 2004 and establishing this task force to gather opinion and expertise from across the state that will lead, we hope, to the

development and implementation of public policies that make high quality and comprehensive health care accessible and affordable to every child, every young person, every adult, and every senior in this state.

And I especially want to thank you, members of this task force, for the time you are devoting to this effort. For 31 years now, American Baptists have been on record in support of health care reform in this country that will be extended in an accessible and affordable way to every person in the United States. Our language is this, quote, universal access for comprehensive benefits.

This assumes, of course, that health care, as has been noted before, is not a privilege but a right of every human being not limited, by the way, to citizenship. With reference to public policy, therefore, the achievable goals we believe must include the following: Comprehensive access care and services to all, citizen and noncitizen alike. Sensitivity to the needs and rights of health care workers, patients, and their cultures. The promotion of health awareness, disease

prevention, nutrition, fitness, and safety, built-in features of rigorous cost control, financial support from the broad base of the entire state or nation, the reduction of unnecessary administrative costs, and the reduction of inappropriate and unneeded medical procedures.

I recommend these principles, these moral components of a just public policy for health care in our state achieved here in such a way that it will be a model not just for us but for other states and for the nation. The unjust health care in this state and the nation that allows so much needless suffering and needless death is human-made. Human-made. It is up to us as human beings to overcome that injustice.

Again, I thank you for the central role you are playing in helping us as a state and as a nation in overcoming that injustice and bringing into being with God's help, I believe, an ever-widening community of health (inaudible), of justice, and yes, in that passionate and compassionate love. Thank you.

MS. GREEN: Pearlie Green. I'm with the

(inaudible), and this has greatly impacted my life. P-e-a-r-l-i-e, G-r-e-e-n. On Tuesday December 13, 2005, my 38-year-old only son was found on the floor of his bedroom floor. Dead two weeks before his 39th birthday. He leaves to mourn his passing a grieving mother and father, four children ranging in ages from 19 to 4.

His untimely death was senseless. He would still be alive today had he been able to afford good medical insurance. The coroner did the work of a physician. He diagnosed him. The cause of death was dilated cardiomyopathy. DCM occurs when the heart muscle is enlarged and weakened and cannot pump adequate oxygen-rich blood to the body.

DCM is the most common cause of heart failure. I know this because I am a nurse, and I worked the cardiac units for years. He was being attended by a coroner physician. Coroner physicians are the doctors who open clinics in poor neighborhoods, accept medical cards, and give band-aid care. If you go into a poor neighborhood, there is a clinic on every corner.

He displayed the classic symptoms. Edema

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in his lower extremities, dyspnea on exertion, shortness of breath, fatigue, crackles and wheezes and palpitations. But how did the coroner physician treat him? He drained the fluid from his knee and he told him he needed a knee replacement and to lose weight.

I concur that he was 6 feet 2 and weighed 270 pounds and needed to lose weight. But doctors, what about the other symptoms? If he had had good medical insurance, would you have scheduled him for some other tests? Perhaps an echocardiogram, a CT scan, an MRI, or how about a simple chest x-ray? With all the clinics in the neighborhood, what happened?

To our legislative branch of government, this is a simple request from the tear-stained face of a grieving mother who is seeking justice in health care. It's too late for my son and for babies and premature babies born with birth defects because of inadequate prenatal care. But it's not too late for working poor, the uninsured, and the elderly.

We need to have continuity of care and familiarity with one doctor. This is crucial for

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real quality health care. We need doctors that we can build a relationship with in order to best take care of ourselves. We desperately need reform in our health care system. There is no reason for millions of people in the richest nation in the world to be without adequate health care. Again, I challenge our legislative body of government to make a reform, to make positive reform in our health care system. Thank you.

DR. YOUNG: Next is Jan Bleich, Bathsheba Wyatt-Draper, Brian Schwarberg, Ann Kleboe and Thomas Parrott-Shaffer.

MS. BLEICH: My name is Jan Bleich. J-a-n, B-l-e-i-c-h. I'd like to thank all the members of this task force for the opportunity to speak today. I'm the public health nurse for Pike County Health Department in rural west central Illinois. I've been a practicing nurse for more than 30 years.

When I think about adequate health care and access to it, I think of using the already established research we have available to not only treat disease but take it a step further and prevent disease. We have numerous studies

indicating that with healthy nutrition, adequate physical activity, avoidance of tobacco products, we can prevent or delay the onset of numerous chronic illnesses.

Illnesses such as diabetes, high blood pressure, heart disease, and cancer can be prevented or at least delayed frequently with healthy lifestyles. We have focused too long on a disease model of health care, and it is time we focus on the wellness model of health care. Statistics indicate that more than 95 percent of health care dollars are spent on treatment, and less than five percent is spent on prevention.

Fiscally it would be wiser to invest in prevention and wellness. Policies such as eliminating soda from schools, making our communities more walkable, and promoting smoke-free legislation all have a positive impact on health. So I would encourage decision-makers to support these types of efforts.

In addition, I think all communities need to look at ways to collaborate to meet health care needs. Right now in Pike County, we are looking at forming a community health partnership. We are

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working with Illinois Institute for Rural Affairs, SIU School of Medicine, and five local entities to see how we might meet the needs of our community (inaudible).

This type of model could eliminate duplication of services, streamline access, and provide more basic integrated care. It might also help to look at community health assessments done by all health departments in Illinois. These assessments involve the community and are done to identify health priorities. In Pike County priorities are adolescent health, poverty, and access to care and lifestyle (inaudible). A community health plan has been developed around these priorities.

Knowing the community health priorities for all the counties in the state could be helpful to you in your planning. At some point, I think discussions have to include some type of universal health care coverage. Through my work with Pike County I have heard numerous stories of individuals needing assistance with basic health care needs. From dental care to prescription medication to doctor visits, access is an issue.

Most of these individuals would fall into the working poor category. None of them has health insurance.

Finally, I would encourage you to endorse additional funding for safety net health care providers at the local health departments. Programs for maternal-child health, environmental health, chronic and communicable disease all promote and prevent disease at cost-effective levels. These types of programs cannot continue if funding remains at the level it has for the last nine years.

For example, Pike County receives approximately (inaudible) dollars annually (inaudible) programs. It actually costs over $150,000 to conduct these programs. In closing, I would just like to (inaudible). It seems that you have numerous commonalities in your goals. Again, thank you for the opportunity today.

DR. YOUNG: Ms. Wyatt-Draper.

MS. WYATT-DRAPER: Good evening. My name is Bathsheba Wyatt-Draper. B-a-t-h-s-h-e-b-a, W-y-a-t-t-D-r-a-p-e-r. Members of the task force, this evening I stand before you representing those

people who would probably like to be here but they're still at work. So therefore, I'm talking about those of us who work every day and have insurance and yet are not getting services.

Those of us who go to work have insurance and get sick. We get sick, we need therapy. We go for therapy, we're told that we're covered a hundred percent by our insurance, but we have to pay a $30 copay every time we go to the therapist and we're prescribed to go three times a week. Ninety dollars a week, $180 every two weeks. And that is expensive, so we have to choose whether or not we can afford to go to therapy so that the pain in our hands will go away. Or do we continue to work, not being able to go to therapy, and suffer the pain.

The people who would be in these seats I'm quite sure if they were not at work would tell you that they have stories just like the people who talk about they have to choose their medicine. We have to make those decisions too. We work every day, have to decide, which medicine will I buy this pay period? The $40 one, the $15 one? Because the insurance companies and our

businesses, the companies that we work for, are constantly negotiating, trying to find a lower insurance rate for the company, which causes us to have to pay more money.

I am an extreme advocate of everybody in and nobody out. I think that we have to include everybody. We just can't say it. Everybody's not here, and I'm just trying to stand here and say for those that could not be here, please. It's not just the unemployed, it's employed. It's just all of the people in the state of Illinois. And they have an opportunity morally and ethically to provide a better health care system for everybody. Thank you.

DR. YOUNG: Brian Schwarberg? Not here?

We'll go ahead with Ann Kleboe. Thank you.

MS. KLEBOE: My name is Ann Kleboe. A-n-n, K-l-e-b-o-e. I've worked at Madden Mental Health Center, I've worked at Grant Hospital in the psychiatric unit, and I've worked at ILLC, which is a place for people who have mental illnesses who want to go back to work. All I want to say is that by cutting Medicaid, some of the better

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medications that are newer--all medications have side effects, but the new medications that have side effects cost more and are not now paid for by Medicaid. I'd like to see that change. Thank you. Thank you for being here.

DR. YOUNG: Thomas Parrott-Sheffer.

MR. PARROTT-SHEFFER: I'm the Reverend Doctor Thom Parrott-Sheffer. T-h-o-m, P-a-r-r-o-t-t-S-h-e-f-f-e-r. I've been in the ministry for 26 years. And I've seen good and bad in hospitals, in doctors' offices, in the streets of Chicago, in southern Illinois. We have a health crisis. We all know that or we wouldn't be here. But what needs to be understood is that it is a crisis of faith as God calls us to care for each other. It is a crisis of morality, it is a crisis of government.

Nobody is looking to the government to fix anything; only for the government to be a part of the solution and to connect the dots for us. There is a cost to health care. And there is a cost when health care is denied. There is a cost in human life and human suffering, and there is a dollars and cents involved. And I'm challenging

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you all to think outside the box.

Perhaps what we need in the state of Illinois doesn't bear any resemblance to what exists today. I challenge you to be broad and wide and high and carefree in your dreaming about what health care in this state can be as we attend to the needs of all the people who are in this state. Thank you.

DR. YOUNG: The next five people we want to here from: James Thindwa, Bonnie Marks, Annetta Wilson, Gina Farag, and David Bates. If you guys could come forward and speak in that order.

MR. THINDWA: T-h-i-n-d-w-a. And I'm the executive director of Chicago Jobs with Justice. We are a coalition of labor organizations, unity groups, religious groups, and (inaudible) who are committed to safeguarding the rights of workers to organize. So we are hoping to support workers who are trying to maintain benefits at work and maintain decent working conditions.

I want to make a confession today. As a long-time activist, I've always been on the side of the workers, the picket lines for the workers who want better health care and so forth. And

oftentimes we get this tunnel vision where we don't see the other side. We tend to see good employers today who are being forced to make bad decisions or at least decisions that hurt their own workers.

They're being forced because we're witnessing a medical shift in our economy, the transformation of such proportion as we've not seen in a long time. We are losing high-paying unionized manufacturing jobs, and (inaudible) recently say there's been a $6,000 income loss for families in Illinois since 1999 directly attributable to this shift in the economy where service-sector jobs are replacing factory jobs with decent pay and wages and provide health benefits.

So along with that, the number of people who are no longer able to afford health insurance is increasing. The service-sector employer is often quite unable to provide the kind of health insurance manufacturers do. But with also increased globalization, employers are making some tough choices to stay, keep wages low and, and, you know, not provide health insurance or just go

overseas to another country where they can do business in a much more efficient and cheaper way.

So that we're dealing with companies that are operating (inaudible) the health care system has been nationalized. It's a national health care system that guarantees access to everybody. And if you look at the automobile, there's a $2000 differential for a car between a car that's made in Detroit and one that's made in Toronto, Canada attributable again to differences in the health care systems.

So this is an anticompetitive situation we have here in American business. Sounds strange for me to advocate businesses, but the survival of workers, the interest of workers is working (inaudible). When employers do well, workers tend to do well too, so with that, the best way to do this is to harmonize health care systems.

The United States companies need to be more competitive. The only way to do that is by adopting health care systems that can allow them to do that, to compete with nations where health insurance is a right, health insurance is accessible, it's comprehensive, there's cost

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containment, and all the things.

How we get to here is not my place to say. We just support these strong principles that health care needs to be seen as a right, and it needs to be accessible to everyone, it needs to be comprehensive, it needs to be of high quality and has cost containment features. Thank you.

MS. MARKS: First or all, I want to congratulate this groundbreaking task force for the first steps you've taken. But in the words of a famous poem, we've miles to go before we sleep. And I really concur with all the esteemed people before me and all of the longstanding problems that we've had in this society that people that don't fit into the boxes have had.

I lived in Europe for over four years and was, at that time was a social worker and was astounded at the difference between the health care system there and what I saw through all the developed world and here. My best friend is a Dutch citizen who moved here with a husband not long after I returned home, continued to be friends.

She will not give up her Dutch

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citizenship because she said after being here 30 years, she developed--she was a producer for Leo Briggett (sp), was luckily caught in their safety net. But she said she developed COPD and said, there was no way I could afford to become an American citizen. She needed the protection of her country.

I myself, the profundity of what's been happening in this country and is escalating--degree of the problem is beyond comprehension. What's happened, I now represent a group that was never thought to have problems before. I am an attorney who's wound up a hundred thousand dollars in debt after law school who went first into a small law firm that--and I was uninsured. At that time luckily I was healthy but in a sick building, and even my costs for pulmonary problems were coming out of my pocket.

With high loan payments it was a real deprivation for me back then. I am now in my mid50s, part of the baby boomer population, and caught in that quagmire, and I have now developed a chronic disease, diabetes, and because, as they say, I used to say as a social worker, even if you

don't want to look at this from a humanitarian aspect, look at it from a practical aspect.

What we as a society are not willing to pay for now we will pay for much more in the future. With people that cannot, both cannot exist that will be on the streets. So if you want to just be a practical person, please handle it from that aspect. I have a faith-based group to help me. I now have escalating problems because I couldn't do the preventative work that I needed to do. And if it were not for that group, I would have no coverage at all. No insulin, nothing that I need.

What you need to do is--we've met today with Representative Currie. She had an excellent point. She said that what we need to do is look at, look out of the box and look at the systems in the developed world. There may not be one particular system, but we need to look at them all. I think it's fabulous that we have all segments of the community and organizations from professional to service groups, organizations now willing to work together out of the box.

We need to look at all the extant systems

and see how we can make something unique work for us. As I said, if we don't do it now, we'll be doing it in a different way tomorrow. I really appreciate everything you're doing, and as the poet said, we still have miles to go before we sleep. Thank you.

MS. WILSON: Good evening. My name is Annetta Wilson, A-n-n-e-t-t-a, W-i-l-s-o-n. I am the CEO of Sankofa Organization in Chicago. As I have observed the testimonies presented to the Adequate Health Care Justice Task Force, many have addressed the need for adequate insurance. However, having insurance does not address the health disparities of minority citizens in Illinois.

Based on the Institute of Medicine Report, racial and ethnic minorities tend to receive lower-quality health care than whites do even when insurance status, income, age, and severity of conditions are comparable. Therefore, I am working with State Representative Mary Flowers to pass legislation to establish a center of minority health in the state of Illinois.

This center will assure that any

insurance plan recommended by the task force would limit fragmentation of care, equalize access to high-quality services, build in culture and linguistic competency for Illinois minority patients.

The goals of the center initially will address the following. Examine the conditions under which gaps in the health and health care services for minority communities in Illinois exist and recommend methods by which the gaps will be closed. Design methods for disseminating health information and educational materials especially designed for the minority community. Develop models to improve access and utilization of public health services.

Develop strategies to improve the availability and accessibility of minority health professionals. Foster a sense of personal responsibility in minority communities. Initiate measures to foster systemic changes to remove barriers to accessible, acceptable, available, and affordable services. Work with the Department of Insurance, IDPH, and the Attorney General's office to enforce regulation and statutes. Help to

foster evidence-based cost control in any system developed by the Adequate Health Care Justice Task Force.

I applaud the hard work of this task force and urge the group to closely follow the roll-out of the All Kids program. Barriers such as provider discrimination, slow pay by the government, recruitment, quality control, and cost containment will be transferable lessons for product developed by the Adequate Health Care Justice Task Force. Thank you.

DR. YOUNG: Gina Farag.

MS. FARAG: My name is Gina Farag. G-i-n-a, F-a-r-a-g. I just want to thank you for taking leadership on this issue because I feel like it is, as everybody else has been pointing out, a crisis. A few years ago after, right after I graduated from college, I was doing an internship and I didn't have coverage where I was. I was getting it from my parents because they had an HMO.

I could only get coverage if I was in Illinois and I (inaudible). So I had some sort of skin problem, and it got really painful. And

finally one day I couldn't stand it anymore. I decided to go to the emergency room. No doctors were obviously open. So I went to the emergency room, and when I finally get inside, I saw it was completely packed. It was a week night, and there was no place to sit. People were coughing, standing face to face, and I thought, you know, if I stay here, I'll probably be sicker.

And when I asked them how long they said probably (inaudible). I thought, I'm probably better off at home sleeping (inaudible) until I can go see a doctor, and I'll just pay the extra money. So I'm luckily okay now, but I'm not the only one (inaudible). Today the big buzz word is family values. But the way we have insurance hurts families. I have seen in my work in social services as I look at cases, stories where families start with an illness and because of it develop financial problems and down the line the family breaks up.

About a year ago, one of my parents (inaudible). He has two children, he's been married to his wife for about 10 years, and we were looking at their eligibility for Medicaid.

(Inaudible) over a thousand dollars a month. He found out that he doesn't qualify anymore because he needs just a little help. So you have to need (inaudible). Because that was the only way he could continue to get coverage the only way (inaudible). Thank you.

MR. BATES: Good afternoon. (Inaudible) coming from the south suburbs. (Inaudible) and I've only got a few minutes, so I'll talk the best I can. I'm sick and tired of this patriotism crap rap. I'm sick and tired of it. And I'm going to have to (inaudible). You can't sell me patriotism when you got second-class citizens. You can't tell me that. You can't tell me that when I got up at 4:00 this morning to come to Springfield and couldn't even get the respect of most of the legislators.

I hope I don't talk too much (inaudible). But I find it hard to get up, come down here, and talk to people who are supposed to represent me, and some of them didn't even want to look me in the face. Some didn't want to talk, some looked past me. I'm not (inaudible). I find this horrible (inaudible) America to my door. Two

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weeks ago as a father (inaudible) for the first time. Going up by himself. (Inaudible) go ahead, first day. South suburbs not that bad.

Driving back an hour later. And it so happened we had to open our garage door. (Inaudible). My hand got caught in between the garage door and she smashed her hand. Smashed it. And again, there it goes again. They ain't got health insurance. Don't have it. Know what that does to my manhood? I mean, I couldn't get (inaudible). What I'm talking about, I can't provide health insurance for her.

I've been working--I'm 40 years old. An African-American male, working good jobs. (Inaudible) uninsured two years. Two years. Good jobs. We have a problem. We have a problem if you got to help me to be able to explain to my daughter what is a real American and what is a first-class citizen, what is a second-class citizen. And this is just not my daughter. You look at the (inaudible). American.

Nothing we're talking about has anything to do with the (inaudible). This is what it's all about. It's not about status. I have

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(inaudible). But the bottom line is you guys, legislators, you need to help me work this out with my daughter. You need to help me out. Because it's not really good for America. My daughter's growing up like the majority of the citizens are growing up being told they're special but in reality they're second-class citizens. Thank you.

DR. YOUNG: The next four people are Margaret McDonald, Marcia Rothenberg, Anne Logue, and Donald Graham, please.

MS. McDONALD: Good afternoon. My name is Margaret McDonald. M-a-r-g-a-r-e-t. Capital M-c, capital D-o-n-a-l-d. And I guess you could say I'm sort of like a lone activist for Medicare part D. I think it's very confusing to us as seniors, and I'm upset about it and I'm from the south side of Chicago. So I'm out here sort of like trying to get a petition together to just get them to revisit this and to give us something that we can better understand and that's really beneficial to us.

Because before this, I had Medicare, and I had Blue Cross and Blue Shield as my extra

insurance for the past five years. When I got ready to sign up, I was always asking, do you have any prescription drugs? We don't have anything for seniors, no prescription drugs. But all of a sudden since they brought this prescription drug plan out, Medicare part D, Blue Cross and Blue Shield was the first one to get on the bandwagon to offer a prescription plan.

So for me, from what the government is giving us, it's to help them make the pharmaceutical companies rich. Because this is what they're offering us. It's crap. If you always have to pay a premium each month, pay for the prescription plan. Then you're going to have to pay a high copay. It depends on--I'll just say, for example, I have three medications that I'm taking.

One, two of these medications I have paid $59 a piece as copay. The other one because they negotiated it for us I have to pay $40. Ones that are generic I have to pay $12 for. But in order to get to this $2,250 that I'm going to have to pay, they're not charging me the copay. They are charging me the actual cost. And what I'm saying

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is one of these medications costs 90, another one costs 100, another one costs another 80, and the other one is costing I think 25.

So this is what they're going to use to add up to come up to the $2,250. I have not heard anyone talk about what insurance is out there to fill the med gap. And the only thing that I have been able to figure out from reading and listening would be an HMO that would take up the med gap. But if you want to be in private insurance, I haven't heard of anything being offered.

Okay. The next thing that you have to do is spend $3,600 out of your pocket after you spend the 2,250 before you can receive any more coverage to your prescription plan. And you still have to pay your monthly fee in order to belong to this prescription plan. So I'm just asking them to revisit it and take a look and offer us something better. Because what they're offering us is helpful, but it's not really the best. Thank you very much, and I'm glad I had an opportunity to speak here today.

MS. ROTHENBERG: My name is Marcia Rothenberg. M-a-r-c-i-a, R-o-t-h-e-n-b-e-r-g. I came up here

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with the Campaign for Better Health Care (inaudible) for a long time and that is to try to get universal health care in the U.S. I first started in the 90s (inaudible) Prudential Health Care, and it's more than 10 years later and things have gotten worse. And it's rather discouraging.

When I came up here and went to the (inaudible) and went up there to call out the representatives, I suddenly had the feeling that I was playing a card game in the theater of (inaudible). There were five groups out there who were talking about medical care. One group wanted charity care in the emergency room because many of them couldn't afford to pay for the emergency care, the only care (inaudible). That's where you go if you don't have medical insurance and you're really sick.

There were people who wanted things for people who were suffering from AIDS. There were health care workers who were taking care of people who are disabled or old people and they have no health insurance themselves besides making minimum wage. There was somebody there who was concerned about autistic children and wanted to ask for some

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rehabilitative care for children with autism so they could live a more productive life in the society.

I won't go on any further, but if that doesn't seem absurd to you, it really seemed absurd to me that all these people had traveled from all over Illinois to come with hat in hand to ask for some help. What we are asking for is affordable health care. And all of the things these people have come to ask for are included under my conception.

And I think most of our conception of universal health care would be everybody in, nobody out from the cradle to the grave. Preventive care, rehabilitative, and long-term care. So that's one thing. I wanted to share that observation with you.

The other thing, the task force is here. I think that, okay, I think that everybody is quite well aware of the problems. What to do about it is the other thing. And I want to say that it can't be a profit-making venture. It has to be a single-payer, something simple, and it can't be anything like the Medicare part D where

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you kind of hobble together some profitability for insurance companies onto a government service which is supposed to take care of people.

MS. LOGUE: Hello. A-n-e, L-o-g-u-e. I am 49 years old and a working person but not very wealthy, and I am not able to afford health care. This year I was diagnosed with breast cancer, and ironically I was lucky. If you have breast cancer here in Illinois, there's a treatment-specific program that pays for just about all your medical expenses. If that program was not out there, I literally would be dying.

The cancer which at first barely indicated a need for further testing and they suggested I have an MRI which is $3,000 and I definitely could not afford that. But thanks to the local programs, I was able to get that. And very grateful for the funding and the care for this type of cancer, but I'm very alarmed that treatment for just about any other type of life-threatening illness is not out there.

I feel very sad and frightened for anybody below the poverty line or the working poor who must choose between death or being haunted by

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a lifetime of massive medical bills. We did this for breast cancer in Illinois. Why not for everything else?

DR. GRAHAM: My name is Donald Graham. D-o-n-a-l-d, G-r-a-h-a-m. I want to tell you that I've been a physician for more than half of my life. I'm proud to be a physician. I have enjoyed this practice very much. I've seen very great advances that have occurred just in my practice lifetime. Although medicine is expensive, it is worth it in most cases. I want you to remember that George Washington would have, did die of strep throat. For $10 now he'd be cured of that strep throat.

We've seen advances in our extended life. We now have added just since I've been born 10 years to the average life span of Americans. I know there's problems with Medicare, but before I was born, even when I was a boy, there was no Medicare. Since then people have gotten care that they wouldn't have had before. You have to think of some of these good factors too.

Physicians work very hard. I want you to know that every physician wants the patient to do

well. We are very sad when we see patients can't afford their medication. We work very hard sometimes to seek alternatives. Many times you don't need these $100 medications, you can get by with a $10 medication. You have to work with the physician.

I think one thing that was brought up today is the importance of working with a primary care physician. It's extremely important to be able to call a doctor to your home. It's very difficult when people come to the emergency rooms, to coroner clinics, free clinics to then leave and then come back later on and not have someone who knows what care was involved previously.

I worked for many years in such areas. I used to be on the board of (inaudible), a center in St. Louis. That project now is closed, it's not even there, but it is the kind of practice that I've enjoyed for many years to work with people who are ill. I think you want to know that doctors want to take care of patients because of illnesses they have and want to help them.

You ought to realize that here in central Illinois we've been very lucky to have a lot of

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good doctors. We've seen more doctors come in than leave, but in southern Illinois we've seen more doctors leave than have come in. And that's because many of them want to make it, but they just can't afford to practice there anymore. The stresses are too great, and doctors just don't want to work there because it costs too much and they're getting too many pressures to their practice for a variety of reasons. This has to be dealt with too.

I'm going to close by saying I commend this committee for having me here. There is no solution that we can offer today. I can't hope to have a solution today, but just to have a health care committee. I want to commend Dr. Backs, who is a practicing physician on your committee who has worked for many years seeing these problems firsthand. This is the type of membership we need on this committee, and I'm happy to help work in any way to complete testimony. Thank you.

MS. MAGLIOCCO: Maureen Magliocco. M-a-g-l-i-o-c-c-o. A few months ago my 28-year-old son and his wife of one year were planning to come for a visit from out of town. At

10:00 the night before they were to arrive, our daughter-in-law called to say that our son was very sick and had been for the last three days. He had a fever, a horrendous headache, and aches all over his body. When I told him to go to the emergency room, he said they couldn't afford it, that their insurance didn't cover it. I told them his dad and I would pay, that he should go immediately.

My daughter-in-law and I were on the phone for the next two hours as the physician in the ER suspected meningitis and ordered a CT scan, with the possibility of a follow-up spinal tap. Since their insurance wouldn't pay for those tests, I again told them we would pay. After massive IV doses of antibiotics and good results from the CT scan, my son was released but told to return the next day if he still had the headache.

At noon the following day, he felt better, but the headache continued to cause him pain. I told him to return to the emergency room, that we again would pay. Fortunately his headache gradually left, but the situation was scary and left me thinking about others in similar

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situations whose parents could not afford to pay. It brought home in a real way my belief that this country is facing a health care crisis.

A couple of months later, after suffering for two years with ear pain, our son finally went to see a doctor. That led to more tests and referral to an ear, nose and throat specialist who referred him to his dentist who in turn referred him to a jaw specialist. All these doctors cost a lot of money because our son's insurance only allows four doctor visits a year and doesn't cover dentists.

Fortunately, the last specialist was able to diagnose the situation correctly, but the splint he recommended cost $1200. After paying out of pocket for the doctors and dental specialist, our son had no money left over for the treatment. Again, we told him we would pay. Our son is one of the working poor. He works very hard, sometimes in temperatures over 150 degrees, as a saute chef at a private club which has around 500 members. He earns about $10.50 an hour.

The club, while it prides itself on providing insurance for its employees, has

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recently had to raise premiums and decrease coverage because of its own high insurance costs. While it wants its employees to make a good appearance, it does not cover dental and vision care or prescriptions. And remember, only four doctor visits a year.

Fortunately, at the moment my husband and I can afford to pay for his health care costs, but we are both retired and will soon be spending more and more of our retirement income on our own health care. I have high blood pressure, while my husband has diabetes, problems associated with his prostate, and other health problems. We both have increasing dental costs.

The time is coming when we will not be able to pay for both our own health care and that of our son and his wife. We urge the state to develop a plan that will guarantee universal health care coverage to all its citizens. Thank you.

MS. MICHALSKI: My name's Laura Michalski. L-a-u-r-a, M-i-c-h-a-l-s-k-i. I'm currently the director of clinical relations at Community Health, Illinois's largest volunteer-based free

clinic. I'm also the president of the Illinois Free Clinic Association. The Illinois Free Clinic Association represents 34 free clinics throughout the state of Illinois. We serve over 34,000 uninsured individuals each year.

Free clinics are a grassroots effort to help the uninsured health care crisis. We don't claim to be the answer, but we're a grassroots response. Quite often free clinics are overlooked in the attempts at a solution. We know the uninsured the best. We work with the safety net providers in both the public and private sectors. We work with them together and have (inaudible) response to our patients.

Currently in Chicago our clinic cannot access mammograms or colonoscopies. We have a waiting list of over 500 patients that need colonoscopies or mammograms, and we cannot access them.

There are four main issues that I'd like to address today. First, all Illinois residents need to be included in any type of health care plan. That includes the undocumented, the documented, income range regardless of low income,

middle income, or high income. Those with special health care needs, not just sick kids or chronic diseases; everyone has to be included.

The inclusion of anyone on the public and private health care (inaudible) individuals. If a class of individuals is not covered, expenses will be shifted to taxpayers, and we will ultimately be responsible for covering the costs of health insurance through increased taxes and higher insurance premiums. The cost should be dealt with up front instead of through indirect costs.

Second, the health care system should not just be the health care insurance, or the system should not be directly linked to your employer. It should be portable. It should not cause a significant financial hardship to the employer.

Third, access to prescription drugs must be included. As we know, most people are on multiple medications for chronic diseases. At least 40 percent of uninsured seen in free clinics have one or more chronic diseases requiring more medications. Of course, the cost of medications are increasing. Without affordable health care coverage, individuals will go without needed

medication.

Finally, a significant consideration has to be set on finding a sustainable and comprehensive universal health care plan. Looking at our existing systems right now is very fragmented. You can apply for Medicaid, Medicare, you have Kid Care, All Kids, there are indigent drug programs available through different pharmaceutical access programs.

It's very time-consuming, very cumbersome in filling out the forms. There's Medicare part D, but if you don't have part B, you can't qualify, you have to pay those premiums. It's very difficult to navigate. What we need is a comprehensive solution. We cannot continue to look at what we're doing right now. Bringing everyone together is a joint partnership which is the only way that we can provide any hope for the future.

Currently 45 percent of free clinics in the state of Illinois had to close their doors to new patients. How can a free clinic turn their back if no one else is there to do it? We had to do this because of the constraints of the

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financial hardships of this. That's not fair. This community is in charge to explore the potential solutions for this problem. Thank you.

MS. KNOEPFLE: My name is Peggy Knoepfle, and it's K-n-o-e-p-f-l-e. And I'm with the Mary Wood branch of Women's International League for Peace and Freedom here in Springfield. We've been in Springfield for 50 years working for human rights and peace at the local, national, and international level.

In 2004 we decided as an organization to join the Health Care Justice Campaign because every one of our members was facing severe problems in access or affordability or quality of health care or because they knew a friend or relative who was suffering the same. And I'm just an ordinary citizen, and I'll just give you kind of a shotgun approach to the health care problems that I have seen.

A friend of mine died at the age of 49 here in Springfield; a working woman and a head of a family. She had no health insurance, so she did not have a physician or her own physician. She didn't have checkups, she didn't go to the doctor

except when she was really, really sick. And her colon cancer was discovered too late to save her life.

I work at the Springfield overflow shelter for the homeless. Some of the people there are there because of catastrophic health costs that have taken them out of their home. Last night we sent a man to the emergency ward. There were, a complex of causes were the reason, but the main one that started the whole crisis was that he had a very bad toothache. That is not a sustainable way to take care of people.

When I worked at the Auburn food pantry for several years, the seniors who came in for food regularly either had a catastrophic health problem that had just bankrupted them and taken all their money away or else it might be a woman who for some reason did not have Social Security or someone living on very--didn't have Medicare or someone living on very low Social Security.

I am the mother of two mentally ill sons. Brilliant sons but facing chronic mental illness. One of them is not on his medicine and has been homeless on occasion. He has had health care

twice that I know of since 2001. Both times were in the emergency wards of hospitals. And they were both things which he could not pay them for nor could we. And I have this recurring fantasy of winning the Illinois state lottery and paying all these hospitals back. But this isn't a sustainable way to pay for health care either.

And my other son is on Medicaid, is on SSI, and is taking his medicine, and he works with a support group and probably saves the state where he lives much money because he fights daily for suicide prevention and to keep his friends out of the state hospital. He suffered from a problem in his state that mentally ill patients here in Illinois are also suffering from.

The drug that has kept him stable for years, Zyprexa, is one of the drugs that the pharmaceutical companies can still make a lot of money on so they don't want to put it on the list of preferred drugs. They want people to pay the full price for them at the state. And so my son was taken off of Zyprexa and spent 10 days in the state hospital at great expense to the state. He's now back on Zyprexa.

My own psychiatrist here in Springfield has told me that the same thing has happened to five of his patients. It's just, it's weird. It's not the way to treat mental illness. Finally, another member in our organization suffered severe spinal cord injuries 35 years ago when her car, when the car she was driving in was hit by a drunk driver. She heroically managed to rehabilitate herself, worked for many years, was a single head of household.

She has been poor all her life because she could get no compensation from the uninsured driver. She had to struggle to pay the COBRA costs because she had a pre-existing condition, so she's always had to pay very high costs for insurance. Finally--and she now lives in assisted housing. At one point when she was raising her children, both herself and her child needed a surgery. She tried to pay the hospital back--okay.

I'll stop now. But anyway, you can see just this big scattering of things. And we can and must do better, and I think you've got the people here to find a way for Illinois to do

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better and make it accessible to everybody.

MR. CARRELL: Good evening. David, D-a-v-i-d, C-a-r-r-e-l-l. I want to share with you my story of insurance. I am a retired school administrator out of Danville, Illinois. I spent 43 years as an administrator. I took early retirement, and I wanted to spend some time traveling and doing fun things with my wife. But when I decided to retire, I could not afford the state teacher retirement insurance. It was too costly. So I opted to stay with the District 118 insurance.

Little did I know each year they would slowly increase the price of my premium. Last fall I get a very curt letter from the district and my insurance company. It said simply, your rates will be as follows. Not I'm sorry, I don't care. Very curt. It said, your rate will be $504 a month for you. Now, if I want to insure my wife along that plan, it will cost you $1800.

Now, I'm retired. I don't have a lot of money. But that $1800 a month came to $21,000 a year. That would have been one-third out of my salary going to insurance. Now, part of the problem is it's sad that when you are old--I am a

victim of cancer. Once--and I'm cancer-free for 11 years. But once that gets on your medical records, it's next to impossible to find an insurance company that will pick you up.

I started calling around through the month of November and December. I had very little time; they told me in November make a decision by January 1. I called insurance companies and they were glad to get my name and they were going to sell me insurance. Fine and dandy. Then they said, well, how old are you. I'm 66. Sorry. There's no companies that will cover you past 65.

Then the next thing they said, well you qualify for Medicare, go down and sign up. Sure. Did you know that teachers, you're not qualified for Medicare unless they have 40 quarters of work outside of the system? You know what I'm doing right now? I am subbing and working, trying to get 40 units so that I can qualify for Medicare.

Why are we so against anyone when they reach the age of 65? We are being discriminated against, and I think it's a sad day that every year your insurance goes up and up and up. I'm still insured with my former district. I can't

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leave. I'm a victim. Because if I leave, I'm not insurable. I need your help, and I'm sure there's thousands of people in the state of Illinois that need someone to address this issue.

Get busy in this General Assembly. Don't let it be a political issue. Get off your duff and start doing something. I'm glad someone up here is addressing the issue. It's time that we have insurance for everyone in the state of Illinois at a very reasonable cost. These insurance companies are making out big time, and I'm tired of paying the premiums. Thank you.

MR. BURG: Thank you. My name is Gary Burg. G-a-r-y, B-u-r-g. And I'm from Chicago, Illinois. I came down here for an AIDS Foundation lobby day tomorrow. I've not been down here testifying for (inaudible). I'm glad that I came because it gave me the opportunity to find out that this testimonial was going on today, and I wanted to share my story of what happened with me.

I have AIDS. I'm a licensed Illinois dentist. I found out I was HIV positive in 1991. I left my practice and decided that I'd just wait for my demise. In 1994 I was diagnosed with

full-blown AIDS and CMD retinitis whereby I lost, I had very bad scarring on the retina in my eyes, could not see very well. And I have peripheral neuropathy beginning, and the senses in my hands and my feet are greatly diminished.

At that time I qualified for Social Security disability. I now am on Social Security disability. And because I paid in a high rate for many, many years, I qualify for a higher disability amount, which is $1644 a month. At that time there was no coverage for drugs. I had a health insurance plan which I continued to pay out on my own which I continue while I'm on Medicare health insurance which is my primary, and my private health insurance became a secondary insurance to pay for my drugs because my drugs were getting very expensive.

And because of protease inhibitors, that's why I'm standing here in front of you today is because they saved my life. And they're very, very expensive. And each year since the year 2000, my insurance premiums have dramatically increased. In 2000 I was paying $200 a month for my health insurance. I just got a bill which I

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have to pay bimonthly. My insurance payment for my secondary insurance, formulary drugs is $1,147.

I have--like I said, I get $1600 from Social Security, my mortgage is $1108. My health insurance is more than my mortgage. My real estate taxes are 425, my house insurance is 115 a month, my heat to heat my house is 350 a month, electric is 100 a month. It doesn't leave a lot for food. And it's very difficult for me to stand up here in front of you to talk about this. But something needs to be done.

And I looked into Medicare part D, I talked to my insurance company. My drugs are $5,735 a month. When I calculated what it would cost me, it would be, I'd have to pay (inaudible), that would be 300 a month. A five percent copay on $5,735 a month is $286 a month. To get a supplement program to cover what Medicare doesn't pay is $415 a month for a total of $11,001.78. So any way that you look at it, it's $1000 a month for coverage, and I think something needs to be done about that. And I thank you very much for your time for listening to me.

DR. YOUNG: Mike Keeney.

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MR. KEENEY: Hello. I've been here before. I'm down here for lobby days as well. And I just found out a couple hours ago that this hearing is taking place, so I'm not prepared at all. I'd just like to say basically I was diagnosed with full-blown AIDS in 1986. At that time I had my own business. I took retirement, and after two catastrophic opportunistic infections I wanted to go on disability.

Just as much for financial reasons as for health reasons I was basically forced out of my business. So that these all came against me in terms of qualifying for insurance. But since then (inaudible), and I'm on the higher end of Social Security check as well, and it's very, very difficult to go to a place and say you're in financial trouble and to have to ask for food. It's even more devastating to be told that you don't qualify.

One my cousins who lives in (inaudible). She has had breast cancer two times now. And with all of the stress and difficulty recovering from a cancer illness is one thing. But what they don't have to think about is how am I going to pay for

this. That never crosses their mind. They always have a doctor, they always have medicine. They don't need insurance. So that's my viewpoint. Thank you.

MS. JOHNSON: My name is Dell Johnson. First name is D-e-l-l; Johnson, J-o-h-n-s-o-n. And I work in the health care field. I'm testifying today in possibly two parts. One to tell my own story and then to talk about what I think are maybe some missing parts in terms of thinking about solutions for universal health care.

My own personal experience is in 1992, my mother passed (inaudible), and she was one of those people that was always (inaudible). And she was unemployed, (inaudible), and she became ill at some point before her insurance kicked in. Actually a week before her health insurance kicked in she had to go to the emergency room for swelling in her legs and they found clotting. They then (inaudible) cancer of the liver that had advanced to first stage (inaudible) giving her all these drugs.

At that particular time, she had gone to a hospital in Indiana (inaudible) to a hospital

(inaudible) because it was suggested by others that it would be better for her to go there in terms of care because the situation in Illinois might not be as (inaudible). Even in that particular situation a social worker there working with us, the family because it was a religious (inaudible), we, it was very difficult to navigate the system in terms of the prescription, the times that she would come home, her physician, doctors visits, that sort of thing.

Her primary care physician that she had for years had gone into retirement, and so there was just all these different things to navigate. And there was someone who's ill at a time very difficult for her to navigate. It was left to those of us who were taking care of her ourselves. And so I know the experience of having a family member who's uninsured.

And though I think you've done great things here in Illinois with All Kids and Kids Care and Family Care, I think we definitely need to think about in terms of when you say what family care is that it does include these (inaudible) because they have to be (inaudible) at

the time. So that is my story in terms of my personal experience of what happens when a person isn't able to access insurance.

She actually got (inaudible). And you could come up with a million reasons of why there wasn't enough care, wasn't enough to worry about the cost of this and all those extra things that (inaudible). Ultimately after she passed she actually got a letter saying she qualified for Medicaid. And some of those hospitals were paid, interestingly enough.

But nonetheless, I stand here today, I work in the health care field, I've worked as an LPN sometime ago, (inaudible) but it's because of some of the things that my mother went through hoping that I could be a part of the process, make things better for someone else and still stand here to today (inaudible) for that same reason.

One of the things that I noticed during the process of (inaudible) we had a lot of the members who were on the task force, which I commend all of you. You did an awesome job. But to me one of the major components of I think some people I think there needs to be more of an

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interest from the private side of insurance or pharmaceutical corporations.

Some of these things related to cost come from inside. And I think that they need to be very much asked to be a part of this process in coming up with solutions. I don't think it is just the burden of the government or just the burden of constituents. I think we all exist in the world together as a whole.

If we look at some of the systems in other countries, they've done some innovative things about insurance, private insurance companies and medical supply companies to help do some things to help with cost so it can help with the burden put on people and (inaudible). That's pretty much all I have to say. And coming from the health care field and working with semiprivate insurance company, we are always wanting to be part of those discussions, and any information that we can get in our experience we appreciate. Thank you.

DR. YOUNG: On behalf of the group, I want to thank all the people who came and gave testimony. We greatly appreciate it. And we will try to meet your needs. We're adjourned.

C E R T I F I C A T E

I, Rhonda K. O'Neal, a Notary Public, Certified Shorthand Reporter, and Registered Professional Reporter, do hereby certify that on the said date the foregoing public hearing was taken down in shorthand by me and afterwards transcribed, and that the foregoing transcript contains a true and accurate transcription of all such shorthand notes.

I further certify that I am a disinterested party to the proceedings herein, and that I am not a relative of any of the parties hereto, or their attorneys, that I am not in the employ of any of the attorneys for the parties hereto, and am not otherwise interested in the outcome of this cause of action.

In witness whereof, I have hereunto set my hand affixed my seal this 14th day of March A.D., 2006.

Notary Public and
Certified Shorthand Reporter
and Registered Professional Reporter
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