

# **HEALTH CARE FOR AMERICA NOW!**

## **Who's Really Rationing Care?**

Letters from Ohioans

to

Insurance Industry Executives

**We are here to demand that United Health Care CEO Stephen Hemsley, who made \$3.2 million last year to deny care to United Health Care customers, agree to the following.**


**Effective immediately:**

United Health Care will not stand between a doctor and a patient when it comes to deciding what care that patient needs. If care is recommended by a qualified physician no one at United Health Care will substitute their judgment for the judgment of the patient's physician in deciding if care is medically necessary.

United Health Care will not deny coverage for a pre-existing medical condition.

United Health Care will terminate any policy or incentive that rewards employees financially or otherwise for denying care and rejecting claims.

United Health Care will not use any resources – including funds, employees, and facilities — to oppose any aspect of the health reform proposals supported by President Obama and being considered by members of the United States Congress.



## Worst Practices: UnitedHealth Group

- **2008 revenues: \$75.4 Billion (#25 on the Fortune 500)**
- **Customers: 70 million Americans**
- **Spending on Federal Lobbyists Since January 2008: \$7.33 Million**

**UnitedHealth Agreed to Pay \$50 Million After N.Y. Attorney General Sued Them Over Unreasonable Charges.** In 2008, Attorney General Andrew Cuomo sued UnitedHealth “as part of a broad probe into how insurers pay doctors and hospitals that aren’t in the companies networks.” According to Cuomo, UnitedHealth’s Ingenix unit “operates a defective and manipulated database that most major health insurance companies rely upon to set reimbursement rates for out-of-network medical expenses.” “UnitedHealth agreed to give up the database and pay \$50 million to revamp it under a nonprofit.” [Wall Street Journal, [2/13/08](#); Star Tribune, [5/31/09](#)]

**California Subsidiary Charged With Record \$3.5 Million Fine in 2008 For Mishandled Claims.** In 2008, “After an unprecedented eight-month joint state probe triggered by hundreds of complaints, [California] state health insurance regulators...slapped the PacifiCare unit of UnitedHealthcare with a record \$3.5 million fine.” The investigation found that “30 percent of the HMO claims were wrongly denied and 29 percent of the disputes with doctors were handled incorrectly.” [Sacramento Bee, [1/30/08](#)]

**Subsidiary Fined \$2.8 Million For Late Payments.** In 2006, United Healthcare and subsidiaries United Healthcare of Georgia and Golden Rule Insurance Company were fined \$2.8 million by the insurance and fire safety commissioner of Georgia. “The fine comes after an examination was done by the Georgia insurance department which found that UHC was late with between 75,000 and 80,000 claims in accordance with Georgia’s law that requires prompt payment. The inquiry into UHC’s claims came after numerous complaints about the insurance company. Georgia’s prompt payment law requires that a claim must be paid within 15 business days, or explain to their customer why there is such a delay.” [Americus Times-Recorder, [1/3/06](#)]

**UnitedHealth Refused to Say It Would Stop Dropping Coverage.** “An investigation by the House Subcommittee on Oversight and Investigations showed that health insurers WellPoint Inc., UnitedHealth Group and Assurant Inc. canceled the coverage of more than 20,000 people, allowing the companies to avoid paying more than \$300 million in medical claims over a five-year period.” The executives, including

Richard A. Collins, chief executive of UnitedHealth's Golden Rule Insurance Co, "would not commit to limiting rescissions to only policyholders who intentionally lie or commit fraud to obtain coverage." [Los Angeles Times, [6/17/09](#)]

**UnitedHealth CEO Forced to Resign and Pay \$468 Million For Manipulating Stock Options.** In 2006, UnitedHealth head William McGuire was forced to resign after an investigation "concluded that he had received stock option grants that were 'likely backdated' to allow insiders to maximize financial gains." During his tenure as CEO, McGuire was granted more than \$1.6 billion in stock options. In 2007, McGuire agreed to pay \$468 million to avoid going to trial. Before he resigned as CEO, McGuire downplayed his backdated stock options, saying, "This isn't a giveaway of money that occurs out of the premiums of health care recipients. These are shareholder dollars." Stephen Helmsley, who replaced McGuire as CEO, also received backdated stock options and in February 2009 made nearly \$100 million when he exercised his options, which had been re-priced after the McGuire resignation. [Los Angeles Times, [12/7/07](#); Pioneer Press, 5/23/04; New York Times, [12/31/06](#); Wall Street Journal, [2/11/09](#)]

**United Health Group Urged Employees to Attend Anti-Reform Town Halls in 2009.** In 2009, MSNBC's Keith Olbermann reported, "United Health Group is now directly urging its employees to attend anti-reform rallies, mass-mailing a letter, and setting up a hotline to direct its own callers, its own people to local events. Quoting from the letter, 'It is critical we, as leaders in the health care industry, are communicating with our members of Congress to ensure that they understand our story and views.'" [MSNBC, [8/19/09](#)]

## Stephen Hemsley, CEO, United Health Group

- **2008 Compensation: \$3.2 Million**

### **Hemsley on Profiting from Reform:**

“Leading companies take advantage of disruptive change in the marketplace... Our shareholders will prosper.” [Star Tribune, 8/5/09]

### **Hemsley on Competition:**

“...There are literally hundreds of health plan organizations operating in the commercial marketplace alone. Across all of UnitedHealth Group's businesses, they are literally competing with hundreds if not thousands of competitors large and small.” [Sanford C. Bernstein & Co. Strategic Decisions Conference, 5/29/09]

“If you consider a public plan that is built more along the Medicare model, that is profoundly disruptive to the delivery system and we would suggest wouldn't be a sustainable proposition at all.” [Sanford C. Bernstein & Co. Strategic Decisions Conference, 5/29/09]

### **Hemsley on Medicare:**

“There are 30 million senior Americans living in traditional government-run Medicare program. That is a 1960s indemnity program that is totally unmanaged in terms of care and arguably seniors are the one population that benefits the greatest from managed care.” [JPMorgan Healthcare Conference, 1/12/09]

**Richard Collins, CEO, Golden Rule Insurance Co., a Subsidiary of United Health Group**

**Collins on Rescissions:**

“Rescission is an unfortunate but necessary recourse...” [House Energy and Commerce Subcommittee on Oversight and Investigations Hearing, 7/27/09]

**Collins on Competition:**

“We think that there is competition in the market today; there's robust competition in the individual market today. It's a very transparent market today.” [Goldman Sachs Global Healthcare Conference, 6/10/09]

**LETTERS FROM OHIOANS  
TO  
HEALTH CARE INDUSTRY  
EXECUTIVES**

Claudia

Franklin

Anthem

Our story is no different than any family with an individual policy. To reduce our monthly bill to Anthem which right now is \$576.50 per month for 3 people, we have a \$5000 deductible per person. No wellness plan. So we only see a physician when absolutely necessary. Everything is out of pocket. In effect, our healthcare is rationed by high premiums and even higher deductible. In December Anthem will send us our annual rate increase, probably another \$100 per month. For that increase they have provided...\$0 in healthcare. I'm not sure what we will do. For a \$1200 rate increase you would think they could cover something to "insure" our health, like an annual pap smear, mammogram or physical. They are not insuring our health but ensuring we are unable to practice recommended healthy guidelines. Luckily we are physically healthy, so far. Financially, not so healthy. We want a public option so that all American families have options.

Danielle

Knox

Aetna

A couple of years back Aetna, my Federal Employees Health Insurance Company, refused to pay for a female ER doctor who treated me saying she was not part of their "network" when the Knox Community Hospital and the very first male ER doctor who treated me (who used to be my primary care doctor) was part of their "network." I had to appeal via FEHB appeal procedures and after much time and effort on my part, I got Aetna to pay up. I knew that Knox Community Hospital was part of Aetna's "network" but had no idea until I got the bills that the doctors were not under the hospital and were not in Aetna's "network." I hope and pray health insurance reform will fix this kind of problem.

Herb

Licking

Anthem

In the past, I have used a provider who is not on the preferred provider list and my insurance had delayed reimbursement of my payment to the provider by as much as 4 months. More recently, I have been reimbursed in a more timely manner, which I appreciate. I have also been able to find a provider for this specific medical service who is a preferred provider and have had little difficulty. The biggest problem I currently have with coverage is the amount I am charged for each service after meeting the annual deductible has increased dramatically for my son, who is on my plan. I cannot keep up with the payments for all the services provided him.

John

Franklin

Aetna

When my wife's employer switched from United HealthCare to Aetna to provide medical insurance, I had to find a new doctor because my primary care doctor was not under the Aetna plan. This happened about four years ago and I still have not found a primary care doctor with whom I am really happy.

Rebecca

Franklin

United Health Care

MY HUSBAND IS 75. HE IS AN INSULIN-DEPENDENT DIABETIC. HE GETS HIS DRUGS FROM UNITED HEALTH CARE WHICH REQUIRES HIM TO GET THEM FROM MAIL-ORDER COMPANY CAREMARK. IN JULY, CAREMARK FAILED TO SHIP HIS INSULIN UNTIL HE WAS TOTALLY OUT OF IT FOR 2 WEEKS. THEY SAID IT WAS AGAINST POLICY FOR HIM TO BUY EMERGENCY MEDICINE LOCALLY, BUT GOING WITHOUT INSULIN WOULD BE NO PROBLEM. WRONG! HE WAS ALSO OUT OF HIS BLOOD PRESSURE MEDS. HE LANDED IN THE HOSPITAL WITH A SEIZURE. THAT COST WAS COVERED BY MEDICARE, BUT IT WASN'T NECESSARY IF UNITED HEALTH HAD NOT DENIED ACCESS TO INSULIN

Colleen

Franklin

Aetna

I was diagnosed with tendonitis. The doctor and the pt agreed that administering the cortizone electrically would be the best action. This has been the normal care for this condition for years. The Aetna agreed to cover it and then said no. The treatment was "experimental". Then they lied about why they were not covering it. Then they delayed until it was past the appeal period. Then I just paid for it. Glad I didn't have cancer.

Ami

Fairfield

United Health Care

I am a 28 year old Type 1 Diabetic who works for a small business that does not provide health insurance. I pay for individual coverage through Golden Rule (part of United Health Care). I have had continuous health insurance my entire life, including when I was diagnosed at age 10 with Diabetes. I waited the obligatory year to have my pre-existing condition be covered, all the while paying premiums and purchasing my diabetic supplies and insulin. If I could do this for a year then Golden Rule would cover my Diabetes. So the "happy" day comes when they will cover my pre-existing condition and I go to the pharmacy to purchase insulin and my \$100 vial with insurance costs me \$98. I soon find out that the supplies for my insulin pump are not covered. Somehow, over the year I had to pay, the policy was changed. The sad irony is that Golden Rule Insurance does unto others whatever it pleases all the while cashing the checks!

Jeffrey

Franklin

United Health Care

"Rationing is what it's all about with health insurance companies. Otherwise, how would their executives be able to get those multi-million dollar salaries?"

My wife has five incurable diseases (MS, epilepsy, asthma, anemia, and a blood-clotting disorder). She is confined to a wheel chair with MS, and SHE CAN'T GET HEALTH INSURANCE.

I have to change her diapers, bathe her, prepare her meals, and lift her in and out bed and into her wheel chair. We were denied the aid of a Hoyer lift by an insurance company when I had health care insurance before I lost my job. The lack of support in lifting her takes a toll on my own health and well being as well as hers. I could drop her and cause potential hospitalization and further disability.

We lived in the U.K. for 10 years and had excellent health care with no waiting, no charge for any of Faith's medications, and no denial of service. Our doctor was right across the street from us, but we could have chosen another doctor if we were willing to walk farther. Our doctor made house calls.

What happened when we came back to the States?

\*denials by health care administrators

- \* doubling of the cost of Faith's seven medications during the time we were out of the country
- \* having to pay \$2,000 for a wheel chair when the company I was working for changed insurers
  - \* waiting two months to see Faith's MS doctor
  - \* long waits in doctors' offices
- \* rudeness and lack of basic organizational skills on the part of medical administrative staff

The U.S. does not have high-quality medical care, just too much of it for people with lots of money and NONE for 47 million people."

Karen

Franklin

No health insurance

"YES!... My healthcare insurance is rationed.... I DON'T HAVE ANY!

I believe it is positively immoral and despicable that the richest country in the world cannot offer healthcare to ALL it's citizens, especially it's WORKING citizens. My taxes pay for Congress's excellent healthcare insurance. This really sucks!"

David

Franklin

No health insurance

I have moved six times in the last ten years and been in and out of work. Health insurance should not be dependent on employment because if I am not working I will not seek medical advice since I will be trying to save money.

Steve

Franklin

Cigna

"I have a long-term health condition which the insurance companies, of course, consider a pre-existing condition. I tried ""shopping"" for an individual policy (because I don't work for a company that has a group policy). All the insurance companies have denied me coverage (no matter what price the policy or even if I tried to get a policy WITHOUT drug coverage). I even tried to get a policy with AARP and they denied me!

I am lucky enough to be a member of a professional organization who did offer ""good"" health insurance because they had a group policy from Cigna. After about a year, this organization sent me a registered letter stating that they had gotten into financial trouble in their insurance group and could no longer afford the current policy nor could they accept new members. They were going to drop the policy in favor of a ""cheaper"" policy from Cigna. Specifically, the new policy almost classifies as ""catastrophic"" insurance in my opinion. It has a deductible of \$5000.00, pays very little of drug costs, plus it has a very expensive premium. This year alone I will have to pay more than 1/3 of my income!. Also, the professional group (because of the fact they don't let members buy this insurance) is eventually going to lose its ""group status"" and have to quit offering this coverage (according to them).

I have since tried to get an individual policy from Cigna, but was denied it even though I have been with them for several years.

Looking back I still feel lucky to have gotten in ""under the wire"". However, I feel ""stuck"" with this insurance since I cannot go anywhere else and could lose it at any time!"

Sally

Franklin

Medical Mutual

When an MRI was recommended by the physician who read the x-ray of my spine my insurance company, Medical Mutual, repeatedly denied my doctor's office's request to schedule an MRI for me. After at least three tries by the doctor's assistant, the insurance company finally relented when I sent a well reasoned letter and attachments including the x-ray report recommending the MRI.

However, now that I'm on Medicare I can't get a bone scan to check my osteopenia to see if it's advanced to osteoporosis. That's not right either."

Gail

Frankli

n

United Health Care

My mother was unable to get therapy to swallow and also physical therapy after 5 weeks in a ventilator when United Health Care in a Medicare Advantage Program determined after one day she couldn't be helped. When I returned her to traditional Medicare she was able to get therapy and was able to swallow but by then it was too late.

Patricia

Franklin

Aetna

Yesterday my spouse and I went to a Walgreen to get an annual seasonal flu shot and were informed that we couldn't because Aetna Medicare would not cover it. When we called the representative at Aetna we were told it would be available after 10/01/2009. Although we could get flu shots at our physician's office, where we would pay a copay and be charged for an office visit in addition to the charge for the vaccine. We went early since the CDC and other govt. spokespersons urged everyone to get seasonal flu shots early and H1N1 vaccine in October. How does this save costs for Medicare and keep overall medical costs down?

Laina

Marion

United Health Care

My son is 22, in college, and living at home. He has Crohn's Disease. He is currently covered under his father's employer provided insurance. The day he turns 23 he will be dropped from that coverage. He cannot afford insurance on his own and will be denied anyway because of his Crohn's. I have no idea how he will be able to obtain the medication he needs to stay healthy, it costs up to \$3000 each treatment every 8 weeks, or pay for the frequent colonoscopies to check for colon cancer that his medication has been proven to cause. Help.

Gregory

Wyandot

Anthem

I have dealt with Blue Cross/Anthem for the majority of the past 40 years. I nor my wife were ever rationed any care. Although my wife had a serious illness, the insurance company always treated us fairly. The only issue we ever had were billing issues that were addressed by then.

This issue has improved over the years and I currently have no issues

Debby

Williams

Anthem

My daughter (now 27) reached the age where my husband's health insurance would no longer cover her. She is a very healthy college graduate, however, in her history she had seen a doctor for pain she had in her big toe. Because of this she has been denied coverage. I would really like Congress to tell me how she is supposed to find AFFORDABLE health coverage. If a 27 year old healthy girl is denied then I'm quite sure there are millions of people being denied. I DO NOT need a bill that requires her to buy insurance at some ungodly outrageous premium. It's time to hold the insurance companies accountable.

Heather

Lucas

Paramount

While I can't say my life has been put at risk, Paramount has intervened in ways that affect my health and that of my family.

My daughter had a malformed jaw that gave her not only orthodontic problems but problems with eating. We took care of the teeth through dental, although it did not come free. At first Paramount said it would pay for oral surgery to treat this malformity. The orthodontist put it on hold. A few years later, we went back to the oral surgery plan. This was denied, saying it was a cosmetic surgery. I remember arguing with them on a conference call that my daughter had problems eating. The officials still said, well, that's not life threatening, at least she was eating.

Maybe pablum and gruel weren't tasty, exactly, but it was still nourishment. Here I'm being slightly sarcastic, but the point remains, when something interferes with not only a life-sustaining activity as well as one's quality of life, it is not only cosmetic. Not to that extent. This wasn't about being beautiful, it was about being free to choose the items you eat. Well, once I told them they had approved the surgery before, the officials relented.

What about mental health care? My middle child is bipolar, mostly has Aspergers syndrome, plus a host of other issues. When she was little, there was nothing I could do but turn to the criminal justice system for help. Yes, there are private options, but not for the middle class. Then it's choosing a roof over the heads of your other children or putting all your resources into one child. A terrible choice for any parent to have to make.

As for me, I have chronic sinusitis. I have an infection once every three months or so, especially if I don't take a certain medication. The insurance company said it would not pay for this anymore because I haven't tried the lower costing drugs. Of course, I had, but not recently. So I tried the other drugs and remained ill. Not incapacitated, mind you. Just sick enough to be tired all the time, reliant on over-the-counter pain relief, and having trouble remaining clear and bright enough to do my best at my job. I have happily found the generic of this drug, and despite paying a higher cost, I can afford it and it works.

These stories aren't heartbreaking or reveal an insurance company out to kill. All in all, my insurance company has been good to me. But it comes at a price that is taking more and more out of my check that is getting thinner and thinner. I don't want to work just to have insurance.

I have other bills. My husband retired on disability and has high medical cost. My mother, a senior citizen, lives with me. The price of gas doesn't drop, utilities rise, credit-card bills become more punitive yet you can't rent a car or a hotel room if you don't have one, and groceries aren't free. And two years ago, my wages were cut 17 percent and my insurance premiums rose.

Is it any wonder the housing crunch crunched? Don't blame it on Americans who bought more house than they could afford. Why not put the blame on an economy that went up in flames before anyone noticed it? What about the people who could afford their homes but couldn't anymore because of rising health-care costs and wage reduction, or in some cases, wage elimination?

what about those people who dream of another career but can't because of fears about medical coverage?

Again, that isn't a choice between life and death. It's a choice that affects not only quality of life, but one's ability to life, liberty, and the pursuit of happiness.

Isn't that taking away our rights, more so than giving us an option to be liberated from oppressive health-care decisions? We are not free from that."

DEBBIE

Lorain

No health insurance

I was diagnosed with Multiple Sclerosis a week before Christmas. Prior to a year ago a lot of things were happening to me, that I could not understand; everything from my eyesight was going from time to time, my right side was going numb on me, and I was falling down.

A year later I am now on the expensive injections of Copaxone, I have to take one a day. In addition, I am on Baclofen, Neutrin, and Zolof.

This has changed my life forever. I was at a job that I had just received a huge promotion; from store mgr to district mgr, making over \$50,000.00 a year. I had things going for myself. Well, this has all changed now.

I ran out of FMLA, and was approved for longterm disability. I have applied for Social Security. I had no medical insurance, so I had to apply for medical for myself, and my then 17 yr old daughter. We were approved for CareSource thru Lorain County Human Services. I Thank God for that. Without it, I wouldn't be able to afford the medical care I need for my MS.

Thank You for taking the time to read this message. And, to everyone out there Thank You for helping this cause

Jane

Geauga

COBRA/QualChoice

In anticipation of our COBRA insurance running out on Dec 31, 2004, we enrolled in QualChoice, an insurance plan run by University Hospitals in Cleveland. Our health records were clean, and there was no trouble (at least, not much) getting catastrophic, \$5,000/\$10,000 deductible coverage for the 4 months before I would be eligible for Medicare. Qualchoice required that I start paying the \$550 premium in October, when the insurance was approved. On December I was diagnosed with ovarian cancer and operated on. This was covered by the COBRA policy. However, the first two chemo treatments happened in the gap period between COBRA and Medicare, and I assumed that they would be covered by our QualChoice policy. Wrong. In the Fall of 2005 we got a harsh letter accusing us of insurance fraud and demanding immediate restitution of the money QualChoice had paid on my behalf, about \$13,000. I had paid \$8,000 because of the high deductible and charges not covered by the policy. The hospital then billed us for \$57,000, the original billing price before the insurance settlement. We hired a good lawyer who got the hospital to agree to no more than the insurance company had paid. The lawyer said that the insurance company was within their rights to deny coverage, because the contract stated that we must inform them of any change in health status before coverage began on Jan 1, 2005.

Michelle

Lake

United Health Care

I was 46 years old when I got breast cancer with no family history. It was caught by a mammogram and yearly routine screening, which our insurance paid for. Neither I nor my doctor could feel the lump. Only the mammogram detected it and saved my life. Because my husband had excellent insurance at the time, I was able to see the best doctors at University Hospital in Cleveland and had a positive outcome. My husband lost his job in Cleveland in 2002 when his Fortune 100 company was bought out and closed. With that we lost our health insurance. We are not eligible for Medicare yet. We started our own consulting business and bought insurance through United Healthcare, which was one insurer who would take us because of our pre-existing health issues. (my husband is on high blood pressure medicine.) Needless to say, the cost is exorbitant. I continued to have good check-ups until 2003, when I had an angiosarcoma of the same breast due to the radiation treatment I had in '96. Less than 1% of radiation patients have this cancer. But, once again, early detection and an aggressive treatment saved my life. The recent downturn in the economy has resulted in fewer consulting business opportunities. To say we work for our insurance is the sum of it. I believe in affordable health insurance for everyone. And I support "wellness" healthcare to detect chronic illness in their earliest stages and foster good health habits.

Kevin

Cuyahoga

COBRA

I am a solo practicing professional and when income didn't materialize as projected and saw COBRA extensions were expensive, I dropped the insurance, knowing that it was a big risk. As income gradually grew, I added insurance for myself, but now with the economy in decline, may need to drop the insurance for myself as it is reaching \$250/month. There has to be a less costly way to do the right thing and keep insurance in place. If I drop the insurance and I develop a problem or get injured, the emergency room may be able to care for me, but the bills would be huge and even if I was only responsible for a portion of the bill, it would be a disaster for me and for the hospital swallowing a large bill. Health care is expensive. I am trying to be a responsible, working adult, but there has to be a better way to share risks and costs.

Devin

Cuyahoga

COBRA

Four years into a teaching career in inner-city Cleveland, I developed what was initially diagnosed as a partial seizure disorder, and later found to be severe Tourette's Syndrome.

When unable to work any longer, my only health care option was COBRA at a cost of \$1500 a month. All efforts to buy insurance were rejected due to medical history.

Additionally, having spent time working in public schools, and private schools, as well as outside of education, I found myself with not enough time in either Social Security or State Teachers' Retirement System to receive any sort of benefits, though together I had service time enough to qualify for benefits from both.

The system is broken on many levels.

Tom

Cuyahoga

Anthem

Because my employer-sponsor chose to change providers this year, I had the un-solicited option to choose from one of several new programs. Unfortunately, the one option that provided the coverage closest to the modest coverage I had last year would have cost me +\$200/month. But, fortunately, for only slightly more than last year's premium, I was able to "choose" a High-Deductible (\$4,500 In-Network/\$9,000 Out-of-Network), BCBS of Illinois Health Savings Plan Option, for ONLY \$900/month (\$10,800/year), to cover BOTH my wife and me. WHOOPEE!! I CAN'T WAIT TO GET ON MEDICARE! EVERY AMERICAN DESERVES THE RIGHT TO CHOOSE A PUBLIC OPTION!!!!

Kathleen

Cuyahoga

Medical Mutual

Unfortunately I have more than one story to share. First, several years ago my ex-husband didn't pay the COBRA payment and my son lost his health benefits. The poor child needed treatments for a condition being treated at the CCF. He was pre existed for two health conditions Asthma and Port Wine Hemangioma. After going through trying to buy health care for my child I know why people snap. It was one of the hardest things I had to do. Lucky for me Dennis Kucinich's office arranged for my son to get covered for a year under the Bureau of Birth Defects and Handicaps. How many people would know to do that?

Currently, I am a small business owner. One of my finest employees suffers from rheumatoid arthritis. My premium for the two of us went up to \$1800/month. Yes, a month. I tried to purchase a plan elsewhere and they laughed at me. No way do they want her on my plan. Now I am left to decide what to do. I can't afford that premium so should I fire her? If I do that she can't get health care at all. I can't fire my finest employee. Should I stop providing health care? I can buy it for me for \$400/month. It is because of her illness that my premium is so high. So I decided to go with HSA. We bought a plan through Medical Mutual with a \$5000. deductible. Even then the premiums are \$1000/month. I figured I am healthy I won't need it and she will have coverage. Three months after that I was sent to the hospital by a doctor who thought my ekg was indicating trouble. I was admitted, had a heart cath and many other tests only to find that my heart is great. No problems. Well, only one. It cost me \$5000. So now I am paying off a bill that I didn't even need to incur.

I am trying to employ people. I am trying to provide this area with a much needed service. We do a great job taking care of elderly people. Wouldn't it be a shame to close down because health care costs prohibit you from doing business.

Sergio

Cuyahoga

No health insurance

My family and I lost our health insurance in 4/2008. This has been extremely difficult for us as my wife lost her 2 jobs and my consulting work in alternative energy and nanotechnology is very sporadic. Our youngest son has Type 1 Diabetes and my wife has severe Asthma. I have quadruple Heart By-Pass surgery along with Gall Bladder, Umbilical Hernia, Back treatment and bad knees during the past 3 years. Medication is very expensive for us and it has been out of pocket payments plus help from family members. Plus my wife and I have cut back on a number of medications because we are unable to afford it. Also, we have been unable to have visit doctors because we are unable to afford it. Also, our son had a foot puncture injury during the 3rd of last Dec and was hospitalized for nearly 2 weeks. Fortunately he is better however the bills total nearly \$35,000 and we are unable to pay them. We "walk on eggshells" each day hoping and trying to get any jobs and possibly health care and hoping that none of us becomes ill.

Helen

Cuyahoga

Kaiser

Was with Kaiser for 20+ years. My premiums jumped to \$1100/month and at 60 years old, I had to find another health care provider. I am self employed and there is no financial assistance from the ""employer"". I now am on Medicare, and for the 5 years after I left Kaiser, I was without doctors that I liked and trusted and did not get the routine preventive health care i.e. mammograms, pap smear, blood work etc, because my deductible was so high.

Now that I'm on Medicare, I have to find doctors who will accept Medicare.

Carla

Cuyahoga

My husband, who had had a heart condition for 18 years and was experiencing heart symptoms, was denied a referral to a cardiologist by his internist. The internist (gatekeeper) was paid a bonus for NOT referring patients to specialists. Although he had insurance, for which we paid a high premium every month, my husband died of cardiac arrest without seeing a cardiologist. He was a smart, sweet, funny man, and he was only 60. This happened in 1997, and since then, things have only gotten WORSE. Anyone who defends our patchwork "system" of for-profit health insurance companies should be ashamed, because it is indefensible.

Louisa

Cuyahoga

Anthem

My Cobra runs out the end of July, 2009. I had neck surgery, a fusion, over a year ago, July, 2007, so I have a pre-existing condition. Fortunately, the Anthem insurance will cover me if it has been over one year. However, I am not able to be on any medications that are related to my neck surgery. I have to have been off of them for six months. I found this out on March 20, 2009, and stopped the Celebrex I was on. This means that when I need the new coverage, in August, I will have been off celebrex for only four months. That means that I have two months where I will have coverage for all but any neck problems. The coverage including my neck is too expensive (We are told \$2000-3000/month. I hate not having coverage for those two months because there is no knowing what could happen in that time. I think it is crazy that this is happening. I am 62 years old, married to a retired attorney and am the daughter of a doctor. I never imagined I would be a statistic.

Philip

Cuyahoga

Anthem

A few years ago, I suffered a severe asthma attack. Upon being discharged from the hospital, my Dr. wanted me to be in Pulmonary re-hab, but Anthem would not cover it. I made a

change to AARP and I was in re-hab within two weeks!

Marcia

Cuyahoga

United Health Care

Health Ins. costs for 2009: AARP United Health Care supplementary to Medicare: \$171.25 per month and the company will not cover anything Medicare doesn't cover. My fiance's costs (male, 59 yrs. old): \$495.50 per month. The insurance covers a portion of each doctor charge.

All doctor visits and services cost more than the ins. pays. We pay on every bill and every prescription. The problem is the ins. companies.

Cheryl

Cuyahoga

No health insurance

I have no health insurance. I owe for emergency visits and must borrow money for the doctor or dentist.

Jean

Fayette

No health insurance

I've been rationed - I don't have any health care nor can I afford to provide it to my two employees.

Barbara

Delaware County

At age 63 I applied for a Health Savings Account after I was laid off and could not afford COBRA payments. I was rejected for the Health Savings Account that I applied for. After that rejection, I was unable to get health insurance until I turned 65, and Medicare took over. I filled in the gap with catastrophe insurance which covered me for 6 months at a time with a \$2,500 deductible every time it was renewed. (Thank goodness, I haven't had any major health problems, and didn't have to make any major claims.) I think it was Golden Rule insurance that I applied to.

James

Cuyahoga

United Health Care

My son has C.P. and is wheelchair bound and in diapers.

My wife needed a heart transplant which she received on 5/15/2009.

Because of her condition she could not lift my son to move him from the bed to the wheelchair in order to change his diapers or to get him ready for school. In 2002 tried to purchase a voyager lift so my wife could take care of my son when I was at work. United health care rejected our claim and said that the unit did not qualify as durable medical equipment. I appealed and found out that the appeal process is the biggest joke in healthcare right now. After almost 4 months of dealing with the appeals process I finally purchased the unit on my own and then submitted a new claim the claim to United Health Care. Again the claim was rejected and I had to go through the appeals process. Thankfully my union representative stepped in and got United Health Care to approve the Voyager lift as durable medical equipment. However this was not until April of 2003 almost a year later.

Now 6 years later the Voyage lift I purchased has an electrical problem that requires the unit's replacement to fix. I have been fighting with United Health Care since May to receive pre-approval so we can purchase the unit. However United Heath Care again says that the Voyager lift is not durable medical equipment. The factory where I was employed for the last 12 years was closed in October of 2008; I currently do not have a job and cannot afford to purchase the unit on my own. Therefore our family has had to suffer with lifting my 15 year old 140 lb son in and out of bed to change his diapers while United Health Care executives swindle Millions of dollars in bonuses every year.

Debbie

Cuyahoga

I would really love to retire sometime in the next few years. As a public school teacher, I have fairly good health care for my family now. If I would retire, however, the cost of covering my family is so high that retirement seems out of the question right now. I know many teachers who would have retired already, but they were faced with the same dilemma. If the cost of health care were more affordable, more of us would retire, and that would open up more teaching jobs for others.

Liz

Cuyahoga

I'm executive director of a breast cancer advocacy group, Northern Ohio Breast Cancer Coalition Fund. Many of our members and clients who are uninsured or underinsured face impossible barriers when diagnosed with breast cancer and need treatment. In addition, growing numbers of survivors are experiencing difficulty purchasing affordable health care coverage, with many often facing 10 yr pre-existing condition restrictions and excessive co-pays and deductibles for prescriptions and testing for breast cancer follow up care.

Jeanna

Summit

Anthem

Any one who denies health care rationing is either lying or terribly uninformed. First it's rationed by poverty for those who cannot afford coverage. Then it's rationed by pre-existing conditions, by denying claims or by dropping coverage. Then it's rationed by raising premiums, as in my case. I dared to have very dangerous spinal surgery and then watched my premiums raise by 70% over the next two years. this despite the fact that my insurance reimbursed less than 1/3 of what the hospital billed. To be able to afford coverage, we now have a \$7500 deductible per person.

Of course we cannot change insurance companies because I now have a pre-existing condition. The people who have the least rationed health care are those on Medicare--a government program. I vote for Medicare for everyone.

Jacqueline

Wayne

WellPoint, Anthem, United Health Care,  
Cigna

All insurance companies have the criteria of what is "medically necessary" pick any condition and look it up on line aetna makes there's available to the public they determine what they want to pay for in response to rampant ordering of unnecessary whatever so doctors can make money not what is in the best interest of the patients doctors own hospitals infusion companies etc.... i know i used to work for a company that paid doctors for referrals so they could make more money and had to testify in a grand jury in columbus ohio

Eileen

Summit

No health insurance

I do not have health care. Every time I have been on unemployment I have not had health care. The last job I worked at the mental health doctor was not on the list of doctors the insurance would cover. In order to get the doctor on the list it would take SIX MONTHS to become a doctor on the care list.

Laura

Summit

Hometown

For me ... I was diagnosed with alopecia areata in the late 1990s. My primary care physician referred me to a dermatologist for two treatment visits plus ongoing care. The insurance company (Hometown) changed his referral to one consult without telling me or the doctor. I went for what I thought were permitted visits and found out when the bill arrived that care had been denied because alopecia (although it could have been related to a condition like lupus) was considered ""cosmetic.""

My son had severe asthma growing up and needed the care of a specialist to keep him from frequent hospitalizations. Every 6 months, I had to go to the primary care physician and request a referral for his checkup with the specialist.

Jane

Trumbull

WellPoint, Anthem, United Health Care

You probably noted I used a phony name and address. I am a licensed insurance agent who owns my own insurance agency specializing in individual and group health insurance. My first or last name or zip code would be recognizable by executives of the companies I represent. All commercial insurance companies ration care. They limit the number of chiropractic care visits they cover, the number of physical therapy visits, speech therapy visits, occupational therapy, cardiac rehab visits, home health care visits. If you have an accident and become a paraplegic, your insurance company will only pay for 40 physical therapy visits or less per year. That's less than 1 visit per week. Many require that patients go through less expensive sometimes ineffective treatments before they can get the test or treatment their doctor recommends. For example, someone with a knee injury can't get an MRI or expensive scan procedure which the doctor recommends until they go through weeks of alternative treatment. Insurance companies limit the amount of drugs people can get; a good example is viagra or other sexual dysfunction drugs. Regardless of how the doctor writes the script, people can't get more than 6 pills a month. All insurance companies raise peoples premiums if they have a lot of claims (get sick), whether it's individual coverage or group coverage. If a person with individual coverage becomes ill, they can't get coverage with another company because certain conditions make people uninsurable. So they are stuck with escalating premiums. In the group market, Medical Mutual makes a habit of "auditing" small groups whenever someone in the group becomes ill or has a lot of expensive claims. If the small group can't meet the "underwriting regulations" for small group coverage, Medical Mutual will cancel the group. I just had a group audited today. They have been with Medical Mutual for 10 years and were never audited. An employee's spouse had several expensive claims in the past 12 months, and suddenly their group gets audited. I have had Anthem audit a few groups, but Medical Mutual is the worst. Money is the driver of all healthcare. Insurance companies are profit driven organizations. They are simply operating to make money. Doctors, hospitals, and drug companies are just as guilty. I recently changed family doctor after my old doctor became rude when I asked her to make sure my pap smear was sent to a laboratory in my insurance network. When I left, the doctor handed me my pap smear in a paper bag and told me to take it a lab myself. When I called a new doctors office to get an appointment, their first question was "do you have insurance?" They won't take any new patients with Medicare or Medicaid. Why do doctors charge \$5300 for a procedure and then accept \$1800 from the insurance company? Labs charge \$30 to process a test and accept \$7. from the insurance company. Hospitals do likewise. We need to stop the gamesmanship. People should have the option of buying into Medicare if they need coverage. I'm 59 and my husband is 60. He was laid off 7 months ago. We are now on COBRA coverage. If he doesn't get called back to work, we may be unable to find coverage when COBRA expires. Conversion policies cost in the neighborhood of \$1700 per month per person and have very limited coverage. Who can afford that? We're both several years from Medicare. What if one

or both of us get seriously ill? We're using up our HSA account to pay COBRA premiums. We have a \$4000 annual deductible. We need the ability to buy into Medicare before age 65. Mandating that everyone has to buy insurance and funneling all the subsidy money to private insurance companies will do nothing but make the insurance corporations richer. Cooperatives and exchanges are not the answer and Dick Armey's Freedom works organization wants large deductible insurance policies so wealthy people can use Health Savings Accounts to shelter income from taxes. They want to wrest regulation of insurance away from the states and federalize it so they can write policies with even more limits and greater restrictions.

They claim these policies are the future of healthcare and will save money. It shifts even more expense to the policyholder. Low income folks can't afford to pay for \$2500 of medication out of their pocket before their insurance begins to pay. They also want to sell policies direct to consumers and eliminate agents such as myself who help consumers find and compare plans from several companies. Agents also help consumers navigate the maze of claim denials and make sure the insurance companies pay legitimate claims.

Megan

Mahoning

Anthem

When I sprained my ankle I had x-rays taken at the hospital in the emergency room. They were read there. When I went to my family doctor for my follow up appointment, his technician also read my x-rays. My insurance company would not pay for the "second" reading because they were the same x-rays. Even though it was a different doctor, and a different building.

Grover

Butler

United Health Care

The problem is more a matter of where the needed services were available. Due to the insurance company limitation on which hospitals were used, I had to go past 3 hospitals for my wife's surgery.

Nancy

Hamilton

Anthem

I have an individual account. I tried to get my teenage son on the account.

As an eight year old he was diagnosed with Asperger's syndrome. For the past 4 years at least he has not been on any medication nor does he see a therapist of any kind. He is a 3.5 average student taking 4 AP classes and very active in music and theater.

A number of years ago he had acne and used Accutane for six months. His complexion is now enviable.

He is essentially uninsurable on any private plan, despite the fact that his health is excellent. Except for routine checkups, he hasn't even been to the doctor's for several years, as he is extremely healthy. Nevertheless, the acne and Asperger's make him anathema.

Elizabeth

Hamilton

No health insurance

I have no healthcare to ration. I am a single mom with 2 kids and 3 quarters of a bachelors degree in political science at Xavier University. I had to stop going to school to work full time to support my family. I make 10 dollars an hour, and was recently denied state funded medicaid. About 6 years ago I was hospitalized for about 10 days with meningitis. Ever since I have been plagued with frequent migraines that are absolutely debilitating. My prescriptions cost over 600 dollars per month. Without them, I am not well enough to have consistent attendance at work. I must either work just to pay my healthcare costs and struggle even more to pay my bills, or quit working just to have medicaid, in which case I would necessarily also apply for foodstamps. I know it is not the MOST dramatic example, but for me it is an every day struggle. How is a single mom with 2 kids making 10 dollars an hour above the poverty line? We are very much in poverty, and that is without my healthcare costs. Thank you, Elizabeth

Sue

Hamilton

Humana

Humana does not have my very common prescription for migraine medicine (Imitrex) on their RX list and thus I can not get this medicine through the cheaper mail order and it is over \$100 per month (for 9 pills) at the local pharmacy.

Could not get an answer as to why when I had Humana insurance through previous employer (NKU) this drug was on the RX list but now under KY State Employee Retirement plan Imitrex is not on the list. Was told to ask my doctor for different prescription.

I have been taking this medicine for years and it works -- why should I have to experiment with new meds? Same company -- different rules & games.

Bonita

Hamilton

WellPoint, Anthem

Anthem made payments so difficult to my doctor, that he quit using them. The doctor is a surgeon who did reconstruction on a mastectomy I had to have because of breast cancer. I need to have some additional surgery done, and now I can't have him do it. He is a wonderful surgeon who repaired a botched up reconstruction from another doctor, and I do not want to change doctors. It is bad enough having to go through this, let alone have a trusting doctor that no longer wants to deal with your insurance company because of slow pay.

Brenda

Clark

I am a Social Services Coordinator for a small apartment building for elderly and disabled. Wednesday September 9, 2008, a tenant was scheduled for a procedure concerning his heart.

The tenant had been instructed not to take his heart medications for 6 days prior to the surgery. The day of the surgery, the hospital called and told him not to come in as his insurance did not cover the procedure. The tenant had been very ill due to his health issues for many months before the procedure was scheduled and for 1 year after he was denied services due to insurance coverage. He passed away exactly 1 year later on Wednesday September 9, 2009.

Greg

Hancock

Medical Mutual

My insurance company which is Medical Mutual of Ohio has been pretty good unless you call \$2,500 maximum deductible and a individual deductible of \$1,000 on top of paying over \$4,500 in premiums for my wife and I we had out of pocket medical payments of \$10,254 this year and our salary together is \$52,000 its every year they went from covering 100% to down to 80%. It's the deductibles and co-payments that are killing us. Medicare has been the ones who have denied claims for us since it is our secondary insurer they usually say is not needed when is a quadriplegic not needing a wheelchair and then what type of wheelchair is necessary? I am a teacher and need a stand up wheelchair to write on the board and keep pressure off my buttocks after having a stage IV pressure sore. Medicare has never been there for me to pick up the remaining 20% off the balance after my main insurance company has paid the 80%.

Donald

Allen

Anthem, Nationwide, Medical Mutual

I am 50 years old, and a family physician. Unfortunately, I was diagnosed with testicular cancer at 40 years of age. I have been cancer free and released from care. But, I was denied insurance from Anthem, Nationwide, and Medical Mutual due to this pre-existing condition. I even asked my present insurer Golden Rule to change my policy to a Health Savings account, but they denied that due to the cancer history, even though they have been my insurance carrier for 19 years!! I am stuck in a high deductible policy that I got 19 years ago!

Edith

Aetna

I am currently covered by my husband for health care, but due to high premium, both are switching to Medicare by the end of the year. I was pre-screened for health care acceptance via AARP Aetna and other individual insurance policies as COBRA is not an option. I was told I would be denied, because of back surgery 12/08 and that I was still under physiatrist care. The back surgery was extensive, but I have just started with exercise's on my own under her guidance, and I was told until I'm off the medication (Soma), and her care it will not be considered resolved.

Kathy

Cuyahoga

Anthem

When I was finally diagnosed with fibromyalgia, my doctor had no treatment that improved my condition. When I found a doctor who did have the expertise to help me, the Fibromyalgia and Fatigue Clinic was not in my plan. Thus, I pay cash. If I submit paperwork, often with more than one denial, and endless documentation the insurance company will reimburse me for 20% of the doctor visits. They will also pay for part of the prescriptions for hormone replacements, but not one dime for the prescribed supplements that actually allow my to improve my function and drastically decrease my pain. The supplements run approximately \$6,000 a year. All this expense is not even applied to my deductible. I am watching my debt rise as I try to pay the bills for my care. My Master Card was paid on time in the past. Now the debt is growing because of my fibromyalgia and the fact that my insurance pays for almost none of my care. This is a chronic condition. I am also newly diagnosed with celiac disease. Having autoimmune diseases is my way of life. There is no insurance that would cover my real bills. I am stuck paying cash or going into debt, while I have health insurance.

David

Anthem

My insurance company refused to pay for basic doctor-ordered xrays because they were performed at a hospital instead of a for-profit diagnostic company.

Donald

Franklin

Anthem, Medical Mutual, Aetna

Worked 35+ years in hospitals. Retired but too young for Medicare. I tried Anthem and they declined me coverage because I took a few generic meds. Medical Mutual of Ohio declined me for the same reason. Of course, being 62 does not work in my favor either with those saps.

Aetna approved me, but immediately doubled the rate that I had been quoted on the application, saying I was high risk. Well, my lab values are fine, have never been an inpatient, I jog 2.5 hilly miles every other day, and I am perfectly height/weight proportionate. I just have a pre-existing condition so I am not in their ideal pool of youthful applicants. They are not interested in care, they are profit hungry and that is what they "care" about. Satisfying stockholders and their golden parachute needs.

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