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UNCOMPENSATED HEALTH CARE COSTS FOR THE UNINSURED

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JULY 23, 1990

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UNCOMPENSATED HEALTH CARE COSTS FOR THE UNINSURED

MONDAY, JULY 23, 1990

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[Press Release No. H-42, July 12, 1990]

FINANCE SUBCOMMITTEE TO HOLD HEARING ON CARE FOR UNINSURED PROVIDERS' FINANCIAL COSTS, ABILITIES TO BE EXPLORED

WASHINGTON, DC—Senator Donald W. Riegle, Jr., (D., Michigan), Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, announced Thursday that the Subcommittee will hold a hearing on problems facing hospitals and doctors who provide care to the uninsured.

The hearing will be on *Monday, July 23, 1990 at 10 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

The focus of the hearing will be the impact of uncompensated care on the financial status of hospitals and other health care providers.

Riegle said, "Uncompensated care costs are threatening the availability and quality of health care in this country. Every day, and from every part of the country, I hear about a hospital or doctor that is having financial problems or cannot deliver needed care because of uncompensated care costs."

"This problem underscores the need for a national strategy for providing health care for all Americans," Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. Let me welcome everybody in attendance this morning and invite everyone who is here to find a seat. I want to welcome our distinguished witnesses we have here this morning that will be testifying before the subcommittee. I will introduce them at a later time.

Let me indicate that Senator Chafee very much wanted to be here this morning, but has an urgent matter in his State of Rhode Island that required his attention. He had to be there this morning and expresses his regret that he cannot be present for this hearing.

Today, we are going to examine the problems that are faced by health care providers, the people who provide our health care, and especially to those in our society who have no health care coverage or no insurance. We are finding across the country that uncompen-

sated health care costs are threatening the availability of health care in this country. This has an implication for every citizen.

No matter what someone's personal circumstances, at any given time, they can find themselves in a medical emergency situation. If it happens that they are not able to get the kind of care they need and to get it promptly, lives can and are lost. This situation is becoming an ever more threatening problem throughout our country.

Each day, from every part of the United States, we read about a hospital, a physician, or a clinic that is facing financial problems or other difficulties in delivering needed care. Our witnesses today—hospitals, doctors, and clinics—from across the country will testify to the pervasive nature of this problem and the financial and social impact on these providers of health care services.

Clearly, the adverse impact of uncompensated care on our health care system underscores the need to develop a national strategy for providing health care for all Americans. In the last decade, the amount of uncompensated care reported by hospitals has been rising. In 1988, the United States had net costs for bad debt and charity care, less government appropriations to help, in excess of $8 billion or almost 5 percent of hospital expenses. Compared to 1980, just a decade ago, these costs have more than doubled.

In Michigan alone last year, hospitals lost $350 million providing care for those who could not or would not pay their bills. Physicians also appear to be providing more uncompensated care, although the evidence there is harder to accumulate. Conservative estimates show that 18 percent of all physicians provide some uncompensated care to patients outside their own practice. In addition, free or reduced-fee care, lowered physician billings by almost 12 percent.

Shifting costs of uncompensated care over to private payers drives up the cost of private health insurance so that every citizen in the country or every business that provides health insurance for its workers are finding that those rates are going higher, and higher. These increased rates reflecting the cost of the uncompensated care is the focus of the hearing today.

It is estimated that private payers were charged at least a 10-percent surcharge or a hidden tax on hospital services. In the highly competitive health care market a hospital's ability to cost shift—as the phrase is used—lessens, decreasing its capacity to provide care to the medically indigent.

Ultimately, the financial distress of hospitals and doctors that provide large amounts of uncompensated care threatens the quality and the availability of this care. In fact, it is beginning to shut down hospitals all across America, as well as reduce the number of doctors providing care, particularly in the areas where the care is most needed.

In many communities, the hospitals with the greatest burden of uncompensated care are facing severe financial hardships. In order to continue operating, many of these institutions have had to reduce their staff and their services, and some have had to close completely. Last year it was reported that 65 community hospitals closed and a total of 508 community hospitals closed between the years of 1980 and 1989. These hospitals are being forced to close for

a variety of reasons, but a contributing factor is the lack of or inadequate payment for services.

We are finding, particularly in some of the urban hospitals that I have visited, with the large amount of care that comes in through emergency room services, that some of those hospitals are finding the pressures and the costs involved are so extensive that they have had to close those emergency services. And sometimes an ambulance that is carrying a person in an emergency status finds that it cannot even go to the nearest hospital because the situation is such that the patient load at that hospital is so high that another patient cannot be handled.

We also have community health care clinics throughout the United States serving many uninsured people that are also facing severe financial difficulties. These clinics are in underserved areas and serve primarily uninsured people or patients on Medicaid. Therefore, they have no private payers to shift the cost to, thus the burden on them is particularly extreme.

I think it is clear, how ever one looks at this, that our current health care system needs reform now. This hearing is part of an ongoing effort by this subcommittee to solve the problems of the 37 million Americans who have no health insurance at all. A bi-committee, a bi-partisan Senate working group on universal access to health care has been working since last July to develop a solution that will provide universal access to health care and at the same time control rising health care costs.

The Senate working group has compiled a document of the options that the group has been considering. In developing our proposal, we intend to draw on the data and the recommendations of individuals and organizations having an interest in health care issues. Now, more than ever before, this country needs a national strategy for reforming our health care system. With key experts on health policy in the Senate, together with the help of individuals and organizations with a direct interest and involvement in health issues, I think we can and we must accomplish the goal of universal access to affordable and high quality health care in this country.

Today we have two panels we will be hearing from. The first, representing hospitals across the country, bring to the attention of the American people and of the Senate, the extreme problems that are being faced from these circumstances I have just described. Our first panel represents three hospitals that have large amounts of uncompensated care that they are struggling to deal with. They will discuss their hospital's experiences in providing care to the uninsured and the impact of uncompensated care costs on their ability to provide needed care.

Let me invite them to come to the witness table at this time. They are Mr. Edward Thomas, Barbara Lord Watkins and Lawrence McAndrews. Let them get seated and then I will give you the background on each of our witnesses.

Mr. Thomas is president of the Detroit Receiving Hospital and the University Health Center in Detroit, MI. He is also chairman of the Corporate Board of the Michigan Hospital Association.

Barbara Lord Watkins, Ms. Watkins, is vice president of public affairs and human services at Parkland Memorial Hospital in

Dallas, TX. She is here representing today the National Association of Public Hospitals.

And finally, Mr. Lawrence McAndrews is president and chief executive officer of the Children's Mercy Hospital in Kansas City, MO.

I want to say that Senator Danforth hopes at some point to be present and to be part of the introduction of Mr. McAndrews to the committee.

They are three outstanding witnesses. Before you start, we will make your full statements a part of the record and we would like you to go right to the points that you feel most strongly about. I hope that in the course of your remarks you will help everyone understand the nature of the problem when you have a hospital offering medical services and somebody shows up with an urgent health problem that demands immediate attention; and the problems you face when that individual has either no health insurance or no money to pay for those services, but is there on your doorstep with a critical problem. It can be a parent with a sick child; it can be an adult in an automobile accident; it can be somebody with an extreme health problem of some other kind. When you are confronted with that problem, as you are each and every day, I think we need to understand the dimensions of it; what the financial consequences are and what it is doing to our whole hospital system.

So, Mr. Thomas, we are very pleased to have you and we would like to have you start.

STATEMENT OF EDWARD THOMAS, PRESIDENT, DETROIT RECEIVING HOSPITAL AND UNIVERSITY HEALTH CENTER, AND CHAIRMAN OF THE BOARD, MICHIGAN HOSPITAL ASSOCIATION, DETROIT, MI

Mr. THOMAS. Thank you, Senator Riegle; and good morning. I am Edward Thomas, president and chief executive officer of Detroit Receiving Hospital and University Health Center in Detroit, MI. I am here today not only as the Administrator of a large, private, not-for-profit urban hospital but also as the chairman of the corporate board of the Michigan Hospital Association which represents 187 Michigan hospitals.

My comments will be specific regarding my hospital's experience in caring for the uninsured. I will also characterize problems encountered by all Michigan hospitals.

Detroit Receiving Hospital is a 340 bed emergency trauma hospital. It is a subsidiary of The Detroit Medical Center, the Academic Health Center of Wayne State University. It has been the designated hospital, or hospital of choice, for Presidents of the United States, the Pope, and other dignitaries visiting Detroit. It was the first hospital in the State of Michigan to be recognized by the American College of Surgeons as a Level One Trauma Center. Detroit Receiving specializes in the care of the seriously ill and injured, with no elective admissions.

Located in the inner city of Detroit, our facility treats a high percentage of medically indigent persons. This is an essential part of our mission. We are often characterized as a private hospital with a public mission; and for those without adequate health insurance,

a hospital of last resort. Of approximately 10,000 hospital admissions, annually, 23 percent are not reimbursed by any insurance program. Out-patient care for medically indigent persons has a higher percentage of uninsured, namely 40 percent.

All in all, Detroit Receiving Hospital loses more than $30 million annually in the care of the medically indigent. Assuring health care for the uninsured is a humanitarian imperative and a public good. The abandonment of the uninsured is becoming a societal disgrace and a financial disaster for many hospitals. Worse yet, we are forcing the uninsured, many of them the working poor striving for dignity, to become health care beggars.

Until now hospitals have served as the safety net for those without insurance, but hospitals can no longer sustain the burden alone.

In Michigan the situation has become particularly acute. There are more than 1 million citizens in the State of Michigan without health insurance. More men, women and children in Michigan are uninsured than are covered by Medicaid, the health care program for the needy. It is no longer cracks in the health care coverage for citizens that Michigan hospitals are trying to cover, but gaping holes.

In the 1980's the number of uninsured in Michigan exploded. Hospitals provided $92 million in free care in 1980. By the end of the decade that number had jumped to $350 million. A substantial portion of the patients at Detroit Receiving present problems reflective of the social milieu found in other major cities—interpersonal violence, drug abuse, lack of primary health care, and unemployment.

Some typical cases treated at Receiving illustrate the enormity of the problem. A 23-year-old male transported by the emergency medical service, suffered from multiple gunshot wounds to the lower part of his body, leaving his left leg without sensation or movement below the knee. Bullet wounds were found in his thighs, knees and lower legs; x-rays showed a fractured femur of the upper leg. In his third surgery, 7 days after admission, he required amputation of his left leg above the knee. His hospital stay was 22 days. The hospital charges $76,866. Hospital reimbursement: zero.

A 34-year-old male was admitted complaining of malaise, fever, cough, headache, nausea, chest pain, diarrhea and a skin rash. He had no significant past medical history except for a 5-year addiction to heroin. He was admitted to an acute medical unit. Examinations revealed pneumonia, endocarditis and kidney failure. His cardiopulmonary status deteriorated. As a result he was transferred to a medical intensive care unit. After 30 days he was discharged for follow-up in the general internal medicine clinics at Receiving. The hospital charge: $89,481. Hospital reimbursement: zero.

A recent series of articles in the Detroit News and the Detroit Free Press noted that area primary care physicians commonly refer their uninsured and underinsured patients to Detroit Receiving Hospital clinics. Detroit Receiving Hospital is identified as having the only specialty physician group readily accepting the referral of these patients. Also, emergency patients are inappropriately transferred to our emergency department by other hospitals,

in spite of new rules and regulations governing referrals of this nature. The common denominator in all of these cases is that the patients are uninsured or underinsured.

In the 1980's, significant attempts began to be made to reduce health care expenditures. Employers limit dependent coverage, restrict employee eligibility and reduce categories of covered services. Large purchasers use their clout to negotiate lower insurance premiums and reduce payments to hospitals and doctors. Insurers increased their efforts to ensure that their payments to hospitals cover only their insured population. Few remain willing to help subsidize care for the uninsured.

As a result of this unwillingness to share the burden of the growing uninsured population, hospitals lost revenue that helped them offset these losses while providing care for the uninsured. By the end of the 1980's, three-quarters of all Michigan hospitals were losing money providing patient care. A significant portion of those losses was directly linked to the care of the uninsured. Daily losses now total a staggering $1 million a day for hospitals in the State of Michigan. Twenty-three hospitals in my State have closed since 1980, mainly due to financial failure.

In addition, Michigan has the highest medical liability rates for hospitals—some $4,000 per bed higher than the national average. Medicare pays only 89 cents per dollar of care provided by Michigan hospitals. Medicaid payments were so low—just 79 cents per dollar of care provided—that Michigan hospitals in 1989 sued the State in Federal court and won. Yet, since the Federal judge issued his order, State government, while increasing payments to some hospitals, has significantly cut payments to hospitals providing a disproportionate share of uncompensated care.

Taken alone, Michigan hospitals might have been able to absorb the cost of the uninsured, or the underfunding of Medicaid, or the unrealistically high medical liability rates, or the problems of AIDS and drug abuse, but not all together. Health care, like education, housing and employment is a basic human need. Concern for health care issues cannot be separated from other fundamentals. Access to health care is an integral part of Michigan and the nation's future and economic health.

Regrettably the United States is the only industrialized country in the world that does not assure all of its citizens access to some minimum or basic level of health care. Those who see only higher costs while examining the problem of the uninsured ought to examine closely the social and economic failures caused by our present approach. Our credibility and survival, and the health care and well being of millions of Americans, will remain in jeopardy until we rationally and realistically solve the problems of health care for the uninsured.

I wish to thank you, Senator Riegle, and the committee, for the opportunity to make this presentation.

[The prepared statement of Mr. Thomas appears in the appendix.]

Senator RIEGLE. Thank you, Mr. Thomas. Those are very powerful statistics and very alarming statistics. I want to go to our next witness. But before doing so, when you say that Michigan hospitals as a group are now losing $1 million a day, how long can this go

on? In other words, are we not exhausting the financial reserves that have been built up over several years in these hospitals? And are we not going to see more and more hospitals closing?

Mr. THOMAS. I would say that is a trend that is alarming, but it is realistic. Many say that the system is collapsing. I would agree with that without any change in that particular trend.

For example, over the years Detroit Receiving Hospital has been able to build up reserves. We have funded depreciation in the amount of $58 million. But when you are losing $30 million a year in uncompensated care——

Senator RIEGLE. You have a year and a half.

Mr. THOMAS [continuing]. You got a year and half to go. Correct.

Senator RIEGLE. At that point when you end up exhausting your financial reserves, as important a hospital as you are, and as a prime trauma center, what happens? If nothing has changed and we get a year and a half down the road and your reserves are exhausted, how do you cope with those kinds of losses?

Mr. THOMAS. Without the resources of Receiving Hospital being available to the community I would suggest that the mortality rate, people dying in the street, will exacerbate significantly.

Currently many of the other fine trauma centers in Michigan, and particularly in Detroit, are incurring, as you mentioned earlier, the circumstance of closure to emergency medical runs—Code One, specifically—where it is a life threatening or limb damaging condition. This is happening with a degree of frequency that is unacceptable.

If you take Detroit Receiving off line or you take some of the other major trauma centers off line, I think the health care of the citizens in Detroit, Wayne County, and the State of Michigan will be jeopardy.

Senator RIEGLE. When you examine the situation in our major cities—Detroit, or New York, Chicago, any of the major centers—all hospitals are experiencing similar problems. I also find in our rural areas in Michigan and across the country, that the rural hospitals are being ground down the same way. They are finding that their financial resources are being depleted and they are having to trim back. As they trim back to try to keep afloat financially, they become less and less able to be viable as an institution. And, of course, then the community is not served.

If someone has a serious health problem and they have to be driven 200 miles or more to get to hospital care, often times lives are lost just within that period of time. We are seeing this, not just in our major urban centers where it has one kind of extreme profile, but we are also seeing it in the rural hospitals.

Mr. THOMAS. It is very critical, especially in the rural area where the hospital or the provider is the sole provider in that particular community. When you are suggesting that it is reasonable to expect the population to accept the serving of the patient who is in a critical condition by transporting 50, 60, 70, 80 miles I think you are dealing with disaster.

Senator RIEGLE. One of the most important aspects of this hearing today is that I do not think the American people today realize that we have this crisis building up in our hospital system and that it is being created in large measure by the lack of health insurance

for so many people in our society. If our hospital system does crumble that affects everybody, even if the person who has the health insurance. If that individual cannot get to a good hospital and get the services they need, their health insurance may not mean anything to them. They can end up losing a loved one or losing their own life in an extreme situation even though they have the health insurance. Isn't that right?

Mr. THOMAS. That is very true. We experience that probably more so than many other hospitals. While Detroit Receiving Hospital's patient population—80 percent of whom are reflective of the population surrounding our Center—we certainly serve many people with insurance. But when the emergency service is backlogged, intensive care units are filled, we too must close. We too must compromise a patient's condition by the fact of just bringing the patients in.

So that is true. I think access is not only a problem of the uninsured, but access will be a problem of the insured population too as we wind down and put unreasonable constraints on the availability of needed services.

Senator RIEGLE. I want to ask you one other question before going to Ms. Watkins. I am hearing more and more stories and cases of people who are in an emergency situation, they are picked up in an ambulance; and it can be as a result of a heart failure or it can be as a result of an automobile accident or whatever the circumstances are. There can be so many people in that situation at one time that the emergency rooms are not adequate to handle the load of emergency patients that are in ambulances trying to get to the hospital for emergency care. This is, in part, due to the shrinkage of the system, the fact that some hospitals are closing their emergency rooms because of these financial problems.

Is it accurate that we now have situations with greater and greater frequency where you actually have somebody in an extreme situation in an ambulance trying to get to a hospital and have difficulty even finding a hospital that can take them at that particular moment? Is that an accurate situation?

Mr. THOMAS. That is a very, very accurate situation. It is accurate and it is unfortunate. I am sure the emergency medicine staff at the various hospitals are very cognizant of that problem. They attempt to make decisions that will not compromise that patient.

In our area the emergency medical technician who has the patient in his vehicle or so has assessed the patient, is in contact by radio with a senior physician at the trauma center. Certainly have the ability to override some of the closing situations. But even in the overriding of the "closure" it is not good for the patient.

I think demand is outstripping the supply, especially in the trauma emergency area. It is all one of finances or lack of.

Senator RIEGLE. The reason that I take the time to point this out is that somebody can be in a major urban center with the best health insurance plan in the whole world.

Mr. THOMAS. True.

Senator RIEGLE. And think they are in great shape. They are traveling down the road, somebody runs a red light, and they are in an accident and they or members of their family are in an extreme condition. The ambulance comes and picks them up. Even

though they think they are protected, if we do not have a viable hospital system out there that is properly financed and in a position to be able to handle them and others in similar situations, they can find that their health insurance is not worth anything.

Mr. THOMAS. That is very true.

One of the problems is, it goes back to an access problem, especially for the uninsured who are using the hospital emergency services as their primary care source. That causes a tremendous strain in taking care of the kind of patient that you are talking about. The capacity is not there. I would say 60 percent of the patients who present—and we are talking about over 200 patients a day at Detroit Receiving Hospital—are not emergents, but they have no access to health care in any other environment.

Senator RIEGLE. Right. That is a key point that I want to get into as the day progresses. I appreciate what you have said. I know you may be under some time pressure later this morning. I hope you will stay as long as you can.

Ms. Watkins, I—probably like many other people when I introduce you and say Parkland Memorial Hospital in Dallas, TX—am reminded of the time when the late President Kennedy was brought to your hospital for emergency treatment, that terrible occasion many years ago. Your hospital, for that reason among others, obviously brings back some very strong memories.

We are delighted to have you here today and are very interested in hearing what your experience is in Texas these days and how that would relate to what we have just heard from Mr. Thomas.

STATEMENT OF BARBARA LORD WATKINS, VICE PRESIDENT FOR PUBLIC AFFAIRS/HUMAN SERVICES, PARKLAND MEMORIAL HOSPITAL, TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, DALLAS, TX

Ms. WATKINS. Thank you very much, Mr. Chairman. I am Barbara Lord Watkins, and I am vice president of public affairs and human services at Parkland Memorial Hospital in Dallas, TX. Things have certainly changed since the dreadful days when President Kennedy was brought to Parkland Hospital. But I am here this morning representing not only Parkland Hospital but the National Association of Public Hospitals.

NAPH consists of 90 public and non-profit hospitals that serve as major referral centers, teaching hospitals and hospitals of last resort—the safety net hospitals. These are hospitals for the poor of our nation's most metropolitan areas.

I am pleased to have the opportunity this morning to discuss the impact of current health insurance policy on hospitals. But in order to place this discussion in context permit me to begin by describing the current situation of major metropolitan area safety net hospitals nationally, and more specifically the situation at Parkland Memorial Hospital.

America's "safety net" is comprised of a surprisingly small group of hospitals in our nation's metropolitan areas, perhaps no more than 200 to 300 in all, out of 6,000 hospitals nationally. While there are a number of non-profit teaching and community hospitals within this network, the majority are government supported hospi-

tals. These include city and county hospitals, State university hospitals, and hospital districts, such as Parkland Memorial Hospital.

Parkland is a public tax-supported teaching hospital serving Dallas County, TX. Parkland is the region's only Level One trauma center and Parkland provides a number of other highly specialized, but unprofitable services, including pediatric trauma and high-risk maternity care. Approximately 70 percent of our patients qualify for charity care. Our budget for 1990 is——

Senator RIEGLE. What percent did you say?

Ms. WATKINS. Seventy percent.

Senator RIEGLE. Seventy percent?

Ms. WATKINS. Seventy percent of our patients qualify for charity care. Our 1990 budget at Parkland is $230 million—56 percent of our income comes from property taxes. So you can see, we do have a high volume of uncompensated care.

Public hospitals, though few in number, provide a huge volume of care and that volume continues to increase. In 1988 NAPH hospitals averaged over 18,000 admissions per hospital. Short-term acute care hospitals nationally average only 5,600 admissions per hospital. At Parkland Hospital we admitted almost 40,000 patients last year.

Parkland Hospital has the largest birthing center under any one roof. We deliver a baby approximately every 30 minutes, with an average of 15,000 births a year. We also provide a disproportionate share of out-patient services, having over 140 general and specialized clinics.

In 1988, by comparison, NAPH hospitals averaged over 211,000 out-patient visits as compared to an average of 48,600 visits for other urban community clinics or hospitals. Parkland, by comparison, recorded 385,000 out-patient visits last year. Combined with our emergency visits, Parkland had over 545,000 visits last year.

Parkland Hospital also provides many specialized services that are unprofitable and consequently are not offered by other hospitals in the community. The cost associated with the provision of such care can be overwhelming.

For example, many intercity trauma centers provide a high proportion of uncompensated care associated with gunshot wounds and other victims of violent crime. The cost of such treatment is high and most often patients have no insurance or other means to pay for this care. Much of the trauma, as you well know, is drug-related.

A recent NAPH survey on trauma care showed that NAPH hospitals collected an average of 48 cents on the dollar for trauma patients. Parkland receives an average of 30 cents on the dollar for trauma patients.

Public hospitals also provide a disproportionate share of AIDS treatment. At Parkland we treat 1,200 patients with AIDS per month. Sixty percent of Dallas County AIDS patients are treated at Parkland Hospital. Just 58 NAPH member hospitals treated almost 7,800 AIDS in-patients. NAPH members provide an average of 1,427 out-patient visits for persons with AIDS in 1988.

Twenty-six percent of AIDS patients were described as "self-pay" or other in a survey done by NAPH in 1988. At Parkland I can verify that a significant percentage of AIDS patients are nonpay-

ing. Less than 12 percent of Texas AIDS patients qualify for Medicaid. Our annual budget for the care of AIDS patients is $9.6 million.

We have been able to maintain the service and provide the care, but I need to let you know that with the Texas economy, and with our shrinking tax base, we will probably no longer be able to provide the kind of care that we have been able to provide in the past unless there is some relief.

Senator RIEGLE. May I just ask you on that point, Ms. Watkins, when you raise taxes locally to try to provide the money to pay for the hospital services and so forth, do you as we do in Michigan, have to go out periodically and put these issues to a vote? Do you actually have a referendum where an increase in the tax millage has to be put to the voters and they have to vote on it in order for the amount to be raised? Is that how it is done?

Ms. WATKINS. Senator, in Dallas County the hospital district submits a budget to Commissioner's Court and our tax rate is approved by a Commissioner's Court. Our 1991 preliminary budget has been developed. We will be going to the court in early August for their approval. Our fiscal year begins in October. In order to maintain services as they are right now we are going to have to ask for a substantial increase in our budget.

Traditionally, Commissioner's Court has not increased the tax rate over 8 percent. However, a significant increase may be necessary if we are to maintain services as they are present being provided.

Senator RIEGLE. And to the extent that you do not get it—you finally reach a ceiling in terms of what the voters feel they can contribute in the way of taxes or the Board as the intermediary feels that they can afford to give the hospital—you are going to have a situation where you are not going to be able to treat some people. Isn't that the bottom line?

Ms. WATKINS. That is absolutely correct. There are——

Senator RIEGLE. You are going to have people—in the phrase of Mr. Thomas—you are going to have health care beggars. In effect, you are going to have some who desperately need help. If we get into the extreme case where we have individuals who are not going to get care, there is not going to be enough help to go around. Isn't that where we are headed?

Ms. WATKINS. Exactly. As the number of charity and uncompensated patients increase, the hospital district is going to have to make decisions on what services we can continue to provide. We are going to have longer waiting lines. Emergency rooms will become deadlocked making diversion a norm. Like other NAPH hospitals we are the "safety net" for health care in Dallas. We cannot say no, do not enter our doors.

Senator RIEGLE. Let me just ask you one other thing because you are here representing the National Association of Public Hospitals. I take it that what you are describing specifically, what you are facing at Parkland Hospital in Dallas, that these conditions would be similar to what other hospitals throughout the country and urban areas are also dealing with within the National Association. Is that your testimony?

Ms. WATKINS. That is correct. As more and more trauma centers are being closed, we are finding that our metropolitan cities are left with one trauma center available to take care of the increasing number of persons who must have access to the care provided by these facilities.

At Parkland Hospital we have found that we have been on diversion more times this year than we care to. Simply stated, the system is on overload. There are more medicine ICU beds available.

Senator RIEGLE. When you say diversion, that means somebody calls in—an ambulance calls in or a rescue vehicle calls in—and they have somebody they want to bring but you cannot handle them at that point?

Ms. WATKINS. This means there is no medicine ICU bed available.

Senator RIEGLE. So diversion means they have to be sent somewhere else?

Ms. WATKINS. Exactly.

Senator RIEGLE. And hopefully, there is some other place they can get to in time that gives them the trauma care that they obviously desperately need. So diversion means you are saying, "Look, we are loaded to capacity. We cannot take anybody else even if they are in an extreme condition."

Ms. WATKINS. That is exactly what it means. There have been instances when all hospitals in the metropolitan area of Dallas, have been on diversion. They have been on "Red Alert."

Senator RIEGLE. What is so important to understand here is that this condition poses a risk to every citizen. Every citizen is put at risk in that kind of a circumstance because anybody can end up needing emergency care. The wealthiest man in Dallas can be in an automobile accident and be loaded into an ambulance and if there is no room at the hospital, all of his health insurance and his wealth isn't going to mean a thing to him.

I think what we have to try to get across is the risk to the public as a whole. This condition is a risk that in effect creates a risk for all of us. There is the humanitarian aspect of wanting to make sure that the person who desperately needs the help gets it, but it is also important to understand that at any given moment any of us may need that help. If it is not there in a sufficient way, that problem can become, in an immediate sense, our own problem. It can be our own child that is in our arms, desperately needing care, and finding that the care is not available at the moment that your own child needs it or your own spouse needs it.

I do not think America should or wants to be in that position. There is no excuse for us to be in that position. We are a wealthy enough nation that we do not have to put ourselves in that kind of a risk posture and an intelligent nation just does not do that. I do not think a humane nation does it either.

I think our tradition as a society is, if we see somebody by the side of the road that needs help we stop to help that person; we do not just drive on by. So, if that person needs trauma care, we want that person to get trauma care. But if we have a condition developing in the nation because we haven't paid attention to the need to have a broad-based health care system where the costs are compen-

sated properly, we can end up in a situation where we, without thinking about it, have allowed every citizen to be potentially put at risk. It seems to me that that is the problem that we are facing here.

Ms. WATKINS. You are absolutely right, Senator. And unless there is some relief for hospitals that are providing that kind of care you are going to find more and more that medical care will be unavailable for those who can afford it.

The cost of readiness for a trauma center is exorbitant. A trauma center has to maintain everything as if it were prepared to accept the worst on 24-hour, 7 day a week basis.

Senator RIEGLE. Your own case, the President of the United States, years ago was admitted in a desperately serious situation. There is no more powerful illustration than the hospital that you work for.

Ms. WATKINS. And we were prepared, as we are now. The question is: Will we be prepared 2 years from now? Will we be prepared next year to do that? Every citizen deserves the right to assume that a trauma center that has been so designated would be prepared to take care of their emerging medical care.

Senator RIEGLE. I stopped you in the middle of your statement. I want you to go ahead and finish and then we will go ahead to Mr. McAndrews.

Ms. WATKINS. Senator Riegle, I want to talk about drug and alcohol abuse because public hospitals provide a significant amount of care for drug and alcohol abusing patients, especially care for cocaine-involved infants. In 1988, 43 NAPH hospitals treated an average of 104 cocaine-involved neonates; in the first half of 1989, these hospitals cared for an average of 61 babies. The average length of stay for these babies is 7.8 days. At Parkland Hospital between 18 and 20 percent of our pregnant women are alcohol or drug abusers. We have seen a 20- to 30-percent increase in the number of newborns requiring intensive care in our special care nurseries.

The care for a baby in the intensive care nursery is $1,500 a day. Almost all of this cost is uncompensated. As a result, most of the gains we have accomplished through prenatal care are now being lost to drug abuse.

As the preceding data indicates, uncompensated care represents a major financial commitment by public hospitals. In order to provide this level of care, public hospitals are heavily dependent upon Medicare, Medicaid, city, county and State funds. Even with these funds a large number of public hospitals are reporting operating deficits.

In Texas, approximately 80 percent of the uncompensated care is provided by roughly 10 percent of the State largest urban hospitals; and this, of course, includes Parkland Hospital. One of the best solution to the current crisis is to expand health insurance coverage. Congress must move quickly to achieve the goal of universal health coverage and towards that end should enact special legislation expanding employee coverage.

Specifically for Medicaid, as a first step, Congress should maintain and improve access to hospital services covered by Medicaid. By expanding eligibility the burden of uncompensated care will be reduced.

In addition, I would like to urge consideration of the following: Mandating a meaningful disproportionate share of payment; mandating out-patient disproportionate share of payment where States will be required to provide an adjustment to Medicaid for out-patient services provided to individuals by disproportionate share hospitals; increase support for AIDS. AIDS is becoming a disease of the medically disenfranchised including the uninsured, the underinsured, poor children and drug abusers.

Improved Medicaid support is required if the handful of urban hospitals treating AIDS patients are to abort financial ruins. In this regard, we urge Congress to seriously consider the legislation introduced by Congressman Waxman and Senator Moynihan requiring States to make a Medicaid payment adjustment to hospitals with a disproportionate share of inpatients with AIDS.

Further, we would like Congress to continue to permit States to take advantage of all available funding sources and we would like Congress to prohibit States from imposing fixed durational limits on medical necessary in-patient hospital services.

Finally, relating to Medicaid, outpayer reimbursement, outpayer adjustments should be required under State perspective payment plans for medically necessary in-patient hospital services for very high costs or exceptionally lengthy services. The proposed decrease in Texas payment for hospital emergency and clinic fees would cost Parkland Hospital this year alone almost $0.5 million.

As it relates to Medicare, Congress must also protect Medicare reimbursement. The administration's proposed cut in Medicare will wreak havoc on public hospitals. Of the $5.5 billion in Medicare budget reduction measures contained in the budget, $4.1 billion or 75 percent will come directly from hospital reimbursement. In the case of Parkland Hospital, the proposed cuts result in a loss of $3.6 million which is equivalent to the annual costs of treating 2,000 patients.

In particular, I must reinforce the importance of Medicare disproportionate share payments to public hospitals. In a recently released study, CBO concluded that Medicare disproportionate share payments exceed the costs incurred by DSH in treating indigent patients. The reality is that 59 percent of the public hospitals surveyed by NAPH had negative operating margins for 1989. Without a meaningful disproportionate share adjustment, this percentage would have been significantly higher.

Finally, I encourage Congress to consider enacting a new program to address the present and future capital needs of our health safety net infrastructure—including needed alternative care facilities in addition to hospitals. This may include a resurrection of certain aspects of the Hill-Burton program or the creation of new programs to improve access to capital. NAPH is currently drafting proposals and we would like very much to work with your committee in that area.

In conclusion, serving the indigent is a role that safety net hospitals willingly accept but the safety net is being increasingly strained by the lack of national insurance. While we wait for enactment of universal health coverage I urge you to protect the Medicare and Medicaid systems, and to consider additional payments

for those hospitals providing trauma care, treatment for AIDS patients and care for alcohol and drug abuse.

Thank you very much for the opportunity to testify. I will be happy to respond to any questions you may have.

[The prepared statement of Ms. Watkins appears in the appendix.]

Senator RIEGLE. Thank you, Ms. Watkins. I appreciate your testimony very much.

Mr. McAndrews, as I said before, Senator Danforth had hoped to be here to introduce you. I know he holds you in high regards. So we are delighted to have you and would like to hear from you now.

STATEMENT OF LAWRENCE A. McANDREWS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CHILDREN'S MERCY HOSPITAL, KANSAS CITY, MO

Mr. MCANDREWS. Thank you, Mr. Chairman. I do appreciate the opportunity to be here. My name is Lawrence McAndrews. I am the president and chief executive officer of Children's Mercy Hospital in Kansas City, MO. It is a hospital that serves 54 counties in Missouri and 16 in Kansas. And in keeping with the testimony already heard today I am struck by the similarities of the concern in Dallas, and in Detroit, and in Kansas City.

Indeed, the financial health of Children's Mercy Hospital does affect the children throughout the entire region, with or without insurance. Children's Mercy is a Pediatric Medical Center. Last year it served 42,000 in-patient days and 145,000 out-patient visits. We have had since our inception a policy of providing care to all those regardless of the ability to pay.

This task that we have is really logically impossible. We are trying to stay on the cutting edge of medical technology while at the same time being able to provide free care to all those that come to our door. It has been made more difficult in recent years by two, I think, striking events.

The first is that there is a change in the delivery system. Health maintenance organizations and preferred provider organizations in return of a promise for more volume are looking for discounts. The traditional form of paying for indigent care was to charge more to the full-pay patient and to cost-shift or cross-subsidize their care.

We have to compete now in a system in which we have to give discounts. The HMO's and PPO's simply say it is not their duty to provide public service; and in a way they are right. They are competing for business as well.

The second thing that has happened is the tremendous increase in the number of uninsured. With the competitiveness in the insurance business it is not the way to make money to insure sick people. So frequently people who have had insurance all their lives may become chronically ill and are no longer able to afford insurance.

Senator RIEGLE. Let me just stop you right at that point. This is another key point that needs to be illuminated. In the insurance system if you reach a point where you have a serious health problem, usually you are kicked out of the insurance system. The insurance coverer doesn't want you anymore once you finally reach a

point where you really need the coverage. Isn't that a problem that we are finding more and more throughout the country?

Mr. MCANDREWS. We find it particularly for children who have cancer. They are identified with a chronic illness and it is, of course, expensive and you do not make money by insuring sick people. So we find the premiums increasing for some of these kids so that their families can no longer afford the insurance. So we have seen an increase in the number of kids coming to us that are uninsured.

Nationally you have heard the figure of 34 to 37 million uninsured. There are 12 million nationally that are uninsured. And in Missouri, which is more in our neighborhood, there are——

Senator RIEGLE. Twelve million children now?

Mr. MCANDREWS. Twelve million children that are uninsured.

Senator RIEGLE. Yes.

Mr. MCANDREWS. Four million of those will be below the Federal poverty guideline but still too wealthy to qualify for Medicaid.

In Missouri several years ago there was a study that showed one out of five or almost a million people in Missouri had no insurance. At Children's Mercy one out of four children come to us with no insurance.

A good example of how this occurs is that we in the last year had a child admitted through our ER that was 13 years of age. His father was a self-employed handyman and his mother worked as a part-time sewing machine operator and they had an income of $900 a month. With this income they were not able to qualify because the child was 13 and wasn't under the age 6 guidelines, and they had income which exceeded $3,400 a year which is the amount in Missouri for qualifying for Medicaid. There are numerous examples of this sort.

In 1989 Children's Mercy served 1,523 children that had no means of paying for their health care. This was in addition to the 1,549 Medicaid patients. So you can see there are about as many self-pay, which is a euphemism for no-pay, as there are those children that are covered under Medicaid.

Only 43 percent of the patients coming to Children's Mercy Hospital were insured. Thirty were covered under Medicaid and 25 percent were self-pay. I would say parenthetically that we do appreciate the progress that has been made in the Medicaid program. We have seen substantial improvements in the Medicaid program with the improvements for eligibility for mothers and infants. We appreciate that.

But nevertheless the 1,500 patients that came to us that did not qualify for Medicaid we collected 28 percent of the charges. So out of a budget of $96 million last year we wrote off $10 million to free care, $10 million to bad debts, and $13 million to contractual discounts.

The net affect in all three of those areas is still the same—it is not money collected by the hospital. So we had a net income of $63 million. We had $7 million in other operating income for a total operating budget of $70 million and our expenses were $73 million. So we lost $3 million. This was offset by dividends and interest and contributions in the community.

Our hospital has had a long tradition, since 1897, of tremendous support from the community. And otherwise, it would not be possible to do what we do. There are many hospitals that do not have communities that can support the hospital. We are fortunate to have that.

The affect financially on a hospital that is chronically underfunded is it is basically anemic. It has no cash. Last year we had to borrow $1.8 million to pay our vendors and contractors until we were able to get our cash built back up. We are not able to replace or acquire new equipment. We are not able to start new programs. This affects everyone. We serve, as I said, 54 counties in Missouri and 16 counties in Kansas.

We all know clinically that the infants that are born of teenagers are at risk. We serve 1500 of these in a program that we have designed especially for them to reduce the risk of low birth weight babies. We know we could do a much better job. But while we are dealing with the babies that come from this patient population with crack and low birth weight the costs are enormous. We simply do not have enough money left over to do the kind of outreach and the prevention and the education in the community that would avoid the problem. So we are caught up in a vicious struggle to meet the needs that are in our hospital and still go out into the community and do the prevention and the education that would prevent those patients from coming to us.

Senator RIEGLE. If I can just stop you there, I want to relate a situation that illustrates this. I assume this is the kind of thing you are seeing as well. In my hometown of Flint, Michigan at the Hurley Medical Center we have a very advanced neonatal unit where children who are infants that have particular problems or are premature are brought to this particular center.

I visited there recently and I was struck while going into one of the neonatal units where these high tech incubators were in place and seeing these tiny, tiny babies—I recall seeing one that weighed about 2 pounds. The baby is so small that until you see it with your own eyes you almost cannot imagine that an infant that small can be alive. Many of the infants in that particular hospital are born to teenage mothers or born in situations where there was no prenatal care. Therefore, the infant comes too early and then requires tremendous technical assistance to stay alive; and all of that assistance is being provided.

I looked at this one little baby that had been in this condition now for 50 days. It had been born prematurely and the birth weight I think had gone up to 2 pounds, 6 ounces or thereabouts. I said, how much have the costs been so far on this little girl? They said $150,000. That was to bring that little girl just through 50 days. I thought to myself, that is at least a 4-year college education that that same little girl might otherwise get if we could bring that child along to a normal birth so it did not need that kind of extreme medical care and costly attention.

But I looked around the room and there were probably eight incubators just like that. So there were eight other underweight babies there; and then there was a room next door that was also full of underweight babies. I was thinking to myself about the cost that we are incurring to try to meet this problem. I was adding up

in my mind $150,000 in this incubator, $300,000 when you add another $150,000 in the next incubator, $450,000 and so forth; and you could rapidly see how the costs become extraordinary in a situation like this where we want to provide the most modern medical technology and help.

But if certain other things had been done in many of these cases, it would have been far less expensive to get the help to the expectant mother so that she could get in for checkups and good nutrition and so forth. Many of these infants presumably could have been carried to full term and they would have been born in the normal course of events, not needed all of this extreme care. Of course, many of those babies that I saw, these underweight babies, were ones who had no health insurance.

In other words, the cost of providing that care is being born by the society as a whole or by the insured patient with the cost-shifting that we have been talking about. But I gather that this pattern is something we are seeing more and more of all over the country. We are seeing it in Detroit. We are seeing it in Dallas. You are nodding in the affirmative. We are seeing it in St. Louis. This is a national condition. This is not one hospital in one place. This is now a national fact of life that, it appears to me, is getting out of control. This is what I am hearing you say.

Mr. McAndrews, do you want to continue?

Mr. McANDREWS. You are absolutely correct. And to build sadness upon sadness I got a request just recently for another social worker in our neonatal intensive care unit. The purpose of this social worker would be to go out and work with those new mothers, help to prevent a second pregnancy which we tragically see too often, and to work with the siblings of that girl that had the young child.

There is simply no way to finance that because we have spent so much money in just supporting the crisis care. We need to have that properly funded so we can do the work that we know needs to be done, that we know needs additional resources. And by properly funding hospitals the conscience that we see—you cannot work with these kids and not want to go out there and help them or maybe to find foster homes. We are chronically underfunded for foster homes, and help to educate that as well.

So I think to build sadness upon sadness, the underfunding is just creating a huge problem long term. It will show up in the education system, and it will show up in the work force, and it will show up in the military and the defense of this Nation long term.

Senator RIEGLE. It also shows up in our prisons. I had somebody point out the other day in a meeting that the two fastest job categories, job growth categories, in the United States today are prison guards and private security officers. When you think about it the private security officers are being hired by those who have enough money to provide extra protection against some of the crime problems that are out there; and, of course, the prison guards are catching people after criminal activities of one kind or another.

But imagine that those are the two fastest growing job categories in the United States, percentage wise, is a terrible commentary. I realize that is an aside to what you are saying, but it relates to this issue of what the long-term consequences are. If we can reason this

out and put the right amount of resources in on the front end so that we have a more promising situation that would prevent a lifetime of deteriorated circumstances and conditions that ultimately lead to tragedies of all sorts and types.

Mr. MCANDREWS. I am again struck by the similarities in the comments that the two other areas of the country have mentioned about trauma care. We are literally at Children's Mercy reviewing whether we are going to be able to stay into the Trauma Level One network. The expenses have just become so great and the collections so poor that we are not sure we are going to be able to do that. My head says, no, no more, we cannot afford it; my heart says, that is where we need to be. But you do have to meet the bottom line.

The recommendations that I would have for you would be to continue to separate Medicaid from the welfare system. I think you and Senator Bentsen and other members have been very aware of the improvements that have been made in Medicaid and we appreciate those initiatives.

I also believe that we should establish more uniform eligibility and service packages. Ensure adequate reimbursement for the providers and commit the necessary resources. The States around the country, some of them are having difficulty and we just simply must see to it that there are sufficient funds for them to continue the Medicaid program.

In conclusion, I would like again to thank you and Senator Bentsen for your initiatives over the past several years, along with other members, and improvement in Medicaid and offer my wholehearted support for Senate bill 2459.

Thank you very much.

[The prepared statement of Mr. McAndrews appears in the appendix.]

Senator RIEGLE. Thank you.

Let me just ask one question to all of you and then we will go to our next panel because I have been asking questions as we have gone along here. The sense I have for this, and your testimony reinforces that today, that the best way to get at these problems is a comprehensive health insurance system in this country that provides basic health insurance, and access to health insurance for every person—all 240 million people. Isn't that a critical goal that we have to insist upon meeting if we are going to take and solve this problem that is building up in one form in hospitals but in other forms in other places?

Mr. Thomas?

Mr. THOMAS. I think with 37 million Americans uninsured, that is the only approach to the resolution of the problem—national access or national health service and national health insurance. That covers all citizens.

Senator RIEGLE. Mr. McAndrews?

Mr. MCANDREWS. I certainly agree with that. Medicaid is the best thing we have in place right now. I think if some of us had to do it over again we would start from scratch. But we believe in the Medicaid program as being a very good program as we make incremental improvements for all the people in the country.

Senator RIEGLE. As you say, the little 13-year-old boy that came in whose parents did not qualify because of their modest income, is a classic illustration of who is missing out at the time.

Mr. MCANDREWS. Right.

Senator RIEGLE. Ms. Watkins?

Ms. WATKINS. Thank you very much. I must for the record correct that it is Barbara Lord Watkins, not Dr. Watkins.

Senator RIEGLE. I beg your pardon.

Ms. WATKINS. That is quite all right. I know that is what you have.

Senator RIEGLE. Thank you.

Ms. WATKINS. I think that we have to move that way. I believe that if safety net hospitals, such as the public hospitals I represent, are going to continue to serve their vital mission that we are going to need support that can certainly come from enacting universal insurance.

Senator RIEGLE. Let me thank you all. You have given us very valuable testimony today. I think by being geographically representative of the country, you give us something of the scope of this problem as a national problem. We are grateful to your personal and professional commitment to the work you do. It means a great deal to us. I thank you for that personal commitment.

Ms. WATKINS. Thank you, Senator.

Mr. THOMAS. Thank you.

Mr. MCANDREWS. Thank you.

Senator RIEGLE. Thank you all.

Let me excuse this panel. As this panel leaves let me indicate and invite Dr. Norton Greenberger if he will please come forward; Mr. Vidal Perez; and Dr. E. Jackson Allison, if Dr. Allison would also come forward at this time.

As this panel of witnesses is being seated, I want to indicate here as well, and in introducing them this will be obvious, we have in this panel witnesses that come to us from six other States across the country—from Kansas, the Heartland; from Rhode Island; and also from North Carolina. I think as our testimonial evidence develops today we will see increasingly the national scope of this problem. It takes different forms and manifestations given the places. But the pervasive nature of the problem is a 50 State problem, and it is a problem that affects every citizen in our country. It is important that this is understood.

Let me introduce our witnesses. Let me give an introductory note on each and then we will call on them for their comments. Dr. Norton J. Greenberger is the professor and chairman of the Department of Medicine at the University of Kansas Medical Center, and is also a practicing physician. He is at the same time the President of the American College of Physicians which is a very important organization today. I want to say to you how pleased I was when I saw that your organization just recently announced its support for a national strategy for reforming the health care system. It is one of the first instances I have seen where a physician body has really taken a very strong forward position on this issue and I was very pleased to see this. I wanted to acknowledge that.

Mr. Vidal Perez is the executive director of the Providence Ambulatory Health Care Foundation which is a Federally supported

community health center with six clinic sites serving medically underserved neighborhoods of Providence, RI. As you know, Senator Chafee wanted to be here and has been otherwise detained, but he wanted me to specifically indicate his regret at not being here and his strong feeling about the importance of your testimony today.

Finally, E. Jackson Allison, who is director of the emergency department at Pitt County Memorial Hospital in Greenville, NC. He is vice president of the American College of Emergency Physicians, a very important national perspective. Both this organization and the AMA have been active in the debate on how best to improve access to health care.

We are very pleased to have you. Dr. Greenberger, I think we will start with you.

STATEMENT OF NORTON J. GREENBERGER, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, AND CHAIRMAN, DEPARTMENT OF MEDICINE, UNIVERSITY OF KANSAS MEDICAL CENTER, KANSAS CITY, KS. ACCOMPANIED BY DEBORAH PROUT, DIRECTOR OF PUBLIC POLICY

Dr. GREENBERGER. Mr. Chairman and members of the committee, the American College of Physicians (the ACP) appreciates this opportunity to appear before you today to discuss the impact of uncompensated care on physicians and their patients. The ACP is a national medical organization representing approximately 70,000 physicians practicing internal medicine and its subspecialties.

Accompanying me today is Deborah Prout, director of public policy.

This spring the college launched a major access to care project that includes a position statement on the subject published in the Annals of Internal Medicine and the formation of a network of over 4,000 ACP members around the country. These members have indicated their desire to help develop solutions for improving our troubled health care system.

Simply stated, ACP's basic conclusion is that our health care system has significant problems and requires systemic change. It is not serving the uninsured, nor is it serving insured patients, physicians, employers or government.

Our recommendations address not only access to health care but also the cost of health care, quality of care, medical liability, administrative burdens and availability of health care facilities and personnel. All of these factors are interrelated. The college concludes "that nothing short of universal access to a level of basic health care will be fair in the long run," and "that the time has come for a thoughtful re-examination of all aspects of the health care system."

As the college urges comprehensive reform it also cautions against stitching together a patchwork of programs that will not meet long term needs. Some medical organizations have endorsed mandatory employer coverage and expansion of Medicaid as solutions to the access problem. While Medicaid expansion could serve as an interim means for improving access for low income groups, simply putting more money into this system without systemic reform might well increase current, heavy administrative burdens

associated with Medicaid. Any short-term steps should be in accord with projected long-term needs.

My particular focus today is on the problems experienced by practitioners with uncompensated care and the implications of this. My own experience with Medicaid reimbursements is similar no doubt to the experience of full-time practicing physicians and practitioners at academic health centers. I received a total reimbursement of $2,800 for 120 in-patient and out-patient encounters with over 30 Medicaid patients during a 12-month period.

If one defines uncompensated care as lost revenue from (1) charity care, bad debts and write-offs; and (2) contractual allowances from Government programs, the figures from my practice are illustrative. Of charges totalling $125,000 for in-patient and out-patient services for 1 year $35,000 was for charity care, bad debts and write-offs and $23,000 was for contractual allowances. Thus, 46 percent of my gross charges were uncollectible. The data from our Departments of Internal Medicine and Family Practice are similar.

As we have heard this morning, institutions across the country are feeling the squeeze from all payers and their ability to cross-subsidize care for their poorest patients is diminishing. More than one-quarter of the care provided by public hospitals is uncompensated.

Physicians are also seeing signs of distress in the health care system at the patient level as well as the institutional level. ACP research shows that almost half of our members have seen an increased number of patients who delay seeking care or do not follow treatment recommendations because of limited financial resources. Almost all physicians have some patients who do not pay the doctor's bill. The underlying reason being a lack of adequate insurance. Patients either had insurance and lost it or were unable to acquire it.

We know from our survey data that our members employ a number of strategies when a patient cannot pay for whatever the reason. The majority of our internists see these patients at no charge or at a reduced fee. Some patients may be referred to public clinics or hospitals. However, some patients simply do not go to their physician even when there is a long-standing relationship or they anguish over the potential cost of treatment.

I could cite several examples from my own practice, but one in particular comes to mind. A 40-year-old engineer that I have looked after for 15 years with inflammatory bowel disease, his employer changed companies, his insurance is voided. He has a preexisting condition. He cannot acquire insurance.

A patient's ability to have ready access to the care they need is a very important element in a physician's personal satisfaction with their practice. The degree to which physicians are dissatisfied and disillusioned is not generally appreciated. Lack of access to care for their patients is one important element in this dissatisfaction. Internists are increasingly frustrated by unwarranted intrusions in the clinical decision making, by the paperwork and administrative time and expense, by the rising costs of professional liability insurance, and by cost containment actions that restrict a physician's ability to provide appropriate care.

Solutions to the access problem must also address these hassle factors, reduce administrative costs, and permit physicians to provide their patients with appropriate care.

It is important to note that these frustrations had lead to an increasing number of physicians opting to leave primary care, internal medicine practice. Each week in Kansas City we receive two to three phone calls from disillusioned practicing physicians who are seeking opportunities in our affiliated hospitals.

In addition, physician frustration with our current system may jeopardize our ability to recruit and retain sufficient numbers of primary care physicians and this will no doubt exacerbate our access problems.

We conclude that major systemic reform is needed and piecemeal approaches may carry the risk of aggravating some of our current problems. The college has developed a set of 16 criteria to evaluate proposals for achieving a better health care system. And we will be working, as I have indicated, with our members to develop further recommendations.

We maintain that universal access to health care is absolutely essential and that no potential solution should be eliminated from full analysis and discussion.

Thank you very much. I would be pleased to respond to questions during the question period.

[The prepared statement of Dr. Greenberger appears in the appendix.]

Senator RIEGLE. Well that is an excellent statement and it is a very important one for us to receive, especially from you, not only as a practicing physician, but as a representative of the College of Physicians.

I think what you have just said is parallel to what we have heard from the hospitals a moment ago. The way the system is working today is beginning to crush a lot of our hospitals and literally shut many of them down across the country. Your testimony provides evidence that these same types of pressures are working in a different way to damage the ability of doctors and physicians to do their job. Is that right?

Dr. GREENBERGER. That is absolutely correct.

Senator RIEGLE. So the way the system is malfunctioning is beginning to destroy the very system itself, or certainly parts of it. Is that a fair comment?

Dr. GREENBERGER. That is correct. I think one of the strongest components of our health care system is the dedication of caring physicians, and they are being increasingly compromised in their ability to render appropriate care to their patients.

Senator RIEGLE. The reason I think your testimony today is so significant is that you represent practicing physicians and you represent a very important national organization. Around 70,000 or thereabouts?

Dr. GREENBERGER. Approximately 70,000 physicians.

Senator RIEGLE. Seventy thousand physicians that you are speaking for today. It seems to me that this statement coming from providers of health care, people who have devoted their lives and their professional talents to try to bring life-saving care, is a warning and a cry of alarm that I think we have to pay attention to.

When you look at the statistics, you see that the United States spends more money as a percentage of GNP on our health care system, far more than any other nation, and yet we have all of these people uninsured. We have 37 million uninsured individuals at any given time and maybe as many as 60 million in the course of a 12-month year, throughout the country, people of all ages. We finding that hospitals are telling us the system is not working. We are finding noted doctors telling us the system is not working. It should to be clear to us that this system is breaking down. It it is not working in this fashion and it has to be changed.

Your testimony, representing a broad, national group of physicians, is one of the most significant signals that we would get. Some might assume that the doctors are not damaged themselves by these trend lines and circumstances. You are saying exactly the opposite is true. You are saying that doctors in the medical profession itself are also being damaged by a system that is not working properly.

Is that a fair summary?

Dr. GREENBERGER. It certainly is.

Senator RIEGLE. We will come back to you. There are several questions that I want to raise in addition to that, but let me move along to Mr. Perez.

Mr. Perez, in your community health center and the activities that you are involved in in Providence, RI, we would very much like to hear your experiences here.

STATEMENT OF VIDAL P. PEREZ, EXECUTIVE DIRECTOR, PROVIDENCE AMBULATORY HEALTH CARE FOUNDATION, INC., TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, PROVIDENCE, RI

Mr. PEREZ. Well Providence Ambulatory Health Care currently serves more than 20,000 patients, providing them with basic medical and health care services, including the services of primary care physicians, nurse practitioners, laboratory and radiological services, pharmaceuticals, transportation and child birth education, nutrition and case management services.

Nearly 40 percent of our patients are completely uninsured for medical or health care services. For patients, were it not for PAHCF, the only available sources of care would be the emergency room and out-patient departments of the local voluntary hospitals.

Even for the 38 percent of our patients who are covered by Medicaid options for receiving health care elsewhere are extremely limited. Most private practice physicians refuse to accept Medicaid beneficiaries or provide care only to a very small number of them. Thus, while we are regularly overwhelmed with a number of uninsured patients far exceeding our capacity to care for them, you should also be aware that, in Providence, as in so many other communities across the nation, we face an ever-increasing number of Medicaid clients who see us as the only truly available source of care left to them.

I am proud of the fact that over the 23 years of our existence Providence Ambulatory, as is true of other community health centers nationwide, has provided comprehensive, continuous communi-

ty-based care to thousands of Rhode Islanders who otherwise would have gone without care until they were seriously ill or would have sought some form of episodic non-continuous care from some other source.

I know that as a result of our presence and our work our patients, and the community as a whole, is healthier and more productive and that as a result of our emphasis on prevention early diagnosis and treatment, and health promotion, we have saved them and society as well both money, and more importantly lives. But it is difficult even for community health centers like mine to serve so many uninsured individuals and families despite the fact that we receive Federal support to do so.

I have seen in my past 4 years as Executive Director Ambulatory waiting time for new registrants and appointments for nonacute care increase from a reasonable 1-month period to 6 months.

The National Association of Community Health Centers reports that one of the most serious challenges facing health centers today is the ever increasing number of people seeking services. New waiting lists are averaging between 15 and 28 percent of current patient enrollment. Health centers report a 300-percent increase in the number of pregnant women seeking care, placing significant pressure under limited obstetric services.

In rural areas closures of hospitals and physicians offices have left entire communities in great demand of health care services. Between 1986 and 1987 rural centers have 7.8-percent increase in the number of patients. Of those, 83 percent were uninsured. And while demand for services has increased significantly grant funding for centers has decreased over time. Centers are operating at the same level of funding in 1989 as they were in 1987. In fact, 1989 funding is 25 percent lower than 1981 levels after adjustment for inflation.

I have seen the availability of resources for in-patient care and specialty services for our patients become scarcer. Our Medical Director expended nearly 1 week trying to locate an orthopedic specialist who would accept a referral of an infant born with congenital hip displation.

Although there is no scarcity of orthopedic specialists in the State there are none who accept Medicaid or who provide their services on a sliding fee basis for the uninsured. The one physician we did find no longer is available to us as he has been swamped with referrals for care of other Medicaid and indigent patients.

A similar situation exists in dentistry, allergy and other medical subspecialties. The increasing unavailability of tertiary or subspecialty services for our patient population puts a strain on our resources and limits our ability to reach a larger segment of the community with our primary health care services.

As area hospitals have become more specialized in order to remain competitive or improve their financial viability, they have eliminated services that are viewed as a drain on their resources, often times with no idea of the consequences these actions will have on the community at large. Four years ago all four teaching hospitals located within the city of Providence had pediatric in-patient services; today only two of the four hospitals in the city provide pediatric beds in the city. Our physicians have had to seek

privileges outside of Providence so as to assure that they can obtain in-patient care for our patients.

A hospital eliminated its out-patient pharmacy and those patients that obtained care from their out-patient departments come to our community health centers to get their prescriptions filled. Another hospital posted in their emergency room our own call 24-hour number indicating that patients should call our health centers as they may not be in need of emergency care. Our doctors receive calls from patients from other health centers and from other parts of the States, and also found that their referrals to the emergency room, which were appropriate, were being turned away.

Case in point, the chairman of the obstetrics department at a major women's hospital in Providence was working as a consultant covering a session for ours had referred a 15-year-old pregnant girl to the emergency room of his own hospital and she was turned away.

Our physicians are obligated to provide each of the hospitals that they admit and attend 1 month of unpaid service for the privilege of admitting patients there. So it is an odd twist.

Last year the Congress under the leadership of Senator Chafee and other members of the Senate Finance Committee did recognize health centers as disproportionate CR Medicaid providers and mandated cost-based reimbursement under a federally qualified health center program. Building on this foundation Senator Chafee has introduced Senate bill 2538, which would recognize Federally and non-Federally funded health centers as disproportionate share Medicare providers and mandate reimbursement of reasonable costs to federally-qualified health centers.

It is estimated that an additional 100,000 uninsured patients would be reached by assuring Medicare would pay the reasonable costs for the care.

Community health centers are not shielded from the high costs of goods and services for health care providers. Malpractice insurance for our providers has nearly tripled in the past 4 years, while in our 23-year history there has never been a malpractice claim paid.

Recently the Centers of Disease Control in Atlanta and the American Academy of Pediatrics recommended that children be immunized twice during their childhood of measles. In effect, this recommendation has become a standard of care, that if not followed, could lead to litigation if there is a bad outcome from a measles infection that could have been avoided had a second dose of vaccine been administered. The cost of the vaccine is $24 per dose. A private practice physician can easily pass this cost on to his patients. However, no additional funding was made available to community health centers.

Providence Ambulatory sees a diverse patient population which includes five different language groups.

Senator RIEGLE. Let me stop you there for a moment. Does this mean then that in terms of having the money you need to do these two inoculations for measles that you are short of money to do this?

Mr. PEREZ. It is not there. The State Department of Health, for example, provides funding and vaccine for the first.

Senator RIEGLE. Yes.

Mr. PEREZ. Okay, the second is not there.

Senator RIEGLE. Those kids that you would like to treat and give that second measles vaccine shot, are they getting the shots?

Mr. PEREZ. No, we do not have the money and they are not getting it.

Senator RIEGLE. In the United States of America, 1990?

Mr. PEREZ. Yes.

Senator RIEGLE. We are so hard up that we cannot find a way to get that second measles vaccine shot into these kids?

Mr. PEREZ. Yes.

Well we see a diverse patient population representing five language groups—English, Spanish, Portuguese, Cambodian, Laotian, and Monk. Over half of the patients that we see speak a language other than English. Our staff, over half of them are bi-lingual. Our educational materials, forms, consent forms, are all translated on paper and on audio tape. We are the only provider in the city of Providence that assures our patients that they will receive health care in their own language.

Despite these difficulties which might well cause others to give up or quit, I believe that we at Providence Ambulatory have done an outstanding job of meeting the health care needs of the neediest in our community; and I believe we exemplify the mission and purpose of the Community and Migrant Health Center Programs from their very inception, which are to reach out and serve those most in need among us, to do so with dignity, respect and attention to their special needs, to make access to basic primary care possible for them, and to make fundamental change in the way that our patients view health care and the way that local health care systems view the needs of their communities.

Our experience has taught us much and we have tried to learn from it. But one important thing that it has taught me is that when you begin to talk about and consider options for improving access to care for people who are not in the mainstream of health care today it is not enough to focus on how the bills will be paid or by whom. If you truly are interested in improving the health of these populations, whether they be uninsured, low income, minority, non-English speaking, homeless, substance abusing, AIDS infected, or whatever, then it is imperative that you focus on where they will go for care, not just on who will pay.

We need more ambulatory care providers, more clinics staffed with qualified health professionals to be access points for that care and to coordinate and manage the patient's care through other providers.

I happen to think that the community health centers can and should serve as the model for such system with good reason. They have 25 years of proven experience in making health care accessible to underserved people in communities. They are community based and are responsive to the community's needs and circumstances. They are closely monitored for adherence to strict requirements for management and financial systems. They adhere to rigid standards for quality assurance and qualifications of their clinical staff and the provision of vitally important, preventive and early diagnostic services.

They have compiled an outstanding record for the quality of care they provide. Their impact on the health status of their patients in the communities they serve is unquestionable. Their ability to contain costs, operate with a fixed budget and limited resources and their success in substantially reducing the frequency of admissions and length of in-patient care are well proven.

As you proceed to develop your plans and policies to address this most critical access to care issue, I do hope you will take a serious look at community health center programs, its history and its accomplishments. In doing so I am confident that you will share my view that the community health centers can serve as the model for an effective, affordable solution to this most pressing problem.

Thank you for the opportunity to testify.

[The prepared statement of Mr. Perez appears in the appendix.]

Senator RIEGLE. Thank you very much also for an excellent statement. I want you to know that we worked very hard to get into the supplemental appropriations bill an additional $20 million for measles vaccine. So we are attempting to deal with that problem, at least with respect to a Federal response to it.

We have heard from the hospitals. We have just heard from a very important national physician group. You spoke in effect for community health centers. It sounds to me as if you are saying the same thing in a different form. Namely, the build up of pressures on the malfunctions of the way the health care system is working today and the absence of universal health insurance, is creating greater and greater stresses on community health centers. We are beginning to see impossible problems to deal with in the area of health care in which you are working.

Is that an accurate statement?

Mr. PEREZ. Yes, pretty much so. We are more and more becoming the people who the uninsured or the underinsured are trickled down to. That is our mission, to serve that patient population. But it is happening more and more frequently.

Senator RIEGLE. Well the reason I want to point that out is again, when you look at the nature of the health care system, every part of it is in trouble. In other words, the lack of a coherent and sound and smart national strategy which provides access to health care for all of our people is beginning to wreck each part of the health care system. We are seeing it wrecking part of the medical profession as has been testified to here today. We are seeing it wrecking some of our hospitals in an increasing number. We are seeing it beginning to wreck some of our community health centers.

I do not know how much evidence it takes before we decide that this is a national priority that we must fix and in a comprehensive way. You make the point, doctor, very well, as have all of our witnesses have today. We need a comprehensive answer. We do not need another bandaid or a patchwork quilt. We need an "A" to "Z" plan, a comprehensive plan that really looks at all of these issues together.

I want to say to you at this point in the discussion before going to our next witness, the way things get done in this country is what Presidents and what administrations think is very important. That is not the only element of how we deal with problems, but it

is a critical element. I have reached the judgment that if Congress decides next year, 1991, is the year to do a major reform of the health care system and to provide universal access to health care for all of our people, and if President Bush himself decides as well as his administration, then that goal would go up on the short list of national goals for 1991. We could then tackle it and get it done.

Now if it does not go on that short list of national priorities, if other things are seen as more important, or if this is seen as something that can wait or if the health care issue is seen as something that is just too complicated and cannot be dealt with and is put aside, this damage is going to multiply in every direction. The people of the country are going to be hurt and our country is going to be hurt.

I think we have an obligation, all of us who are taking part in this discussion, to decide here and now that we are going to do everything we can to get the need to revise the health care system on that short list of national goals to be tackled and solved in the year 1991. We will try to persuade the President and his administration, try to persuade the leaders of Congress in both parties that out of our competing objectives and problems that this one cannot wait any longer. This is one that is getting worse, the damage is spreading, and that creates a risk for our society. It is time to fix it. It is just that simple.

We are smart enough to fix it. If we all put our minds together to come up with an answer, we can come up with an answer. I do not suggest that it is easy or that there will not be a lot of give and take. There will be people who will not like aspects of it and so forth. But it is in the nature of solving a problem like this that there has to be the give and take and something will be worked out in the process.

In my view, if there are to be five national goals of this magnitude pursued next year or even three—I do not know what the number will be—the reform of the health care system and access, universal access to the health care system, has got to be on that short list. It has to be one of those top three goals or four goals if it is going to happen.

I will pledge to you that I will do everything I can as the Chairman of this subcommittee and as a member of this Finance Committee to push in every way I know how to get that kind of priority assigned to it and to work the problem through. We need something in the nature of a national outcry of effort and emphasis in this area. We are going to need all the doctors in the country coming forward and asking that this be done.

In the interest of good medicine and in the interest of meeting the health care needs of the country, we are going to have to have every hospital doing it. We are going to have to have every community health center doing it. We are going to have to have teaching hospitals doing it. We have to have people across the spectrum, regardless of party, speaking with one voice and saying, "Look, the time has come to take this system apart, fix it properly and put it back together, so that it is an encompassing system that gets adequate health care, decent health care through to all the people in our society."

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I think we can do that. Other nations are doing it. They are finding ways to do it. There are only two nations left that are called industrial nations that do not have a universal health coverage system—ourselves and South Africa. That is a pretty sorry list to be on when you think about it. When the fact that the Germans have found a way, the Canadians have found a way, the British have found a way, the French have found a way, the Italians have found a way, why can't the Americans find a way? Well we can find a way, but not if we keep putting it off.

We have to see this as an urgent national need. I think anybody that has had a medical emergency in their family and knows how important it is to get the right kind of help to that family member, right at that point, understands that this issue has to go right up at the top of the list.

So I invite you to do all you can with me and with others to promote this discussion, to get this issue up on the short list of national priorities so that we make 1991 the year in which we actually move on this problem and get something done. I think we can if everybody gets behind that goal.

Thank you for indulging my comments on that. I feel very strongly about it and I just wanted to say it at that point.

Dr. Allison, you are here not only as the director of the emergency department of the East Carolina University School of Medicine, Pitt County Memorial Hospital, but you are testifying as well on behalf of the American College of Emergency Physicians and the American Medical Association. We are very pleased to have you speak in those dual capacities.

STATEMENT OF E. JACKSON ALLISON, M.D., F.A.C.E.P., DIRECTOR, EMERGENCY DEPARTMENT, EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE, PITT COUNTY MEMORIAL HOSPITAL, TESTIFYING ON BEHALF OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS AND THE AMERICAN MEDICAL ASSOCIATION, GREENVILLE, NC, ACCOMPANIED BY STEPHANIE A. KENNAN, LEGISLATIVE REPRESENTATIVE, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, ALSO ACCOMPANIED BY FANNY L. HASLEBACHER, COUNSEL, WASHINGTON OFFICE OF THE AMERICAN MEDICAL ASSOCIATION

Dr. ALLISON. Thank you very much, Mr. Chairman. I am Dr. Jack Allison, director of the emergency department of Pitt County Memorial Hospital in Greenville, NC; and vice president of the American College of Emergency Physicians.

I appear today representing both ACEP and the American Medical Association to discuss the access to care problem and the way in which it affects emergency departments.

I am accompanied by Stephanie Kennan of ACEP and Fanny Haslebacher of the AMA.

Emergency physicians are among those who have had to respond most directly to the problems of the uninsured. A study conducted in 1986 for ACEP found that on average 31 percent of the care provided by emergency physicians was uncompensated care. At my emergency department we expect nearly 50,000 visits this year. Thirty-two percent of the care we provide is uncompensated and

our uncompensated care rate is increasing by approximately 5 percent each year.

My hospital is the only hospital in the county and is a major referral center for 29 other counties. By definition, we are rural. We too are a Level One regional trauma center. We presently have 570 beds which will grow to 750 beds in the next 2 years. We too have a drug problem; we too have an AIDS problem.

Sixty percent of our hospital admissions come from other counties and many come because they do not have insurance. Emergency departments are the only entities mandated by Federal law to provide care to all who need it regardless of ability to pay. Congress must understand that we represent the only source of health care for many Americans and that we as physicians are very concerned about our ability to provide needed health services when one-third of our patients have no source of payment. For many, we are the provider of last resort.

My emergency department is no different from any other ED in the type of health crises we encounter. We treat everything from chest pain, to the farmer who has been run over by a tractor, to the results of violence and crime. To our patients their health crises, no matter how they are ultimately diagnosed, are very real emergencies to them.

My hospital serves a predominantly rural area with an agrarian economy. Many of the uninsured patients we treat are farm workers or small farmers who cannot afford to carry insurance. In addition, these patients frequently cannot afford to take time off from work to visit clinics and they usually have no personal physician of their own.

For example, several months ago I treated the 5½-month-old daughter of a farm hand. She was severely dehydrated. The mother had received little prenatal care and followup care after the birth of her baby. When I asked why they had not seen a physician before the baby had become so ill, the mother responded that they did not have a doctor because they simply could not afford one. I wonder now who will take care of that child for the normal pediatric care that even well babies need.

Another case I recently treated was that of a farm worker also without insurance. He was treated successfully for a sexually transmitted disease. Another test later came back positive. The patient now cannot be located. I had a similar incident with a 59-year-old male who lost his group insurance when he lost his job. He is now unemployed yet must pay $300 monthly for health care coverage for himself and his wife. I think it is impossible.

These cases illustrate three points. First, if there had been earlier intervention the patients would not have been as ill as they were when they arrived in my emergency department. Second, these patients need followup care, have no access to that care, and the emergency department cannot adequately provide it. Third, emergency departments are being asked to do more and more with more sickly patients, but with less and less. All these problems would be addressed if health coverage would be available.

One related issue I would like to mention briefly is that of emergency department overcrowding. This is not just an urban problem. One day last week my department treated 150 patients, the majori-

ty of which were seen during my 5:00 p.m. to midnight shift. We had nine patients waiting for admission to the hospital—three of whom had to wait in beds placed in the hallway. Three of the nine did not have insurance. Nevertheless, the next available bed went to the sickest patient, regardless of health insurance coverage.

Overcrowding diminishes access to care, not only to the poor and uninsured, but for anyone suffering an emergency medical condition. Because of our concern with the deterioration of access to health care physician organizations—individually and in concert are working to achieve enactment of legislation that would assure access to needed health care. For example, the AMA has its own proposal entitled, "Health Access America." In addition 21 physician organizations, including ACEP and the AMA, have formed a coalition earlier this year.

The member organizations of the Access to Health Care Coalition believe the preferred approach is one that builds upon the strengths of the public, private system of insurance and contains the following essential elements. Employers should be required to provide health insurance to their employees and dependents with appropriate cost sharing. Medicaid must be both expanded and substantially improved, including the enactment of minimum eligibility and benefit levels, and incentives to enhance provider participation.

For those not eligible for employer-based insurance and who have incomes in excess of the enhanced Medicaid eligibility level, provisions should be made for participation in a subsidized program with cost-sharing on a sliding scale. Health insurance, whether public or private, should provide access to basic physical and mental health benefits.

Mr. Chairman, we are committed to working with Congress and the administration to achieve enactment of legislation embodying these principals. The medical profession recognizes its responsibility to work with others, to assure quality care to delivered in a cost-efficient manner. The health of the nation is reflected in the health of its people.

Thank you so much, Mr. Chairman.

[The prepared statement of Dr. Allison appears in the appendix.]

Senator RIEGLE. Thank you, Dr. Allison, for another very important statement for us today.

I want to ask just a couple of other questions. Dr. Allison, how long have you been practicing? How many years?

Dr. ALLISON. Twelve. I am in my 13th.

Senator RIEGLE. All right. Now when you look back over that span and you watch this build up of pressures that you are citing here and the difficulties in the health care system, what kind of a trend line do you see over those 12 or 13 years? Where is this trend line taking us based on your relevant experience?

Dr. ALLISON. It is definitely on a crescendo in terms of access to care. As Dr. Greenberger mentioned, I think that this problem is really detracting from the physician/patient relationship. Access is a tremendous problem now, not only for the underinsured, for the uninsured, but for the insured themselves. We have a gridlock situation in many emergency departments throughout the country.

Senator RIEGLE. So it has gotten worse over this 12 or 13 years and it is building to a crescendo that you see as being very damaging, I gather, to our interest as a country?

Dr. ALLISON. Yes, sir. And I agree with Mr. Perez as well. Is that, these people when we see them in the emergency department they need followup care, they need access to appropriate care because we deal with acute episodic illnesses and injuries; and yet these people need continuing care.

Senator RIEGLE. Now let me just ask, Mr. Perez, how long have you been at it? What is your professional time span in community health service work?

Mr. PEREZ. About 10 years.

Senator RIEGLE. When you look over that 10-year time frame and the trend lines and where are they taking us, do you come to the same conclusion? Have things deteriorated over that 10-year period of time and are we really now moving into a crisis state?

Mr. PEREZ. Yes, they have. I would say we were pretty much at a crisis state a couple of years ago. I think we are beyond crisis at this point.

Senator RIEGLE. Now, Dr. Greenberger, how long have you been at it?

Dr. GREENBERGER. I graduated medical school in 1959 and I have been practicing medicine in an academic setting since 1965.

Senator RIEGLE. You have even a longer time frame to look at here. When you look at this thing over a time span and you see the build up and the change in overall circumstances, can you give me an equivalent comment?

Dr. GREENBERGER. Well I span the pre-Medicare era; and I remember the time when doctors used to make rounds at hospitals, give of their time, were free of a lot of the administrative pressures that now afflict physicians and compromise their ability to do just that. I have lived through the Medicare era from its inception. I think one of the things that has not been sufficiently emphasized is the costs of the administrative system and the burdens that it imposes on practicing physicians, on hospitals.

These administrative costs, incidently, if one totals the administrative costs from physicians, from hospitals, from nursing homes and from third-party payors, it is $120 billion a year and it exceeds all of the professional fees that are generated by physicians. To me, that is a staggering amount of money and it also indicates one of the directions for the future. It is one of the reasons that the college has argued that there needs to be consideration of significant systemic reform to alleviate these very significant administrative burdens which are so costly, not only in terms of money, but also in terms of patient and physician disillusionment and dissatisfaction.

Senator RIEGLE. I agree with you on that point. I also want to pick up on a related point and that is the astronomical rises in malpractice insurance that physicians must carry. Also, Mr. Perez, you spoke too about how there are extraordinary increases in liability insurance.

In the package that we are developing and that we have put out for comment and so forth, I see the reform need as a wall-to-wall

set of changes. In other words, we cannot just change one part here. We have to change the whole thing at once.

Now I must tell you this at the same time. We had a meeting not too long ago. We had a number of leaders in the Congress, both parties present, a number of distinguished Governors that have been active in the health care issue—it was a private meeting—there was in that meeting an expression by some that maybe the problem is just too big and too complex and the political consensus to change it just may be too difficult to achieve. As a result, maybe we will just have to keep talking about the problem but not do anything about it. That view was actually expressed by some in the meeting who were just disillusioned with the prospect of actually getting something done.

I want to tell you, I reject that thinking 100 percent. I think we have an obligation, an affirmative obligation to hit this problem head on. I mean really hit it head on. Now we need a lot of people in the act to do it. We have to have the AMA; we have to have all of the medical affiliation groups; we have to have the hospitals; we have to have the health centers; we have to have everybody. We have to have the insurance industry that has an important part to play in this, participating constructively. We have to have the private sector. We are hearing from more and more of them because we are finding that the companies that provide health insurance are finding their rates going through the ceiling because they are picking up the tab of the uncompensated care as it gets shifted back over to them. They are being crushed by that burden.

So there is an emerging consensus. But somehow or another it has to go directly into the decisionmaking sort of nervous system of our government. Somehow within the decisionmaking, within the White House and the top reaches of the Congress, there has to be a decision made in the next few months that says that 1991 is the year in which we do this.

Now, we are so far through 1990 and are currently in the Budget Summit. We have an election coming and so the window is not there for us to get this done in a sweeping way now. When we move into the next election cycle, from 1990 to 1992, there is a Presidential election at the end of that period of time and that makes the 1992 calendar year a difficult year in which to really tackle and enact sweeping changes.

This is why from the point of view of looking at this problem and these deteriorating trend lines, I think we have to take 1991 and we have to say 1991 is the year in which to get this done; and that we cannot take no for an answer. Anybody that does not want to get involved in it ought to be invited to get out of the way so that those that are willing to press ahead to get it done can get it done.

I think every doctor in the country is going to have to speak up. They are going to have to talk to their Senators, their House Members, to their people—whatever party they may be affiliated with—they are going to have to get the message into the White House. This is going to have to be true from anybody that has anything to do with this system, including citizens themselves who have the biggest stake in having a decent system that is going to provide the health care that we need to have for our families.

I would like to end on the note of saying that to elevate this urgency that I hear all of you testifying to from different vantage points, into a decision to drive this country ahead to solve this problem. It takes a political judgment. We have got to make a national strategic judgment as a country that this is something that we want to get done. We want to get it done now because it is good for us and it is good for our people, and we would be fools not to do it.

We are going to be increasing the degree of damage on people's lives and in our health care institutions if we do not get it done. We are going to find more emergency rooms closing; we are going to find more doctors leaving primary medicine; we are going to find health centers that cannot even give measles vaccines to kids and so forth if we do not face up to the need to do this.

I finish with those comments because I think you have given us such an important dose of testimonial evidence today from all of these respective vantage points.

I thank you all for your testimony. It has been very helpful.

The committee stands in recess.

[Whereupon, the hearing recessed at 11:52 a.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF E. JACKSON ALLISON

Mr. Chairman and members of the subcommittee, I am E. Jackson Allison Jr., MD, MPH, FACEP, Director of the Emergency Department at Pitt County Memorial Hospital in Greenville, North Carolina and Vice President of the American College of Emergency Physicians (ACEP). I am pleased to appear today representing both ACEP and the American Medical Association (AMA) to discuss the important issue of access to health care. ACEP is a medical specialty society representing over 13,600 emergency physicians, while the AMA represents 297,000 physicians and medical students across the country.

Emergency physicians meet the need for prompt treatment of patients with bona fide emergencies regardless of a patient's ability to pay. ACEP believes that quality emergency care is a fundamental individual right and should be available to all who seek it. In addition, emergency departments often serve as the entryway to the entire health system for uninsured patients, because alternative treatment sites may be in short supply or even unavailable in the community. Thus, like every emergency department across the country, my emergency department is frequently the provider of last resort, providing some access to health care for those without public or private health insurance protection.

CHARACTERISTICS OF THE UNINSURED

The number of uninsured Americans has increased significantly since the late 1970s, when about 26 million people were uninsured. During the recession of the early 1980s, the number of uninsured increased dramatically, reaching approximately 34 million in 1983. Since that time, there have been some changing estimates of the number of uninsured, ranging from 31 to 37 million. The most recent estimates are that about 31 million are uninsured.

The uninsured are a surprisingly heterogeneous group. According to the National Medical Expenditure Survey (NMES), the employed uninsured, with their dependents, accounted for 75 percent to 80 percent (about 24 million) of the uninsured population. Of the 24 million employed uninsured, 85 percent worked for firms of fewer than 100 employees, while 48 percent worked for firms with fewer than 10 employees. Many of the employed uninsured are low wage earners. About one-third earn $10,000 or less annually. Approximately 30 percent of the uninsured have incomes below the Federal poverty level.

It is estimated that about 1 million of the uninsured are persons who are considered to be "medically uninsurable." These persons are unable to obtain health insurance coverage, or can obtain such coverage only at extremely high rates because of poor health status, previous medical history, or employment in a medically hazardous occupation.

In addition to the uninsured, millions of other Americans lack adequate health insurance coverage. Thus, while these persons have health insurance, they still may be financially vulnerable and may lack access to necessary health care services.

REASONS FOR INCREASE IN NUMBER OF UNINSURED

The rise in the uninsured population is most often attributed to a combination of factors: Medicaid's failure to keep pace with the increase in the number of people in poverty; the high unemployment from 1980 to 1982 followed by shifts in employment away from manufacturing to relatively low-paying service sector jobs; and increasing numbers of part-time workers.

While the number of persons on Medicaid has increased during the 1980s, the number of persons below the poverty level has risen even more sharply. As a result, Medicaid, which initially covered over 60 percent of the poor, now covers only about 40 percent of this group.

The number of Americans covered by employment-based insurance increased dramatically during the period from 1945 to 1979. While there has been a significant increase in the number of employed persons since 1980, the number of workers and dependents covered by employment-based health insurance has remained constant at about 141 million people.

A reason frequently given for the increasing number of the employed uninsured has been the major shift away from manufacturing jobs with high rates of employer-provided insurance into the service and retail sales sectors that have lower rates of employer-provided insurance. There has also been a growth in the number of small businesses which frequently do not provide health insurance. In addition, there has been increased use of part-time workers who generally do not receive health insurance.

A final reason cited for the increase in the number of the uninsured is that fewer spouses and dependent children are being covered by employer health plans. Some plans just do not offer such coverage, and others make it too costly for many workers to afford. In addition, a growing number of workers who are offered and can afford coverage simply decline it.

The major reason that some businesses do not provide health insurance appears to be the cost of such coverage. The over 600 state mandated benefit laws are significant factors in increasing the cost of coverage. The cost of coverage is particularly high for small businesses which tend to be less profitable and face large administrative costs. In addition, small businesses that have employees in poor health may not be able to purchase coverage at any price.

Studies already indicate that the uninsured use less medical care than the insured, and that they are less likely to seek care when ill. As physicians, we are concerned that, with the U.S. health care system becoming increasingly competitive and cost-conscious, this situation can only become worse.

THE UNINSURED AND EMERGENCY MEDICINE

Emergency physicians are among those who have had to respond most directly to the problems of the uninsured. No other physician is available 24 hours a day for unscheduled care. A 1984–1985 survey conducted by the National Opinion Research Center for the Health Care Financing Administration found that uninsured patients accounted for 19 percent of the visits to emergency physicians. Another survey conducted by Mathematical Policy Research, Inc., for ACEP in 1986 found that on average, 31 percent of the care provided by emergency physicians was uncompensated care.

For example, at Pitt County Memorial Hospital, we expect to treat 48,000 patients in the emergency department this year, and project that we will have 50,000 emergency department visits in our next fiscal year. My hospital is the only hospital in the county and is a major referral center for 29 other counties. Sixty percent of our patients come from other counties, and many of these patients come because they do not have insurance.

Of the care we provided last year, *32 percent was uncompensated care.* Only 17 percent of our patients were covered by Medicare and only 8 percent were covered by Medicaid. Commercial health insurance covered only 36 percent of our patients. Over the past three years, *our uncompensated care rate has increased by approximately 5 percent each year.*

This year we project that there will be 90 million visits to emergency departments nationwide. If one-third of this care is uncompensated, we are stretching the safety net of the emergency department and asking emergency physicians to do more and more with less and less.

State and Federal policy requirements imposed on emergency departments have increased the responsibilities of emergency physicians and emergency departments to fill gaps in the health services delivery system. In 1986, Congress required that every patient presenting with complaints to a hospital emergency department be given an appropriate screening examination. The goal of a screening examination is to determine whether the individual has an emergency medical condition or is in active labor. The law further requires that patients found to have emergency medical conditions or to be in active labor must be provided necessary medical treatment within the hospital's capability to stabilize their condition.

Therefore, emergency departments are the only entities mandated by Federal law to provide care to all who need it. Patients come to our doors knowing they will

receive care regardless of their ability to pay. Congress must begin to understand that we represent the only source of health care for many Americans, and that we as physicians are very concerned about our ability to continue to provide these needed services when one-third of our patients have no source of payment.

My emergency department is no different from any other ED in the type of health crises we encounter. We treat everything from chest pain, to the farmhand who has been run over by a tractor, to the results of violence and crime. To our patients, their health crises—no matter how they are ultimately diagnosed—are very real emergencies to them. For many of the uninsured, we are their only access to the health care system.

My hospital serves a predominately rural area with an agrarian economy. Many of the uninsured patients we treat are farm workers or small farmers who cannot afford to carry insurance. In addition, these patients frequently cannot afford to take time off from work to visit clinics and they usually have no personal physician of their own.

For example, several months ago I treated the five and a half month old daughter of a farm hand. She was severely dehydrated. The mother received little prenatal care during pregnancy and minimal follow-up care after her daughter's birth. When I asked why they had not seen a doctor before the baby became so dehydrated, the mother responded that they did not have a doctor because they did not have the money to pay for a doctor. I wonder now who will take care of that child for all the normal pediatric care that even well babies need.

A second case was that of a migrant worker with no insurance who presented with vague symptomatology. We determined that he had Rocky Mountain Spotted Fever, which is potentially fatal. In addition, he was abusing alcohol. We wanted to admit him, but he left the hospital and we were forced to locate him through the sheriff's office. He was admitted and successfully treated.

A third case involved a farm worker who presented with vague symptoms and who also had no insurance. We determined that he had a sexually transmitted disease. We ran additional tests to determine if he had any other diseases. These tests took more time. When the tests results arrived, it was several days later and they were positive. The telephone number the patient provided turned out to be a Catholic Church, where the priest thought he knew who we were looking for. This worker has a communicable disease, and it is vital that he be treated for it.

All three cases make several points. First, if there had been earlier intervention, the patients would not have been as ill as they were when they came to the emergency department. Second, all three will need follow-up care, but they have no access to that care and the emergency department cannot adequately provide it. Third, emergency departments are seeing patients with an increase in acute needs, but there is a decrease in the ability to pay for the services needed. All these problems would be addressed if health coverage had been available.

For many hospitals, emergency departments are financial drains. Even if our uncompensated care rate were to hold steady at this unacceptably high level, the cost of medical care continues to escalate.

EMERGENCY DEPARTMENT OVERCROWDING

A phenomenon that many emergency departments across the country are now experiencing is emergency department overcrowding. This is not just an urban problem. In one day last week, my department treated 150 patients, 90 of which were treated on my shift—5:00 pm to midnight. That night, we had nine patients who had to wait in beds placed in the hallway. One-third of those patients did not have insurance. Nevertheless the next available bed went to the sickest patient regardless of health insurance coverage. My hospital and emergency department are not unique.

In 1989, ACEP conducted a survey of its 54 chapters to help assess the extent of emergency department overcrowding which had initially been reported in New York, Boston, and Los Angeles. Our chapter survey showed that 41 states reported overcrowding problems. While solving the problem of the uninsured would not completely solve the problem of emergency department overcrowding, it would go a long way in assisting the already tightly stretched safety net of the emergency department. This growing problem will affect the delivery of emergency medical care to all patients, whether they have adequate insurance or not. Overcrowding diminishes access to care not only the poor and uninsured, but for anyone else suffering an emergency medical condition.

PHYSICIAN EFFORTS TO ADDRESS THE UNINSURED

As physicians, we are concerned that, with the U.S. health care system becoming increasingly competitive and necessarily cost-conscious, the plight of the uninsured and the effect it has on emergency departments will only become worse.

Across America, physicians are committed to finding solutions to assure adequate and affordable health care coverage for physical and mental illness for all our citizens. The medical profession strongly believes the preferred solution is one that preserves and builds upon the strengths of the public/private system of insurance. ACEP has been active in seeking legislative solutions. The AMA has its own proposal entitled Health Access America, that addresses these issues. (See attachment) In addition, 21 physician organizations formed a coalition earlier this year to achieve enactment of legislation that will assure ready access to needed health care. (A listing of the members of the coalition is attached.)

ACCESS TO HEALTH CARE COALITION

The health care needs of the uninsured population, a significant percentage of which are children, make it imperative that Congress enact legislation guaranteeing access to adequate and affordable health care coverage for all Americans. The medical profession has historically maintained that health care services be available to all our citizens and is strongly committed to finding a solution to assure access to health insurance for the estimated 31 million people in this country who currently lack coverage.

The member organizations of the Access to Health Care Coalition believe the preferred approach is one that builds upon the strengths of the public/private system of insurance and that contains the following essential elements:

- Utilizing the traditional approach of employer based insurance, employers should be required to provide health insurance to their employees and dependents with appropriate cost-sharing by employees. Recognizing the potential financial burden this could impose on certain small businesses, Congress should include provisions which would ameliorate the impact of this requirement such as tax relief, subsidies, phased-in implementation, risk pools and other reforms which would make insurance more available and affordable.
- Medicaid must be both expanded and substantially improved including the enactment of minimum eligibility and benefit levels, and incentives to enhance provider participation. Due to uneven eligibility criteria and benefit levels across the states, the current Medicaid program covers fewer than 42 percent of Americans with incomes below 100 percent of the Federal poverty level.
- For those who are not eligible for employer based insurance and who have incomes in excess of the enhanced Medicaid eligibility level, provision should be made for participation in a subsidized program with cost-sharing on a sliding scale premium basis.
- Health insurance programs, whether public or private, should provide access to basic physical and mental health benefits.

We are committed to working with Congress and the Administration to achieve enactment of legislation embodying these principles. Further, in order to meet the immediate challenge of the uninsured population, and the longer term challenge of a better health care system for all Americans, the medical profession recognizes its responsibility to work with others to assure quality care is delivered in a cost efficient manner. We can do no less. The health of the nation is reflected in the health of its people.

Attachments.

ACCESS TO HEALTH CARE COALITION

American Academy of Facial Plastic and Reconstructive Surgery; American Academy of Family Physicians; American Academy of Neurology; American Academy of Ophthalmology; American Academy of Physical Medicine and Rehabilitation; American Association of Clinical Urologists; American College of Chest Physicians; American College of Emergency Physicians; American College of Nuclear Physicians; American College of Obstetricians and Gynecologists; American Medical Association; American Psychiatric Association; American Society for Gastrointestinal Endoscopy; American Society of Addiction Medicine; American Society of Anesthesiologists; American Society of Hematology; American Society of Internal Medicine; American Urological Association; College of

American Pathologists; Joint Council on Allergy and Immunology; Society of Nuclear Medicine

THE AMA PROPOSAL TO IMPROVE ACCESS TO AFFORDABLE, QUALITY HEALTH CARE

BACKGROUNDER

Alter several decades of scientific and technological advance, the United States has become the premier nation in providing high quality comprehensive medical care and education. No health care system in the world can match the high caliber of medicine practiced throughout this country nor the widespread availability of medical procedures and technology now considered common in the U.S.

However the outstanding level of care found in our system has not provided solutions to serious problems that leave millions of Americans without health insurance coverage. Despite national spending of over $500 billion and 11 percent of the U.S. gross national product on health care each year 33 million Americans do not have access to affordable medical insurance for themselves and their families. Public opinion polls find Americans are discontented with this inequity despite the very high level of satisfaction with the quality of medical care practiced in the United States.

Americans desire access to high quality health care services at affordable prices and a health care system that is easy to understand and use. Public opinion polls show that Americans favor a system of employer-provided health care insurance that would slow rising costs, improve access for the poor and elderly and remove the bureaucratic paperwork that serves only to complicate and stretch the resources of the system.

Who are the uninsured? Approximately 213 million or 87 percent of Americans today enjoy access to fine health care services through private or public insurance. Unfortunately that leaves about 13 percent or 33 million without adequate access to care because they can not afford private insurance and public assistance is unavailable, About 70 percent of the uninsured, around 24 million, are working Americans and their families. About three million persons, some of whom are employed, are considered "medically uninsurable" by private companies due to health conditions. The Medicaid system, designed to aid those below poverty levels, assists only about 40 percent of our poor many of whom are children.

While many in our society lack sufficient access to the system, an overwhelming percentage of Americans who do have proper access are satisfied with the level of care they receive. It is a system that allows many persons to remain uninsured, and rising costs trouble many Americans.

American physicians, who are represented through the American Medical Association, share the view that improvements need to be made promptly to our health care system, especially addressing the access and cost problems. In basic terms, certain principles should underscore the national discussion on improving our health care system:

- **Strength.** Improvements to the American health care system should preserve the strengths of our present system.
- **Access.** Affordable coverage for appropriate health care should be available to all Americans, regardless of income.
- **Freedom.** The right to determine the manner in which health care benefits are delivered.
- **Affordability.** Health care services delivered at appropriate cost and without excessive liability costs and paperwork interference.
- **Security.** Continued access to health care for the elderly
- **Quality.** Access to care through physicians who are committed to the highest ethical standards.

After an extensive review of the strengths and weaknesses of the American system, the AMA has developed a 16-point proposal to expand access to health care coverage to all Americans, while controlling inappropriate cost increases, and reducing paperwork and bureaucracy Many of the elements contained in the AMA plan have already taken legislative form, such as the Medicare Reform package introduced by Rep. Charles Rose (D-N.C.). Other elements are part of a legislative approach calling for additional action to bring about needed reforms.

Primary to the AMA proposal is the belief that improving our system of health care must be based upon the strengths and successes of our present system. These strengths include:

• The vast majority of Americans are satisfied with their physicians and the health care services they receive.
• Most patients have the ability to freely choose their physician, hospital and system of care.
• Technology is widely available and science remains free to conduct research in the best interests of the patient.
• The medical education system continues to produce highly trained, competent physicians.
• Medical professionals remain free to act as patient advocates rather than agents of the government or other interests.

These strengths are the foundation on which the American Medical Association has based its proposal for reform. The individuals freedom of choice, combined with a free and independent medical profession, remain as the cornerstones of our system—a system that does not allow government to dictate choices to patients.

Clearly our health care system needs substantive revision to provide access to every American, but it would be counterproductive to "fix" aspects of the system that work well. And so, the AMA has selected to begin a process that will ask for the participation of all interested parties—government, the insurance industry other health care providers, and the public—contribute to the dialogue on improving the U.S. health care system.

The sixteen-point proposal

The AMA proposal is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicare program to assure proper health care for all. It is summarized as follows:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level.
2. Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage.
3. Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable.
4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program to assure the aging population of continued access to quality health care. The program would include catastrophic benefits and be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens
5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.
6. Enact professional liability reform essential to reducing inordinate costs attributable to liability insurance and defensive medicine, thus reducing health care costs.
7. Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided, lowering costs and maintaining quality of care.
8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.
9. Develop proposals which encourage cost-conscious decisions by patients
10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance.
11. Urge expanded Federal support for medical education, research and the National Institutes of Health, to continue progress toward medical breakthroughs which historically have resulted in many lifesaving and cost-effective discoveries.
12. Encourage health promotion by both physicians and patients to promote healthier lifestyles and disease prevention.
13. Amend ERISA or the Federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-related health insurance policies, providing fair competition.
14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.
15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike.

16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

Strengthening the American health care system through the elements contained in this proposal will present an enormous challenge to all concerned. For its part, the AMA intends to move forward vigorously on legislative and other fronts, as well as encouraging every interested party to join in the dialogue toward this goal. Our common objective will continue to be providing high quality care at reasonable cost, and access for every American.

PREPARED STATEMENT OF NORTON J. GREENBERGER

Mr. Chairman and Members of the Subcommittee: The American College of Physicians (ACP) appreciates this opportunity to appear before you today to discuss the impact of uncompensated care on physicians and their patients. ACP is a national medical organization representing approximately 70,000 physicians practicing internal medicine and its subspecialties, including gastroenterology, endocrinology, oncology, and cardiology. It includes practitioners providing primary care, medical subspecialists, and medical researchers and teachers.

I am Norton J. Greenberger, MD, FACP, Professor and Chairman of the Department of Medicine at the University of Kansas Medical Center and a practicing physician; accompanying me is Deborah Prout, Director of Public Policy. Coinciding with my election as President of the American College of Physicians this spring, the College launched a major "Access to Care Project" that includes a position statement on the subject and the formation of a network of over 4,000 ACP members around the country to identify local problems and make recommendations for improving the health care system. In the few short months since the ACP position statement was published in the *Annals of Internal Medicine*, thousands of physicians have indicated their desire to help develop solutions to the problems of our troubled health care system.

Simply stated, ACP's basic conclusion is that our health care system has significant problems and requires systemic change. It is not serving the uninsured, nor is it serving insured patients, physicians, employers, or government. We must work for a comprehensive and coordinated nation-wide program. Our recommendations address not only access to health care but also the cost of health care, quality of care, medical liability, administrative burdens and availability of health care facilities and personnel. All of these factors are interrelated. The College concludes "that nothing short of universal access to a level of basic health care will be fair in the long run," and "that the time has come for a thoughtful re-examination of all aspects of the health care system."

In response to the College's position, dozens of heartfelt letters have been sent to me and other officers of the College. I have excerpted passages from several of these letters that exemplify the views of our members and provide a sense of their growing concern:

—from a Baltimore internist, "The recent position of the College on the issue of access to care is truly a very real issue in present day American society and needs to be dealt with in a head-on fashion. Congratulations for having the guts and determination to take the present position. The first step in any long journey is always the hardest to explain. We must face up to the issues. No longer can we afford to continue along the same old path."

—from a Chicago member, "Having spent the last seven years practicing simultaneously in the Chicago inner city as well as near-western suburbs, I have daily felt the agony, frustration, and yes, anger at our nation's embarrassingly inadequate health care system."

—from a general internist in a small town in southwestern Virginia, "The current reimbursement system is making practice for primary care physicians, particularly in rural areas extremely difficult. These factors have strongly influenced my decision to leave rural practice in one month to take a position with a large group practice at a teaching hospital. Changes are needed now to prevent severe shortages of primary care physicians in small towns and rural areas in the future."

—from an internist in Kansas, "tremendous problems in Kansas with access to health care, rural areas are without the necessary number of physicians . . . many are underserved . . . poor Medicare reimbursement."

The thoughts expressed in these and many other letters as well as the calls and face-to-face meetings with physicians across the country emphasize for me that there is a growing appreciation of the need for comprehensive reform of the health care system and that physicians are eager to help in the search for solutions.

Likewise, there is mounting evidence that the health care system is on the verge of fiscal collapse. Health care costs are estimated to reach $647 billion in 1990 and yet the numbers of uninsured continue to rise. Between the period of 1978 and 1986, the percentage of uninsured rose 43 percent. And as the Chairman of the this Subcommittee highlighted in an earlier hearing, the number of Americans without insurance is far greater than the often cited 31-37 million when individuals with interrupted public or private coverage are considered. The Census Bureau figure of 63 million Americans without continuous coverage is staggering, especially in a system that costs the nation over $600 billion annually.

As suggested by a recent study by Robert J. Blendon et al., the high level of dissatisfaction the public feels with the American health care system may be the result of just this interplay between sharply rising costs and inadequate financial protection from health insurance. In this ten nation study, Americans are the least satisfied with their current health care system, in spite of having the highest per capita health expenditure.

As the College urges comprehensive reform, it also cautions against stitching together a patchwork of programs that will not meet long-term needs. Some medical organizations have endorsed mandatory employer coverage and expansion of Medicaid as solutions to the access problem. While Medicaid expansion could serve as an interim means for improving access for low-income groups, simply putting more money into this system without systemic reform might well increase current heavy administrative burdens and hassle factors associated with Medicaid. Any short-term steps should be in accord with projected long-term solutions.

Signs of distress in the health care system are especially apparent in the Medicaid program. Some recent developments in the Medicaid program have reinforced this conclusion:

- The Supreme Court has decided that hospitals have the right to sue states in Federal court for higher Medicaid payments. The Virginia Hospital Association claimed that its members are losing more than $1 million a week providing health care under the Medicaid program.
- There are pending lawsuits against states by hospitals or nursing homes seeking higher Medicaid reimbursements in at least twelve states.
- Of the 16 states reported July 16 by the New York Times to be in or near a recession, four states—Illinois, Michigan, New Jersey and Pennsylvania—face substantial costs from higher Medicaid reimbursement rates. Without a turn around in these state economies, officials will be hard pressed to find additional revenues to cover the extra millions in reimbursements without raising taxes. The Governors who balked at Medicaid expansions are also likely to resist raising taxes to cover increases in Medicaid reimbursements.

My own experience with Medicaid reimbursements at the University of Kansas Medical Center is similar to the experience of full-time practicing physicians and practitioners at academic health centers. A total reimbursement of $2,800 was received for 120 inpatient and outpatient encounters with over 30 Medicaid patients under my care during a 12-month period. If one defines uncompensated care as lost revenue from charity care, bad debts and write-offs and contractural allowances from governmental programs, the figures from my own Department of Internal Medicine are illuminating. In my own practice, of charges totalling $124,587 for inpatient and outpatient services for one year, $34,755 were for charity care, bad debts and write-offs and $22,955 were for contractural allowances. For the Department, of $10,936,286 in gross charges, $2,479,044 were contractural allowances, and $2,083,385 were for charity care, bad debts and write-offs. Thus, forty-two percent of gross charges were uncollectible. The data from our Department of Family Practice at the University of Kansas Medical Center and from the hospital itself are similar. Thus, institutions are feeling the squeeze from all payors and their ability to cross subsidize care for their poorest patients is diminishing.

Physicians are seeing signs of distress in the health care system at the patient level as well as the institutional level. ACP research shows that almost half of our members have seen an increase in the last five years in the number of patients who delay seeking care or who do not follow their recommendations because of limited financial resources. Most physicians had patients who delayed seeking care because they were uncertain of coverage. Almost all physicians have at least some patients who could not pay the doctors' bills, the underlying reason being a lack of adequate

insurance. Patients either had insurance and lost it or were unable to acquire it. Many physicians had patients who were unable to afford co-payments and deductibles.

A physician's ability to provide care is hampered significantly when insurance is interrupted or a patient lacks the ability to pay for needed services. Nicholas Davies, M.D. who will succeed me as ACP President and who is active in his state of Georgia on access to care issues keeps a log of cases in his own practice that illustrate the unjustifiable pain and suffering that results when access is limited. Two typical cases drawn from his practice are illustrative of the growing problem faced by practitioners (copy attached). In summary, the first patient, Betty M., lost her coverage and did not see her physician of thirty years standing because she chose to hope for the best rather than ask for charity. In this instance, her delay in seeing a physician was life-threatening. The second patient was affluent, unlike Betty M. but because of a history of cancer, became uninsurable when her husband's insurance policy was transferred from one of his businesses to another. The result was anxiety about the expense of needed diagnostic tests and continuing anguish over the prospect of depleting savings because of her catastrophic illness.

We know from survey data that our members employ a number of strategies when a patient cannot pay for whatever reason. The majority of our internists see these patients at no charge or a reduced fee; some devise flexible payment schedules. In some instances, patients may be referred to public clinics or hospitals. But as the two case studies illustrate, some patients simply do not go to their physician, even when there is a long-standing relationship, or they anguish over the potential cost of treatment.

We also know that patients' ability to have ready access to the care they need is a very important element in physicians own personal satisfaction with their practice. One of the great secrets in the medical profession is the degree to which physicians are disillusioned. Lack of access to care for their patients is only one, albeit important, element in this dissatisfaction.

Internists are increasingly frustrated by unwarranted intrusions into clinical decision making; by the paperwork and administrative time and expense involved in responding to requirements of government and other third-party payers; by the rising costs of office practice, including the costs of professional liability insurance; and by cost-containment actions that increasingly restrict physicians' ability to provide appropriate care. The message heard throughout the country is that physicians are beleaguered and angry; good patient care is under siege. Solutions to the access problem must address the "hassle factor," reduce administrative costs and burdens, and permit physicians to provide their patients with appropriate care.

These frustrations are contributing to physician dissatisfaction and an increasing number of physicians are opting to leave primary care internal medicine practice. Each week we receive two to three phone calls from practicing physicians seeking opportunities in our affiliated hospitals and Veterans Administration Medical Centers. Importantly, increasing numbers of medical students are opting not to enter training in primary care disciplines. This may ultimately result in a shortage of primary care physicians and will exacerbate our current access problems. In addition, it poses a special problem for the future delivery of primary care services for Medicare patients.

Our conclusion is that major systemic reform is needed and piecemeal approaches carry the risk of aggravating our current problems. The College has developed a set of 16 criteria to evaluate proposals for achieving a better health care system and we will be working with our members to develop further recommendations. We maintain that universal access to health care is absolutely essential and that no potential solution should be eliminated from full analysis and discussion.

Attachment.

EXCERPTED FROM THE ACCESS TO HEALTH CARE LOG OF NICHOLAS DAVIES, MD

Betty M. had rheumatic fever as a teenager in the 1940's. She was from a poor family and treated at Grady Hospital where I was a medical resident. As I went into practice, she married a young man with a fairly good job so she was no longer eligible for care at Grady. For this reason she became a patient of mine in 1957 and has remained a patient of mine over the years. During this time she went through a difficult pregnancy and now has a nice son and some grandchildren.

Over the years she has had three separate sets of artificial heart valves—the first a human valve (a hemograph); the second were pig valves; the last were plastic valves. To prevent clots on these last valves she takes a drug to prevent clotting. It

is dangerous if she takes too much or if she takes too little. For this reason, she needs a blood test called a prothrombin time to see about her clotting status.

Last year she came to see me and I realized that I had not seen her in almost a year. I asked her, Who has been doing your protimes?" Rather sheepishly she said, "Nobody. I trusted in the Lord. My florist business has been doing badly, my health insurance kept going up and I simply can not afford it, so I stopped getting my blood checked." Fortunately she neither bled nor had a blood clot but her problem has not yet been solved.

Mrs. K. is a 55 year-old woman who has been a patient for only four years. Six years ago she had a cancer of the breast and at the same time she had a painful metastasis in a rib. She had a mastectomy, radiation, and is now on chemotherapy and is doing wonderfully well. Last year her husband's small business in Texas failed although his business in Atlanta thrived. Unfortunately, his family's health insurance program was with his Texas business. There was no problem with him changing his policy to his Atlanta company but his wife was underwritten out of the policy because of her prior condition.

Two weeks ago she developed pains in her back that she felt sure was a new metastases. She was terrified not only about the possibility of a return of her disease but about the prospects of a long painful illness without health insurance. An illness of this sort would wipe out her family's savings. It was a terrible few days.

We did do a bone scan and it was negative, an enormous relief for us all. If her pain returns, an extremely expensive MRI scan would be indicated. On symptomatic treatment she has improved and has returned to her normal activities, including tennis.

But what happens if her disease does return?

Prepared Statement of Lawrence A. McAndrews

INTRODUCTION

Mr. Chairman, my name is Lawrence McAndrews and I am the President and Chief Executive Officer of The Children's Mercy Hospital in Kansas City, Missouri. I appreciate the opportunity to appear before your subcommittee today to discuss a critical issue—uncompensated care—and how it affects our organization and the children we serve.

BACKGROUND

Children's Mercy is a pediatric medical center which provides comprehensive and specialized services for children in western Missouri and eastern Kansas. In 1989, Children's Mercy recorded 42,000 inpatient days and 144,000 outpatient visits.

Children's Mercy is equipped and staffed to provide a highly specialized level of care and is well known for its Newborn and Pediatric Intensive Care Units; its state-of-the-art Cardiac Center; its Trauma Center; and its Cancer and Diabetes programs. In all, there are 33 different specialty areas designed exclusively to serve children. Because of such services, Children's Mercy receives referrals from throughout a 70-county referral region, serving as a complementary health care service to community hospitals and physicians throughout the area. The hospital also provides primary care services to uninsured children.

Since its origin, the policy of The Children's Mercy Hospital has been to provide the highest quality medical care to all children, regardless of race, religion, residence or ability to pay. To help offset its charity care costs, the Hospital relies on support from the City of Kansas City, Jackson County, and local and regional united funds and county commissions. Even with these sources of support, the hospital had a loss from operations of nearly $4 million last year. However, through interest and dividends from the endowment and generous private giving, the hospital is able to continue its services.

ISSUE

Historically, hospitals have recovered the cost of free care provided to patients who couldn't pay their bills by increasing the amount charged to patients who paid their bills in full. In the early 80's new forms of delivering health care began forming with health maintenance organizations and preferred provider organizations. These organizations sought discounts in return for the promise of volume. The result of these new payment arrangements is to pare payment down so far that the rate doesn't even cover cost in some cases, much less allow a margin for helping the hospital underwrite the free care it provides. In today's increasingly competitive,

price conscious environment, both public and private insurers are no longer willing to pay higher rates. While the number of patients to whom we can shift unsponsored care has decreased substantially, the amount which must be shifted has increased dramatically.

Nationally, of the 34 to 37 million Americans without insurance, 51% have jobs, 34% have children living with a working/insured adult, and 15% have no jobs or coverage. Typically, a child is under 5, living with working parent who cannot obtain insurance through the employer.

—There are 12 million American children who have no health insurance, public or private.
—There are four million children who live below the Federal poverty level with no insurance and yet are deemed too wealthy to qualify for Medicaid in their home state.
—There are the children of the working poor whose employer's benefit package excludes coverage for dependents and whose incomes are too low to allow them to purchase coverage.

There are roughly 100,000 catastrophically ill children born to families, both poor and wealthy, whose medical needs are so great that many of them have exhausted the limits of insurance coverage. There are nearly two million children who are victims of child abuse and there are the children of teen mothers, drug and alcohol abusers, AIDS victims—children who through no fault of their own began their lives with severe impairments.

At Children's Mercy Hospital two cases illustrate the problem. Charles, a 16 year old, was admitted through the emergency room as a result of an automobile-pedestrian accident. Charles came from a four person household whose family had a yearly income of $20,000. The family is over income guidelines for Medicaid. Missouri is one of only 13 states without a medically needy program which permits medical debts to offset income in the Medicaid program.

Eddie, a 13 year old, was one of 10 children. He was admitted to Children's Mercy as a result of a motor vehicle accident. He had multiple injuries. His father was a self-employed handyman and his mother worked part-time as a sewing machine operator. Their combined monthly income was around $850.00. For Medicaid, once again, Eddie was over the age and income guidelines.

Over the past three years, the hospital admitted:

	Self Pay	Medicaid
1987	1,719	[illegible]
1988	1,570	[illegible]
1989	1,523	[illegible]

While recent eligibility improvements have moved self-pay into the Medicaid category, there are still large numbers of uninsured.

The significance to the hospital is, of course, in its ability to collect for the services rendered. At Children's Mercy Hospital, this past year, 43% of our patient charges are commercially insured, 30% are insured through Medicaid, 25% are self pay and 3% represent other government programs. We collect virtually 98% of our charges from commercial insurance, 48% Missouri Medicaid, 33% Kansas Medicaid, and 28% for self-pay. A full 55% of our patients are subsidized by cost shifting and philanthropy. In comparison, a typical community hospital in Kansas City would have 51% insured, 29% Medicare, 9% self-pay, 6% other, and 5% Medicaid.

As increasing numbers of full pay patients become insured through health maintenance organizations and preferred provider organizations, Children's Mercy has less and less ability to pay for care to those without resources through cost shifting. In addition, the public services provided also create a competitive disadvantage in bidding for full pay business, driving the care of children with insurance to other institutions, thus decreasing our ability to cover our overhead cost and making our per unit of service even more expensive. Children's Mercy has approximately $2,000 of uncompensated care per discharge compared to an average hospital in Kansas City of $500. Children's Mercy and others like it are in a vicious squeeze between the expectation that health care is a right and the pressure to reduce cost.

Every day, we try to do what is logically impossible; to achieve higher standards of pediatric care and to make this care available to all children, regardless of ability to pay. One-fourth of the patients who come to Children's Mercy fall into the self-pay category—they don't have private insurance and they don't qualify for any of the public programs like Medicaid. Whatever bills the child would incur while a patient at the hospital, the family would be responsible for out-of-pocket. You can imagine that even a relatively short stay is going to be beyond the ability of most families to pay for it out of pocket, so we maintain our own internal financial assistance program whereby the child's bills can be discounted according to the families' income.

CONSEQUENCES

Financial

Children's Mercy constantly walks the razor's edge financially. Out of gross patient revenues of approximately $96 million last year, the hospital wrote off $10 million in charity, $10 million in bad debt, and $13 million in contractual allowances. Our total expenses were $72 million. Adjusted for other operating revenues, that left us with a loss of nearly $4 million. With such a large uncompensated care load, there is a little margin for error. A downturn in patient census of even a slight decrease in the collection rate can wreck our cash flow. We have a payroll to meet every two weeks and suppliers who expect to be paid. Even when we are able to meet our expenses, there is little left over to fund new programs or purchase much-needed equipment. Without philanthropy and an endowment, we would go under.

At one point last year, the hospital was required to borrow 1.8 million dollars from a local bank to continue the payroll and pay the expenses. This, of course, added expense in interest. When you operate a facility that is so committed to public service, we are chronically short of cash, operating with just a few days' expenses in hand. We have the support of an endowment, but many other health facilities do not. The other major difficulty in running an institution which is chronically underfunded is that you are never able to build the reserves to replace the facility so you are slowly eroding away the resources that enable you to deliver health care. If compensation is inadequate, you simply do not have the money to develop new programs. And lastly, of course, if any unexpected downturn occurs, it creates a crisis because you don't have the reserves to weather the problem.

Clinical

A poignant example is our adolescent clinic, which serves about 1,500 patients annually. These teens are at high risk for pregnancy and substance abuse. In addition to the usual clinic contraceptive counseling, Children's Mercy also offers a program called Choices Affect Life. Sexually active females whose sisters were teenage mothers are targeted to participate in a series of six group discussion units lead by a facilitator to help develop knowledge, skills and attitudes that serve these young women as they make day-to-day choices and learn to plan their lives. The program has demonstrated positive outcomes with high acceptance and attendance by the teens, better contraceptive compliance and fewer early teen pregnancies. We would like to expand the scope and number of teens reached by the CAL programs and to integrate units specifically addressing substance abuse with the already successful self-esteem and life choices counseling. But, again, identifying funding for outreach and prevention education is a constant problem.

Without intervention, many of these teens would end up as part of the uninsured or Medicaid population delivering babies at Truman Medical Center, the public hospital for adults. When they arrive, they typically have had little or no prenatal care. Even more frightening is the shocking number—15 percent—of the babies who have documented cocaine exposure. The actual number of babies born at Truman who have alcohol or drug exposure is surely much higher.

The sickest of these newborns end up at Children's Mercy. Typically, they are born very prematurely and have a greatly increased likelihood of suffering from severe and persistent physical or neurological damage and/or developmental delays. The average length of stay for "crack babies" in the NICU is 45 days. The average cost is $94,500 for "crack babies" and $70,000 for babies exposed to other drugs. More than half of these babies are uninsured—either commercially or by Medicaid—at the time of admission. The total cost of neonatal care for these children was $3.5 million last year, more than $1 million of which was uncompensated. Of course this contributes to our shortage of funds for outreach, prevention, and education. It is a vicious cycle. We respond to the crisis of caring for these critically ill infants and the uncompensated care losses we incur impair our ability to prevent the next crisis. At this very moment, Children's Mercy is considering withdrawal from the

Regional Trauma Program because we do not have the money to meet the requirements for 24 hour in-house coverage for the operating room, anesthesia, surgery, and neurosurgery.

RECOMMENDATIONS

The vast number of uninsured children is a national tragedy which demands our attention. As dramatic changes in the health care financing system make it increasingly difficult to shift the costs of caring for the uninsured to privately insured patients, I am greatly concerned about how Children's Mercy will continue to reconcile its mission to the needs of children with the financial constraints of the health industry. The only alternative that I can see is to make public funding more reflective of the public service we provide.

We rely on the Medicaid program to enable us to care for those without resources. Although the program does not cover all who are unable to obtain health insurance coverage, it is the most comprehensive and widespread maternal and child health program we have. Considerable progress has been made in the past couple of years, but much more remains to be done, and we would urge the following:

1. Continue to separate Medicaid from the welfare system by expanding the eligibility guidelines and easing the enrollment procedures.
2. Establish more uniform eligibility and service programs.
3. Ensure adequate reimbursement for providers.
4. Commit the resources necessary to make the program successful.

We commend the Senate Finance Committee, under the leadership of Senator Bentsen and yourself, for advancing important Medicaid reform to benefit children's access to health care in recent years. The specific Medicaid reforms which you persuaded Congress to enact are already beginning to make a difference in Missouri. I strongly support enactment of S. 2459, the "Medicaid Child Health Act." This bill will enhance the provisions for children which the Finance Committee initiated last year.

Perhaps at some point in time, a more universal program will replace or supersede Medicaid. Until that time, we see no alternative but to advocate for continued improvements in Medicaid. Although the budget situation makes it unlikely that we will achieve sweeping reform in any one year, we do see windows of opportunity for incremental changes which, over time, will make a big difference.

Thank you for your interest and concern for this vital issue.

PREPARED STATEMENT OF VIDAL PEREZ

Mr. Chairman and Members of the Subcommittee: My name is Vidal Perez, and I am currently the Executive Director of the Providence Ambulatory Health Care Foundation, a federally-supported Community Health Center, with six clinic sites serving the poorest, most medically underserved neighborhoods of Providence, Rhode Island.

PAHCF currently serves more than 20,000 patients, providing them with basic medical and health care services, including the services of primary care physicians, nurse practitioners, diagnostic laboratory and radiological services, pharmaceuticals, transportation, child birth education, nutrition and case management services, just to name a few. Nearly forty-eight percent of our patients are completely uninsured for medical or health care services; for these patients, were it not for the PAHCF, the only available sources of care would be the emergency room and outpatient departments of the local voluntary hospitals. Even for the thirty-eight percent of our patients who are covered by Medicaid, options for receiving care elsewhere are extremely limited. Most private practice physicians refuse to accept Medicaid beneficiaries, or provide care only to a minuscule number of them. Thus, while we are regularly overwhelmed with a number of uninsured patients far exceeding our capacity to care for them, you should also be aware that, in Providence, as in so many other communities across the nation, we face an ever-increasing number of Medicaid clients who see us as the only truly available source of care left to them.

The Community Health Centers and Migrant Health programs, now in their 25th year of existence, and the more recent Health Care for the Homeless program, currently serve nearly 6 million Americans through a national network of some 2000 community-based clinics. Health centers are already reaching the hard-to-serve: their patients are overwhelmingly poor, uninsured and/or minority, and they increasingly include the homeless, substance abusers and those with HIV/AIDS.

At current total spending levels of approximately $1 billion, health centers provide access to basic medical and dental services, as well as important health-related and case management care, at a cost of less than $200 annually for each patient they serve. This compares most favorably with the current average national expenditure of just under $600 per year for the same set of services. Although these costs do not include coverage for inpatient hospital care or long-term care, the services of health centers have been found to substantially reduce the use, frequency and cost of such care for these patients.

Additionally, it is estimated that there are 300-400 community health clinics which do not receive Federal grants. These centers are often supported by state and local grant dollars as well as private foundations and other private supporters. As health clinics provide health care to increasing numbers of uninsured persons, very often these clinics only look different from their federally funded sister centers in that a Federal grant dollar is not present. State and local, public and private grant dollars, then are serving a similar function as the Federal grant dollars.

I am proud of the fact that, over the 23 years of our existence, PAHCF, as is true of CHCs nationwide, has provided comprehensive, continuous, community-based primary health care services to thousands of Rhode Islanders who would otherwise have gone without care until they were seriously ill, or would have sought some form of episodic, non-continuous care from some other source. I know that, as a result of our presence and our work, our patients and the community as a whole is healthier and more productive; and that as a result of our emphasis on prevention, early diagnosis and treatment, and health promotion, we have saved them—and society as well—both money and, more importantly, lives.

But it is difficult, even for Community Health Centers like mine, to serve so many uninsured individuals and families despite the fact that we receive Federal support to do so. I have seen, in my four year tenure as Executive Director of the PAHCF, waiting time for new registrants and appointments for non-acute care increased from a reasonable one month period to 6 months.

In fact, the National Association of Community Health Centers reports that one of the most serious challenges facing health centers today is the ever-increasing number of people seeking services. New waiting lists are averaging between 15 and 28 percent of the current patient enrollment. Health centers report a 300 percent increase in the number of pregnant women seeking care, thus placing significant pressure on their limited obstetric services. In rural areas, closures of hospitals and physicians' offices have left entire communities in great demand of health care services. Between 1986 and 1987, rural centers had a 7.8 percent increase in the number of patients; of these, 83 percent were uninsured. And, while demand for services has increased significantly, grant funding for centers has decreased over time. Centers are operating at the same level of funding in 1989 as they were in 1987. In fact, 1989 funding is 25 percent *lower* than 1981 levels after adjustment for inflation.

I have seen the availability of resources for inpatient care and specialty services for our patients become scarcer. Just recently, our Medical Director expended nearly one work week trying to locate an orthopedic specialist who would accept a referral of an infant born with congenital hip dysplasia. Although there is no scarcity of orthopedic specialists in the state, there are none who accept Medicaid or who provide their services on a sliding fee basis to the uninsured. The one physician we did find is no longer available to us as he has been "swamped" with referrals for care of other Medicaid and/or indigent patients. A similar situation exists in dentistry, allergy and other medical sub-specialities. The increasing unavailability of tertiary or sub-specialty services for our patient population puts a strain on our resources and limits our ability to reach a larger segment of the community with our primary health care services.

As area hospitals have become more specialized in order to remain competitive or improve their financial viability, they have eliminated services that are viewed as a drain on their resources; oftentimes with no idea of the consequences these actions will have on the community at large. Four years ago, all four teaching hospitals located within the city of Providence had pediatric inpatient services. Today, only two of the four hospitals in the city provide pediatric beds in the city. Our physicians have had to seek privileges in a hospital outside of the city so as to assure that they can obtain inpatient care for our patients. One hospital eliminated its outpatient pharmacy and we are finding many patients that use the hospital outpatient department for their care coming to us to fill their prescriptions. In one hospital emergency room, patients were instructed to call the health center prior to going to the hospital as they may not need emergency care. On this poster was our 24 hour "On-Call" number. Our on-call physicians received calls from patients from other health centers and other parts of the state and found that referrals they had made to the

emergency room were being turned away. Our staff physicians are obligated to provide each of those hospitals with one month of unpaid service for the privilege of being able to admit patients there.

Federally funded and non-federally funded non-profit community based health centers across the country are serving large numbers of poor Medicare, Medicaid, and uninsured patients in rural and urban medically underserved areas. The grant dollars from Federal, state, and local sources have increasingly, over recent years, been expected to subsidize the cost of care to Medicare and Medicaid patients because these programs have reimbursed less than the cost of care in health centers. Eleven percent of the patients of federally funded community health centers are over age 65, but only seven percent of the patient revenue of these centers is from Medicare.

Because these health centers are located in underserved areas and serve large numbers of Medicare, Medicaid, and uninsured patients, when the government insurance programs do not cover the cost of care to their beneficiaries there is no place to "shift the cost" except to grant dollars. Please remember that these health centers are required to take Medicare and Medicaid patients and provide care to the uninsured on a "sliding scale, ability to pay basis," thus further exacerbating the fiscal pressures. These grant dollars, therefore, are not able to be used for the uninsured as they were intended. Thus, health centers are truly disproportionate share, primary care providers.

Last year the Congress, under the leadership of Sen. John Chafee (R-RI) and other members of the Senate Finance Committee, did recognize these centers as disproportionate share Medicaid providers and mandated cost based reimbursement under a Federally Qualified Health Center program (FQHC). Building on this foundation, Sen. Chafee has introduced S. 2538, which would recognize federally and non-federally funded health centers as disproportionate share Medicare providers and mandate reimbursement of reasonable costs to FQHCs. It is estimated that an additional 100,000 uninsured patients would be reached by assuring Medicare would pay the reasonable of care for its beneficiaries, thus allowing the grant dollars presently in the system to be targeted to the uninsured and underinsured.

Once the provisions of S. 2538 are in place, health centers could become Federally Qualified Health Centers receiving cost based reimbursement for Medicare, just as centers, because of OBRA '89, can become Federally Qualified Health Centers for cost based Medicaid reimbursement. They would then be able to use their grant dollars to care for the many persons who are without health coverage of any kind, providing cost-effective primary care and preventive health services which will improve health status and reduce the need for hospitalization, emergency room use and other costly drains on the resources of America's health care system. Given the demographic trends and the high utilization of health care by the elderly, passage of S. 2538 will insure ongoing, affordable health care for a vulnerable segment of our population and will strengthen the community health center system nationwide.

Community health centers are not shielded from the high cost of goods and services for health care providers. Malpractice insurance for our providers has nearly tripled in the past four years, while in our 23 year history there has never been a malpractice claim paid.

Recently, the Centers for Disease Control in Atlanta and the American Academy of Pediatrics recommended that children be immunized twice during their childhood for measles. In effect this "recommendation" has become a standard of care that if not followed could lead to litigation if there is a bad outcome from a measles infection that could have been avoided had a second dose of vaccine been administered. The cost of the vaccine is $24 per dose. A private practice physician can easily pass this cost onto his patients. However, no additional funding was made available to community health centers.

The PAHCF serves a diverse patient population which includes five different language groups in addition to English—Spanish, Portuguese, Cambodian, Laotian, and Hmong. Over half of our patient population speaks a language other than English. Likewise, over half of our staff is bilingual/bicultural. All of our educational materials, consent forms, etc., are translated into five different languages on paper and audio tape. We are the only provider in the city of Providence that assures patients that they will receive health care in their own language.

Despite those difficulties, which might well cause others to give up or quit—or perhaps because of them—I believe that we at PAHCF have done an outstanding job of meeting the health care needs of the neediest in our community; and in that I believe we exemplify the mission and purpose of the Community and Migrant Health Center programs from their very inception—to reach out and serve those most in need among us; to do so with dignity, respect and attention to their special

needs; to make access to basic primary care possible for them; and to make a fundamental change in the way our patients view health care, and in the way that local health care systems view the needs of their communities.

Our experience has taught us much, and we have tried to learn from it. But one important thing that it has taught me is that when you begin to talk about, or to consider options for, improving access to care for people who are not in the mainstream of health care today, it's not enough to focus on how the bills will be paid, or by whom. If you are truly interested in improving the HEALTH of these populations—whether they be uninsured, low-income, minority, non-English speaking, homeless, substance abusing, HIV-infected, or whatever—then it is imperative that you focus on WHERE they will go for care, not just on who will pay. We need more ambulatory care providers—more clinics—staffed with qualified health professionals, to be access points for that care, and to coordinate and manage the patients' care through other providers, both specialty and inpatient services, as well. I happen to think that the Community Health Centers can and should serve as the perfect model for such a system, and with good reason:

- They have 25 years of proven experience in making health care accessible to underserved people and communities;
- They are community-based, and therefore responsive to their communities' needs and circumstances;
- They are closely monitored for adherence to strict requirements for management and financial systems;
- They must meet rigid standards for quality assurance and the qualifications of their clinical staffs, and for the provision of vitally important preventive and early diagnostic services; and,
- They have compiled an outstanding record for the quality of the care they provide. Their impact of the health status of their patients and the communities they serve is unquestionable. Their ability to contain costs, to operate with a fixed budget and limited resources, and their success in substantially reducing the frequency of admissions and length of inpatient care are well proven.

As you proceed to develop your plans and policies to address this most critical access to care issue, I do hope that you will take a serious look at the CHC program, its history and its accomplishments. On doing so, I am confident that you will share my view that CHCs can serve as THE model for an effective, affordable solution to this most pressing problem.

Thank you for this opportunity to testify on behalf of the poor and uninsured patients of the Providence Ambulatory Health Care Foundation, and those of health centers across the country. I will be happy to answer questions you may have.

PREPARED STATEMENT OF EDWARD THOMAS

Good morning. I am Edward Thomas, President of Detroit Receiving Hospital and University Health Center in Detroit. I'm here today not only as the President of a 340-bed urban hospital, but also as the Chairman of the Corporate Board of the Michigan Hospital Association, which represents 187 Michigan Hospitals. My comments will be specific regarding my hospital's experiences caring for the uninsured, and will also characterize the problems encountered by all Michigan hospitals.

Located in the inner city of Detroit, our facility treats a high percentage of medically indigent persons as an essential element of our mission. Of the approximately 10,000 hospital admissions annually, 23 percent, or 2,407, are not reimbursed by any insurance program. The value of that free care we deliver at Receiving amounts to $19 million.

Outpatient care provided to medically indigent persons, offered through the Emergency Department and primary care clinics, has an even higher percentage—40 percent is uncompensated, totaling $11.1 million in free care.

All in all, Detroit Receiving loses more than $30 million annually in the care of the medically indigent. The medical center incurs a total loss due to uncompensated care of $60 million.

The following cases that I will describe briefly represent examples of uncompensated hospital care provided at Detroit Receiving. I should note that there are no elective admissions at Detroit Receiving, except in cases of follow-up surgery for previous trauma patients.

CASE NO. 1: PNEUMONIA

A 34-year old man was admitted complaining of malaise, fever, cough, headache, nausea, chest pain, diarrhea, and a skin rash. He had not significant past medical history, except for a five-year addiction to heroin, administered intravenously.

He was admitted to a general medical unit. A chest x-ray revealed pneumonia. The patient was treated appropriately. However, his respiratory status deteriorated. As a result, he was admitted to the medical intensive care unit.

The patient's critical care phase was very complicated and prolonged by severe adult respiratory distress syndrome, severe vasculitis-which is an inflammation of blood vessels, and acute kidney failure, among other problems.

About midway into his hospitalization, a tracheostomy was performed to overcome a breathing obstruction. The patient's condition eventually improved and 10 days later, the tracheostomy tube was removed allowing the patient to breath on his own. He also received 28 days of intravenous antibiotics for endocarditis, the inflammation of the lining membrane of the heart.

He was discharged for follow-up care in the General Internal Medicine Clinic at Detroit Receiving after 30 days in the hospital.

Hospital charge	$89,481
Physician charges	$1,560
Reimbursement	$0

CASE NO. 2: ACUTE MULTIPLE GUNSHOT WOUNDS

A 23-year old man sustained multiple gunshot wounds to the lower part of his body, leaving his left leg without sensation or movement below the knee. Bullet wounds were found in the thighs, knees, and lower legs. X-rays taken in the Emergency Department showed a femur fracture in the upper left leg.

Once the many was resuscitated and initially treated in the Emergency Department, he was taken to the operating room for repair of his left femoral artery and left femur fracture. He was in significant respiratory distress following the operation, requiring the assistance of a ventilator to breath.

He returned to the operating room a day later for further surgery. Seven days after admission, he required the surgical amputation of his left leg above the knee.

Physical therapy was begun in the hospital, but the patient refused a transfer to the Rehabilitation Institute for further therapy. So he was discharged to his home in a wheelchair.

His hospital stay was 22 days.

Hospital charge	$76,866
Physician charges	$7,673
Reimbursement	$0

CASE NO. 3: PANCREATITIS, PERFORATED GASTRIC ULCER, SPLENIC HEMATOMA, WHICH IS A BLOOD MASS IN THE SPLEEN

This 26-year old man came to the Emergency Department complaining of sharp pain in his left side that extended into his abdomen and up his back. He also complained of nausea and vomiting. He had a prior history of pancreatitis as a result of alcohol abuse and admitted to drinking heavily prior to his Emergency Department visit.

He was taken to the operating room for exploratory surgery, with a preoperative diagnosis of perforated viscus, which is the clinical reference to any internal organ enclosed within a cavity such as the abdomen. He was found to have a gastric ulcer and treated. No perforation was found.

However, postoperatively, abdominal pain did not subside. A computerized tomographic scan of the abdomen showed a mass in the left upper quadrant. He returned to the operating room and was found to have a blood mass in the spleen as well as a perforated gastric ulcer. His spleen was removed.

Following surgery, he was given intravenous antibiotics for recurrence of a fever. A later CT scan of the abdomen showed fluid collection, again in the upper left quadrant. The patient returned to the operating room for another surgical procedure to remove this fluid.

The patient was hospitalized for 38 days.

Hospital charge	$545,391
Physician charges	$4,350
Reimbursement	$0

CASE NO. 4: INTRAVENOUS DRUG ABUSE WITH FEVER AND PROBABLE SEPSIS, WHICH IS THE GENERAL CLINICAL TERM FOR INFECTION

A 32-year old woman, who was a regular intravenous drug user, was admitted with fever, chills, altered mental status, and weakness in her right side. An echocardiogram upon admission showed mitral vegetation—clumps of bacteria on her heart's mitral value, a condition commonly found in drug addicts. Blood cultures showed that the patient had a bacterial infection that was resistant to antibiotics.

A lumar puncture, also known as a spinal tap, was performed for possible meningitis, which is an inflammation of the spinal cord or brain. That test was negative. However, the patient tested positive for the HIV virus.

A computerized tomographic scan of the patient's gastrointestinal tract, administered due to the patient's extreme internal pain, revealed an abscess on her spleen, requiring its removal in the operating room. The CT scan also showed a septic embolus—an infected mass on the left side of the brain.

The patient was treated for 54 days.

Hospital charge	$68,547
Physician charges	$3,900
Reimbursement	$0

Assuring health care for the uninsured is a humanitarian imperative and a public good. But the abandonment of the uninsured is becoming a societal disgrace, and financial disaster for many hospitals. Worse yet, we are forcing the uninsured, many of them the working poor striving for dignity, along with some 300,000 children, to become health care beggars. Until now, hospitals have served as the safety net for those without insurance. But hospitals can no longer sustain the burden alone.

In Michigan, the situation has become particularly acute. There are more than 1 million Michigan citizens with no insurance. Incredibly, more men, women and children in Michigan are uninsured than are covered by Medicaid. The health care program for the needy. Last year, the health care bill for those unwilling or unable to pay for health care in Michigan was more than $350 million. It is no longer gaps in health care coverage of citizens that Michigan Hospitals are trying to cover, but gaping holes.

In the 1980s, the number of uninsured in Michigan exploded. In 1980, hospitals provided $92 million in free care. By the end of the decade, that number had jumped to over $350 million. Uncompensated care costs absorbed by hospitals rose some 277 percent in the last decade. Several factors, though not unique to Michigan, contributed to this alarming increase.

Downturns in the state and national economies has a major effect on Michigan's health care in the 1980s. Controlling costs became the driving force in health care policy decision making as Michigan worked to rebound from the recession prompted by the loss of manufacturing jobs early in the decade. Government and business. The largest purchasers of health care services, aggressively began to slash their health care costs. The hundreds of thousands of high paying manufacturing jobs (with comprehensive health care benefits) have been replaced with fewer and lower paying service industry jobs—many with inadequate or no health care benefits.

To reduce health care expenditures, state and Federal governments instituted the Diagnostic Related Group Prospective Payment System, while employers limited dependent coverage, restricted employee eligibility and reduced categories of covered

services. Large purchasers used their clout to negotiate lower insurance premiums and reduce payments to hospitals and doctors, and insurers increased their efforts to ensure that their payments to hospitals covered *only* their insured population. Few are willing to help subsidize care for the uninsured any longer.

As a result of this unwillingness to share the burden for the growing uninsured population. Hospitals lost revenues that had helped them offset these losses and provide care for the uninsured. By the end of the 1980s, three-quarters of all Michigan hospitals were losing money providing patient care. A significant portion of those losses were directly linked to care for the uninsured. Daily losses now total a staggering $1 million a day for hospitals across Michigan. And 23 Michigan hospitals have closed since 1980.

Michigan hospitals' precarious financial position was further exacerbated by skyrocketing medical liability rates, far outstripping the increases experienced in other states. In fact, Michigan has the highest medical liability rates for hospital beds in the nation, some $4,000 more than the national average. In the metropolitan Detroit area, the bed rate for medical liability is a staggering $6,800. Just between 1984 and 1988, rates jumped by 200 percent.

At the same time, payment to hospitals by the state and Federal government for Medicaid and Medicare eroded steadily. Last year Medicare only reimbursed Michigan hospitals 89 cents for every dollar of care they provided. Medicaid payments in Michigan were so low—just 79 cents per dollar of care provided in 1989—that Michigan hospitals were forced to take the state to court to try to gain adequate reimbursement.

While a Federal judge has awarded a summary judgment to Michigan hospitals and found "no merit whatsover" in the State's arguments that its payments were adequate, Medicaid payments continue to be woefully inadequate. This year, despite a promise of a 2 percent update in our rates to begin six months into the year, to date there has been no update. Further, the state budget for 1991, recently passed by the legislature, fails to give any update for inflation in 1991. Despite the judge's ruling ordering the state to pay hospitals' interim relief. the state's interpretation has actually taken money away from Michigan's major Medicaid providers because the state invalidated the disproportionate share indigent volume adjustment. For many of us, that's the only way we can even approach recovery of our costs for Medicaid care.

This, amidst Michigan's governor's announcement that he will work to rollback auto insurance premiums by 20 percent to be achieved, in part, by implementing a fee schedule for health care payments to providers. In other headlines as the big three automakers begin their contract negotiations, controlling health care costs will be a major agenda item—with auto executives pushing for a single health care plan "with enough clout to force doctors and hospitals to curb soaring health care costs."

Taken alone, Michigan hospitals might have been able to absorb the cost of care of the increasing number of uninsured, or the underfunding of Medicaid, or the unrealistically high medical liability rates, or the burgeoning drug abuse problems, or the AIDS epidemic. But not together.

If you throw a man treading water a brick, it's not the first one that will cause him to sink. But by the time he's caught the second and third and fourth, he's in serious trouble. Michigan hospitals are at a similar point today. The crush of the uninsured, the underfunding of Medicaid and Medicare, AIDS, drug abuse, exorbitant medical liability rates, and a government and society unwilling to see the health of the less fortunate as a shared responsibility leaves financially strapped hospitals as the provider of last resort.

In the 1980's our commitment to health care access for all, regardless of ability to pay, took a back seat to concerns for controlling costs. Access to health care was taken for granted. The patchwork, shortsighted, and budget-driven decision making of the 1980s has proved a recipe for disaster. While cost containment is an important element of efforts to improve access, it is not the only factor. We must look behind cost increases to the reasons for them. We must move quickly to renew our commitment to health care for all. Health care must have a higher priority.

Health care—like education, housing, and employment—is a basic human need. Yet, the 1980s passed with little attention given to maintaining our delivery of health care. This *must* change in the 1990s. Concern for health care issues cannot be separated from other fundamental needs. Access to health care is an integral part of Michigan's and the nation's future and their economic heath. We cannot afford to ignore health care or subject it to an endless barrage of short-term, piecemeal remedies. A coordinated health care policy with integrated roles for both the Federal and state governments must be developed to offer a comprehensive safety net for all.

Regrettably, the United States is the only industrialized country in the world that does not assure its citizens access to some minimum level of health care services. Those who see only higher costs when examining the problem of the uninsured out to closely examine the social and economic failures wrought by our present approach. Until then, government's credibility, hospitals' survival, and the health and well being of millions of Americans will remain in jeopardy.

PREPARED STATEMENT OF BARBARA LORD WATKINS

Mr. Chairman, Members of the Committee, I am Barbara Lord Watkins, Vice President of Public Affairs and Human Services at Parkland Memorial Hospital, Dallas, Texas. I am here this morning representing not only Parkland Hospital but also the National Association of Public Hospitals (NAPH). NAPH consists of approximately public and non-profit hospitals that serve as major referral centers, teaching hospitals, and hospitals of last resort—"safety-net hospitals"—for the poor in most of our nation's largest metropolitan areas.

I am pleased to have the opportunity this morning to discuss the impact of current health insurance policy (or the lack thereof) on hospitals. In order to place this discussion in context, permit me to begin by describing the current situation of major, metropolitan area safety net hospitals nationally and more specifically, the situation facing Parkland Memorial Hospital.

I. THE SITUATION OF URBAN PUBLIC HOSPITALS NATIONALLY

America's "safety net" is comprised of a surprisingly small group of hospitals in our nation's metropolitan areas—perhaps no more than two or three hundred in all, out of over 6,000 hospitals nationally. While there are a number of non-profit teaching and community hospitals within this network, the majority are government-supported facilities. These include city and county hospitals, state university hospitals, and hospital districts and authorities, in addition to non-profit facilities.

While these hospitals operate under a variety of legal structures, they share a common mission and many common characteristics that set them apart from other community hospitals. They provide a significantly higher volume of inpatient and outpatient services than their private sector counterparts; they provide many unprofitable specialized services; they are extremely dependent upon governmental sources of revenue (local, state and federal), and typically, have a much lower proportion of privately insured patients. Most significantly, they continue to bear an enormous and increasing share of the burden for care to the poor In comparison to other segments of the hospital industry. In 1986, NAPH hospitals averaged 42,877 inpatient days of unsponsored care, or 25.86 percent of total inpatient days. By 1987, unsponsored care represented over thirty (30) percent of patient days (an average of 48,803 uncompensated days out of 164,691 total days per hospital). In 1988, uncompensated care represented thirty-four (34) percent of all discharges and twenty-nine (29) percent of all inpatient days. At the same time, NAPH hospitals in 1988 averaged 147,501 unsponsored outpatient visits. Fifty-two (52) percent of all outpatient visits.

Parkland Memorial Hospital Is a classic example of the safety net hospital I have just described. Parkland is a public, tax-supported teaching hospital serving Dallas County, Texas. Parkland is the region's only Level I trauma center and Parkland provides a number of other highly specialized, but unprofitable, services including pediatric trauma care and high risk maternity care. Approximately seventy percent (70%) of our patients qualify for charity care.

As this data Indicates, Parkland and other public hospitals are truly this country's safety net, providing an enormous volume of uncompensated care. In order to fully appreciate these statistics, it is necessary to look at the volume and types of services provided by public hospitals.

A. Volume of Services

Public hospitals, though few in number, provide a huge volume of care, and that volume continues to increase. In 1988, NAPH hospitals averaged 18,215 admissions per hospital. Short-term acute care hospitals nationally averaged only 5,619 admissions per hospital. Parkland Hospital admits almost 40,000 patients per year.

Public hospitals also provide a disproportionate share of outpatient services. In 1988, NAPH hospitals averaged over 211,848 outpatient visits as compared with an average of 48,653 visits for other urban community hospitals. Parkland, by comparison, recorded 385,000 outpatient visits last year.

B. Trauma Care

Public hospitals also provide many specialized services that are unprofitable and, consequently, are not offered by many other hospitals In the community. For example, NAPH hospitals are four times more likely to be designated a trauma center than private facilities. Seventy-four percent (74%) of public hospitals are designated as trauma centers, while only about thirteen percent (13%) of other short-term acute care hospitals provide this service.

The costs associated with the provision of such care can be overwhelming. For example, many inner-city trauma centers provide a high proportion of uncompensated care associated with gunshot-wound victims and other victims of violent crime. The cost of such treatment is high, and most often, patients have no Insurance or other means to pay for this care. A recent NAPH survey on trauma care sawed that NAPH hospitals collected an average of forty-eight cents on the dollar for trauma patients. Parkland receives an average of thirty cents on the dollar for trauma patients.

C. AIDS

Public hospitals also provide a disproportionate share of AIDS treatment. In 1988, NAPH members treated an average of 134 AIDS inpatients. Just 58 NAPH member hospitals treated almost 7,800 AIDS inpatients. NAPH members provided an average of 1,427 outpatient visits for persons with AIDS during 1988. At Parkland, we treat approximately 1,200 AIDS patients *per month.* According to NAPH data for 1988, twenty-six percent (26%) of AIDS patients were described "self-pay" or "other" patients, good proxies for non-paying patients. At Parkland, I can verify that a significant percentage of AIDS patients are non-paying.

D. Drug and Alcohol Abuse

Public hospitals provide a significant amount of care for drug and alcohol abuse including care for cocaine-involved Infants. In 1988, 43 NAPH hospitals treated an average of 104 cocaine-involved neonates; in the first half of 1989, these hospitals cared for an average of 61 babies. The average length of stay for these babies is 7.8 days. Parkland has seen a 20 to 30 percent increase in the number of newborns requiring intensive care in our Special Care Nursery as a direct result of the substance abuse of their mothers during pregnancy. As a result, most of the gains we have accomplished through early prenatal care are now being lost to drug abuse.

II. FINANCING OF CARE

As the preceding data indicates, uncompensated care represents a major financial commitment by public hospitals. In order to provide this level of care, public hospitals are heavily dependent upon Medicare, Medicaid and city, county, and state funds. Even with these funds, a large number of public hospitals report operating deficits.

In 1988, funds for the treatment of low-income and uninsured patients represented 50 percent of net revenues of NAPH-member hospitals, at an average of $64.54 million per hospital. Of this total, $37.24 million was from Medicaid and $27.3 million was from non-Medicaid local/state funds. The data also reveals that non-Medicaid local/state funds as a percentage of net revenues received by of NAPH-member hospitals has declined during recent years.

Sixty-one percent (61%) of NAPH hospitals reported operating deficits for 1988. For those hospitals with a deficit, the deficit averaged −$18.2 million. For all NAPH hospitals, the average operating deficit equaled −$8.2 million or 6.2% of net operating revenues.

III. IMPROVING THE FINANCIAL SITUATION OF PUBLIC HOSPITALS

Obviously, the best solution to the current crisis Is to expand health Insurance coverage. Congress must move quickly to achieve the goal of universal health coverage and toward this end, should enact this session legislation expanding employer coverage.

In the meantime, if America's safety net hospitals are to continue to serve their vital mission, policy must recognize the special needs they face. Medicare and Medicaid must adequately compensate disproportionate share hospitals if they are to survive.

A. Medicaid

As a first step, Congress should maintain and improve access to hospital services covered by Medicaid. By expanding eligibility, the burden of uncompensated care will be reduced. In addition, we urge you to consider the following:

• *Minimum Medicaid Disproportionate Share Payments.* While states are required to make such payments, in many cases, these are so low as to be meaningless. In light of the enormous burden of charity/indigent care, Congress should require states to provide meaningful Medicaid disproportionate share payments.

• *Outpatient Disproportionate Share Payment.* As noted above, one of the heaviest burdens falling on safety net hospitals is the provision of indigent care on an outpatient basis. Accordingly, states should required to provide an adjustment to payments for outpatient services provided to individuals by disproportionate share hospitals.

• *AIDS.* AIDS is becoming a disease of the medically disenfranchised, including the uninsured, the underinsured, poor children and drug users. Improved Medicaid support is required if the handful of urban hospitals treating these patients are to avoid financial ruin. In this regard, we urge Congress to seriously consider the legislation introduced by Congressman Waxman requiring states to make a Medicaid payment adjustment to hospitals with a disproportionate share of inpatients with AIDS.

• *Voluntary Contributions/Provider Taxes.* Congress must continue to permit States to take advantage of all available funding sources. Several states use voluntary contributions from providers or provider specific taxes as a means of expanding Medicaid eligibility or available services. HCFA has issued regulations which would eliminate Federal matching of these sources of funds. Congress enacted prohibitions in 1988 and 1989 against such regulations. Congress should permantly prohibit such action by HCFA.

• *Durational Limits.* Congress should prohibit States from imposing fixed durational limits on medically necessary inpatient hospital services. Such limits have the effect of inappropriately forcing the subsidization of indigent care by hospitals already operating at the margin.

• *Outlier Reimbursement.* Congress should require States to provide for an adjustment for payments for outpatient services provided by disproportionate share hospitals. Congress should also prohibit States from placing limits on medically necessary covered outpatient services. Finally, outer adjustments should be required under state prospective payment plans for medically necessary inpatient hospital services for very high cost or exceptionally lengthy cases.

B. Medicare

Congress must also protect Medicare reimbursement. The administration's proposed cuts in Medicare will wreak havoc on public hospitals. Of the $5.5 billion in Medicare budget reduction measures contained in the budget, $4.1 billion, or seventy-five percent would come directly from hospital reimbursements. Given the precarious financial position of public hospitals, such cuts would be disastrous. In the case of Parkland, the proposed cuts would result In a loss of $3.6 million. This is equivalent to the annual costs of treating 2,000 patients.

In particular, I must reinforce the importance of Medicare disproportionate share payments to public hospitals. In a recently released study, the Congressional Budget Office concludes that Medicare disproportionate share payments exceed the costs incurred by DSHs in treating indigent patients. The reality is that 59% of the public hospitals surveyed by NAPH had negative operating margins for 1989. Without a meaningful disproportionate share adjustment, this percentage would have been significantly higher.

Finally, I encourage Congress to consider enacting a new program to address the present and future capital needs of our health safety net infrastructure (including needed alternative care facilities in addition to hospitals); this may include a resurrection of certain aspects of the Hill-Burton program or the creation of new programs to improve access to capital. We are currently drafting proposals and we would very much like to work with your committee in this area.

In conclusion, serving the indigent is a role that safety net hospitals willingly accept but the safety net is being increasingly strained by the lack of national health Insurance. While we wait for enactment of universal health coverage, I urge you to protect the Medicare and Medicaid systems, and to consider additional payments for those hospitals providing trauma care, treatment for AIDS patients, and care for alcohol and drug abuse. I thank you for the opportunity to testify this morning. I will be happy to respond to any questions which you might have.

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DARYL E. WILLIAMS DDS. MS.
DALTON SANDERS DDS.

August 2, 1990

Senator Don Reigle
U.S. Senate
Dirkson Bldg.
Washington D.C. 20510

Ms. Chang:

As per conversation, thank you for the opportunity allowing Dental Survey of America to submit additional written testimony on **PUBLIC HEARINGS ON UNCOMPENSATED CARE.**

The enclosed are the documented stories of broken dreams, destroyed families, and the personal tragedies of honest hard working Physicians, Dentists, and Lawyers, whose lives were uprooted by overzealous, sexist, racist, jealous and dangerous prosecutors and investigators. These healthcare providers having been wrongfully accused of medicaid fraud.

These documents were compiled over a two year period by myself and Howard Fishman (301-831-6361) former Director of Continuing Medical Education at Harvard Medical School, Department of Psychiatry at Massachusetts Mental Health Center and Associate Publisher of Psychiatry Times, along with Dr. Robert Cohen(212-787-8055) of CIM the lead researchers of the group.

According to Dr. Fishman, " this ranks as one of the top forms of malevolent harassment against physicians that we have ever encountered...some physician have been run out of the country and others have been denied due process by Medicaid Fraud Control Investigators." We hope that our investigation will be helpful in identifying issues to be addressed in any pending legislation.

Yours for Better Dental Health Care

Norman J. Clement DDS.
Founder, Dental Survey of America

COMPARATIVE REVIEW OF THE STATE OF MICHIGAN MEDICAID DENTAL PROGRAM:

A GUIDE TO SUBSTANDARD CARE

NORMAN J. CLEMENT DDS.
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INTRODUCTION

It appears nearly all State run federally funded Medicaid Dental Programs fail to meet the minimal standards for Dental care in America as recommended by national established Dental organizations. It also appears that these programs place their current recipients' general health and dental health specifically in imminent danger. Many States have failed to inform medicaid recipients of the conscious decision to employ sub-standard treatment procedures which significantly impacts the quantity and quality of services rendered at the level considered appropriate by the dental profession.[1]

It is clear from this examination of the Michigan Medicaid dental program, that nearly all Federal guidelines as set forth by Congress, Health Care Financing Administration, Public Health Service to provide all Dental Care as early an age as necessary which is needed for the relief of pain and infections, restoration of teeth and maintenance of dental health[2] are being violated. We examined the constructs of dental healthcare policies found in the Michigan Medicaid Dental Program Manual Chapter III (No. 5330-82-01) as it relates to patient care and the providers of that care by utilizing:

1. Federal Core Component Guidelines (basic dental services which every State run Federally funded medicaid dental program must contain) as outlined and used by the Congressional Office of Technology and Assessment (OTA), study on medicaid dental programs initiated April 1989.

2. Presenting basic dental healthcare policies and procedures definitions found in dental textbooks, taught in most Dental Schools and are standards accepted by the Clinical Dental Profession.

3. Making an integrated analysis of these standards accepted by the Clinical Dental Profession with Legal Principles as it pertains to the constructs of these **MEDICAID DENTAL HEALTHCARE POLICIES AND PROCEDURES** found in manuals.

More importantly, for this report by Dental Survey of America we examined the background and qualifications of those individuals responsible for overseeing, developing and implementing **MEDICAID DENTAL HEALTHCARE** related policies and procedures for the Michigan Medicaid Dental Program. Further, we deciphered the manners in which these Michigan Medicaid officials have uniquely contrived dental healthcare policy and procedures as **A GUIDE TO SUBSTANDARD CARE.**

BACKGROUND

Under the medicaid program, the Federal and State Governments share the cost incurred by states in providing medical care to persons unable to pay for such care. This program authorized by title XIX of the Social Security Act, began in 1966. Each State's Medicaid agency is responsible for designing and administering its program.[3] Medicaid is unique in its commitment to preventative health care for children through the Early Periodic Screening, Diagnosis, and Treatment (ESPDT) program. EPSDT is a program that combines informing, outreach, health screening, follow-up care for detected conditions, and case management.[5] Each state

is required to offer EPSDT services to all Medicaid-eligible children and youth under 21.[6] Medicaid children pay no co-insurance for services received and, except in States with recently initiated waiver programs, are free to choose their provider (subject, of course, to the willingness of the provider to serve them).[7]

Provisions for early identification and treatment of physical and mental defects in children was included in amendments passed in 1969 which required Early and Periodic Screening, Diagnosis, and Treatment(EPSDT) for all medicaid eligible individuals under the age 21.[8] Later in1972 and in 1985 the Congress passed additional amendments which imposed penalties for those states that did not implement the EPSDT program.[9] As far as dentistry is concerned these two legislative actions made important changes in medicaid: 1) dental care could be offered to children even if it was not offered to the other categories of public welfare assistance--the aged, blind, and disabled, and 2) dental treatment of children was no longer an optional service but mandated for States to provide.[10] [11]

Each state is required by federal law to provide all dental care, at as early an age as necessary, needed for the relief of pain and infections, restoration of teeth, and maintenance of dental health.[12] Comprehensive treatment services for all clients, which include dental specialties of pedodontics, orthodontics, periodontics, prosthodontics, endodontics, oral surgery, and oral medicine as indicated, as well as comprehensive preventive dentistry programs.[13] Federal Medicaid regulation requires that the state plan specify care that is reasonable in "amount, scope and duration."[14]

Current federal EPSDT program rules, issued in November 1984 and 1985, further state that direct referral to a dentist for examination screening is required for all eligible enrolled children beginning at age three.[15] This does not preclude necessary treatment to relieve pain or restore and maintain teeth for children younger than age three, but rather it strengthens the mandate for preventive care. This requirement is based on recognition of the problems caused by lack of proper dental care and sets a minimum federal standard.[16]

States failing to implement these mandatory guidelines are cited as out of compliance with the regulation at **CFR 441.56(c)(2)** unless this service is made available to children (through EPSDT).[17,18] The Health Care Financing Adminstration has broadly interpreted these requirements(Guide to Dental Care, EPSDT-Medicaid, Pub. No. HCFA 24515), and a federal court affirmed the broad intent of this language (Mitchell v Johnston 701 F 2d 337, 5th Cir, 1983).[19 20] The findings of the 5th Circuit Federal District Court of Texas and affirmed by the Federal Appeals Court were so broad and so sweeping they made possible comprehensive dental services including Orthodontia available to poor Americans and made it impossible for any State to avoid, frustrate or cut in any form or fashion federally mandated orders as intended by the will of the Congress of the United States of America to such services available under EPSDT.

The dental component of the Michigan Medicaid program became mandatory in 1972 and started in 1973. The original program was designed and developed for children under the age of 21. There were no benefits for adults. In 1976 modest benefits were added, dentures and emergency care (**mostly extractions due to pain**) for the adult population.[21]

Throughout the history of this program providers have complained bitterly primarily over difficulties of being paid and limited service benefits to recipients found in the policy manual. Since its formation, Dental Survey of America has made several suggestion of improving dental healthcare policies and procedures found in Michigan's manual. Yet, according to Bruce Huckaby Director of the Office of Prior Authorization (Michigan Medicaid), "these gentlemen (DSA) would say the manual should be a scholarly document with footnotes and references referring to some standards of dental care, when just the opposite is true." Huckaby went on to say, " the purpose of the manual is to advise the dentist:[22]

1) As to who is eligible for the services.

2) What services are covered.

3) How you go about billing for those services.

4) And how to resolve any problems.

In April 1987 the Department of Social Services convened a task force of interested parties to review and evaluate the Michigan Medicaid dental Program. The Task Force addressed several primary problems in the current program:[23]

1) The rigid and arbitrary nature of current prior authorization system.

2) The inability to be paid for treatment completed.

3) The failure of the system to recognize current standards of care in dentistry.

4) The failure of the system to adequately reimburse the professional providing legitimate care to cover his/her overhead.

In summary the Michigan Medicaid Dental Task Force Report (MMDTF 88') Review of Dental Services under the Medicaid Assistance Program specifically stated that,

> "The problems have resulted in an inability of recipients to receive minimally acceptable care as the numbers of quality practitioners providing care has continued to decrease." (see pg 1)2d 337, 5th Cir, 1983)."[24 25]

According to MMDTF 88' over the 15 years since 1973, when dental services were added as a Medicaid coverage in Michigan, the goal of mainstream dental care has been achieved only in part. One measure of this is the proportion of eligible recipients who actually received a service. Ironically, the 1.1 million Michigan Medicaid recipients in FY 1985-86, only 29% actually received a dental service paid by Medicaid.

Provider dissatisfaction with the medicaid dental program increased so dramatically that there has been a significant decrease in

their participation. Over the past three years, according to MMDTF 88', between 7,000 and 8,000 dentists have been licensed to practice in Michigan. However, in 1985, 2,100 dentists were actively providing services to Medicaid patients. In 1987, the number who provided service to a Medicaid patient increased to 2,389.[26]

This would average to approximately 1,100 patients per actively participating provider beginning FY-85 to 1,600 patients per actively participating provider beginning FY-86 or an increase of 16% in medicaid recipient patient load per actively participating dentist in a one year period. These are conservative statistics and don't really reflect the actual amount of medicaid patient load an actively participating provider may be willing to handle in his/her practice.[27] It is well known that many providers are very selective in the number of medicaid recipients they are willing to treat. Practitioners are often selective as to which schedule hours medicaid recipients can be offered appointments. This is to limit care for medicaid insureds to the slowest time of to keep valuable time open for private insured patients.[28] In contrast, data for other persons in Michigan who are covered by a private dental plan indicates that 54 to 58% of eligible persons receive a covered dental service each year.[29]

The Michigan Medicaid Dental Task Force (MMDTF 88') made 60 recommendations in which the Michigan Medical Services Administration (MSA) reviewed and issued their progress report on June 1, 1989. Unfortunately, for the MSA their progress report becomes a indictment of how State of Michigan Medicaid Officials have mismanaged the Dental Program. Nearly all of the 60 recommendations are mandatory requirements under federal guidelines issue in the mid 70's and early 80's to which all states must adhere. States failing to implement these mandatory guideline are cited as out of compliance with the regulation at **CFR 441.56(c)(2).**

FEDERAL CORE COMPONENTS OF MEDICAID DENTISTRY

In February 1989 Congressman Lewis Stokes (D of Ohio), requested Congressman Henry A. Waxman Chairman, Subcommittee on Health and Environment to conduct a full review of medicaid dental programs. On April 17, 1989, Congressman John Dingell, Chairman, Committee on Energy and Commerce adjoined by Congressman Henry A. Waxman requested Dr. John H. Gibbons, Director, Office of Technology Assessment (OTA) to conduct a study on dental care provided under Medicaid. Immediately, this project led by Pamela Simmerly of OTA's healthcare division, began identifying basic dental services that outlines the minimal care (core components) each medicaid program is required to provide.

The Set of Core dental guideline components were the compilation of common components from several sets of dental guidelines, including those suggested by the Health Care Financing Administration (HCFA), the Public Health Service (PHS), the American Dental Association (ADA), and the Office of Disease Prevention and Health Promotion (ODPHP). In all instances, the most minimal aspect of a shared component was selected. For example, a child should receive an annual exam, rather than exams twice a year. The rationale behind compiling a common set of components was that such a set would represent the core of a set of dental services that any child should receive. The purpose for compiling this set was to have a reference against which the level of care provided for by State Medicaid programs could compare, and not to design an optimal dental care program.

(Place chart Here)

MICHIGAN MEDICAID DENTAL TASK FORCE (MMDTF 88') CONCERNS WITH STANDARDS OF CARE

The Michigan Medicaid Dental Task Force (MMDTF 88') further defined standards of dental care that every citizen, irrespective of financial means, deserves. These standards are clearly defined as the right to dental care, absence of active disease, treatment of dental emergencies and other active disease processes, preservation of a functional dentition, and elimination of conditions that contribute to, or if left unattended would lead to a deterioration of the health of the individual.[30] Preventive treatment of oral disease and oral health maintenance are important to support adequate mastication, nutrition, the capacity for normal speech, appropriate physical appearance and an acceptable quality of life.[31]

Caries: All teeth present must be free of coronal and root caries; and all tooth structures and contours must be normal and/or properly restored.

Other Soft Tissues: Mucous membranes, lips, salivary glands and pulpal tissues must be normal

Occlusion: There should be a minimum of 20 teeth (natural and or artificial) present and functioning properly. The temporomandibular joint should be functioning normally and be asymptomatic. There should be no more than five millimeter of overjet of the anterior teeth and no more than 70% overbite of the mandibular anterior teeth (lower incisors must not be in contact with the palatal soft tissue). A handicapping malocclusion index should be used to determine the unacceptable limits of crowded or spaced teeth.

Esthetics: While it is difficult to assess the handicapping nature of unattractive teeth, there must be consideration to correct darkened teeth due to pulpal death and esthetics restoration of anterior teeth currently or temporarily restored with stainless steel or silver alloy restorations.

Dental Survey of America found the MMDTF 88's recommended

guidelines to be clear, consist and consistent with the standards of care utilized within the Clinical Dental Profession and very similar in scope and duration of the federal Guide to Dental Care, EPSDT-Medicaid, Pub. No. HCFA 24515. What was most astounding about the MMDTF 88' recommendations from interviews of task force participants conducted by DSA, was that these recommendations were completely designed without cognizance of federal guidelines. Most task force member expressed no knowledge of established mandatory federal guidelines or of (42 CDF Section 441.56(c) (2) 1985) which states:

> "with regards to dental services, each state EPSDT program is required by federal law to provide all dental care, at as early an age as necessary, which is needed for the relief of pain and infections, restoration of teeth, and maintenance of dental health."

and that Federal Medicaid regulation **42 CFR Section 440.230(b) 1985.** requires that the state plan specify care that is reasonable in:

> "amount, scope and duration"[32]

Moreover, Federal Medicaid EPSDT regulations requires under 42 CFR SECTION 441.56 (b) (2) 1985 that

> "states consult appropriate professional organizations in the development of schedules for periodic visits and within them screening packages."[33]

The intent of this requirement was to ensure that states fashioned EPSDT-Medicaid programs which reflect reasonable standards of dental and medical practice.[34]

Task Force participants did not express any knowledge that the Health Care Financing Adminstration had broadly interpreted these requirements in the Guide to Dental Care, EPSDT-Medicaid, Pub. No. HCFA 24515, and a federal court affirmed the broad intent of this language (Mitchell v Johnston 701 F 2d 337, 5th Cir, 1983).[35] [36]" This underscores the high level of education most dentist receive in their training and the high degree of integrity for dental healthcare which has been established

within the dental profession. It further underscores the degree of indifference that exists between medicaid officials and their dental healthcare policies and the standards of care established by the Clinical Dental Profession.

PERIODONTAL SERVICES THE KEYSTONE IN DETERMINING SUBSTANDARD CARE

If there is one area of service, in the Clinical Dental Profession that can be used as a Keystone in measuring the failure or success of any program these would be services listed under Periodontal Therapy. More importantly one can determine:

1. Whether Substandard dental care, as well as barriers to dental care exist in **any** program.

2. As a predictor in determining the failures of **dental healthcare** policy and procedure found in any programs' manual.

Along these lines Dental Survey of America has developed several laws called Clement's Laws of Dentistry and Clement's Laws of Program Mismanagement which better illustrates these points.

Clement's First Law of Dentistry states:

The failure of any dental program to adequately make provisions for Periodontal Therapy is the determining factor in how all other dental services will be delivered by that program.

Clement's Second Law of Dentistry states:

The failure of any dental program to properly cover Periodontal Therapy, ultimately will lead to the loss of teeth and all other dental services listed within the program are meaningless.

Clement's First Law of Program Mis -Management states:

1. Poor Policy and Procedure design, is reflective of Poor Administration, which leads to mismanagement, always.

Clement's Second Law of Program Mis-Management (is a simple A x B- = -AB) states:

2. When Policy and Procedure design is incorrect then any inferences draw from data of the incorrect policy and procedure design will be incorrect.

According to the Proceedings from the State of the Art Workshop on Surgical Therapy for Periodontitis sponsored by the National Institute of Dental Research, National Institute of Health held May 13-14, 1981, "**Periodontitis**, causes more tooth loss than dental caries and costs the American public an estimated 4 billion dollars a year to treat and repair its ravages."[37] This major oral health problem (one of the most ubiquitous of all human diseases) is strongly correlated with age and oral uncleanliness." The Workshop defined, "The goal of periodontal therapy is to restore health and function to the periodontium and to preserve the teeth for a lifetime."

The objectives of the workshop were to review and evaluate the available scientific evidence on the efficacy of surgical therapy for adult periodontitis and to formulate summary recommendations on this treatment modality. The scope of this workshop was intentionally limited to address the technical question of whether the surgical treatment of periodontitis is scientifically sound, safe and efficacious.[38] Social and economic issues impacting on treatment were omitted from the workshops' agenda.

In 1988, the Michigan Medicaid Dental Task Force established recommendations for the Minimal Standards for Oral Health Status of Medicaid Beneficiaries that are very similar to the goals of periodontal therapy outlined by the Workshop. The MMDTF 88' recommended that the

Michigan Medical Services Administration adopted a philosophy for **Periodontal Disease** which states, "There should be no active periodontal infections, teeth and supporting tissue must be healthy and functioning normally with reasonable prospects for continuance of normal health and function.[39] Further, the MMDTF 88' stated that, "Medicaid beneficiaries, within Program constraints, have the right to a standard oral health that is no less than what is expected by any other individual in the State. The quantity and quality of services rendered must be at the level considered appropriate by the dental profession."[40]

In assessing Periodontal Services in the Michigan Medicaid Dental program manual, Dental Survey of America found that medicaid officials to have uniquely designed these policies and procedure to be inadequate, confusing, and as vague as possible, so that no meaningful treatment could ever be rendered. What is unique about the Michigan Medicaid Dental Program is that both Adult and Children's periodontal therapy is covered.

Periodontitis is the major cause of tooth loss in adult populations.[41] Yet in the Michigan Program, as with DSA's evaluation of the Ohio Program, there are absolutely **No** provisions that appear to cover adults presenting with periodontal disease of a Type II (early periodontitis), Type III (moderate periodontitis), or Type IV (advanced periodontitis). Even basic periodontal service of a Type 1 (gingivitis), in children such as effective plaque control through patient education, without which no meaningful type of Dental Care could ever proceed forward.

Treatment methods designed according to the Proceeding from the State of the Art Workshop to meet the goal of periodontal therapy are divided into four general sections.[42]

1. Initial therapy to Control Etiological factors.
   - (a). *Plaque Control*
   - (b). *Scaling and Root Planing*
   - (c). *Chemotherapy*
   - (d). *Occlusal and Orthodontic Therapy*

2. Reevaluation
   - (e). *Evaluation of Plaque Control*
   - (f). *Indicators of Periodontal Inflammation*
   - (g). *Need for further Periodontal Therapy*

3. Periodontal Surgery.
   (h). *Gingivectomy*
   (i). *Subgingival Curretage*
   (j). *Apically Positioned Flap with and without Osseous Recontouring*
   (k). *Open Flap Curretage*
   (l). *Modified Widman Flap*
   (m). *Excisional New Attachment Procedure.*
   (n). *Osseous Grafts*
   (o). *Clinical Evaluation-Autografts*
   (p). *Clinical Evaluation- Allografts*
   (q). *Histologic Observations*
   (r). *Osseous Grafts Compared with Nongrafts Regenerative*
   (s). *Free Gingival Grafts*
   (t). *Pedicle Gingival Flap, etc.*

4. Maintenance.

This is based on a sequence of care that should be delivered to a patient manifesting chronic periodontitis. The listing of treatment phases and of the procedures included in each phase does not represent the order on how each phase is delivered. In Michigan the procedure's codes listing is defined as:

V. PERIODONTICS

Under 21	21 and over	
		SURGICAL SERVICES
•	•	04220 Gingival curretage
		ADJUNCTIVE PERIODONTAL SERVICES
•	•	04340 **Periodontal Scaling and Root Planing** (entire mouth)
•	•	04341 **Periodontal Scaling and Root Planing** (12 teeth or less)

For brevity on this very complex issue we will only address services in the Initial Phase, and Surgery phases of periodontal treatment and define the relationship of the other two phases to these services.

The purpose of initial therapy is to remove and control the etiological agents (anaerobes) responsible for periodontitis and to establish an oral environment that facilitates oral cleanliness. Because the etiological agent of chronic periodontitis is microbial plaque, plaque control measures are necessary not only to treat it but also to maintain periodontal health. Thus the routine daily prevention or removal of plaque on the tooth surface by the patient is a major objective of presurgical phase of treatment. The means in which the patient and the clinician can control dental plaque formation is through mechanical devices such as tooth brushes, flosses, wooden points, rubber tips, toothpicks, interproximal brushes yarn and many others.

The procedures of **Periodontal Scaling and Root Planing** are a part of the *Initial phase* of periodontal therapy. Scaling is the removal of calculus, bacteria, and their by products from the root surface. Root planing is a meticulous and more definitive form of scaling to smooth roughened root surfaces and is a prerequisite for the cure of periodontal disease.[43] Combined with plaque control root planing is an integral part of the effort to prevent the periodontal disease and is a part of every treatment of gingivitis and periodontitis.[44] It may bring about the eradication of some of the shallower pockets through the resolution of the inflammation.

Root planing should precede most surgical procedures since it creates a cleaner environment, reduces hyperemia and edema and improves the healing tendencies of the tissues. It is also repeated during some surgical procedures and after healing to ensure the complete debridement and thorough polishing of the teeth so that the patient can maintain gingival health by proper oral hygiene.[45] In practice the procedures of Root Planing and Periodontal Scaling are often done in combination as a single operation.

Gingival curretage is a part of the *Surgical phase* of periodontal therapy and represent only one part of this phase. Gingival Curretage (subgingival c. soft tissue c.) consist of scraping the inner surfaces of the gingival wall of the periodontal pocket to clean out, separate and remove diseased soft tissue and granulation tissue. The technique is seldom used as a single procedure but is usually combined with scaling

and/or root planing.[46] Without scaling and root planing, however Gingival curretage has no demonstrative value.[47]

Evaluation of Plaque Control is important to maintain the beneficial effects of periodontal therapy. After the initial phase of therapy the *Reevaluation phase* is where further determination are made for additional therapy. Included in this phase of therapy is cooperation and effectiveness of the patient in controlling plaque; the improvement in gingivitis, pocket depth, and clinical attachment level; and the systemic status of the patient.[48]

Maintenance Therapy (periodontal) is the term applied to the measures taken by both patient and therapist to preserve periodontal health and thereby to prevent further destruction of the periodontium by recurrent periodontitis. Maintenance therapy consists of plaque removal from the teeth by the patient; periodic examination of periodontal status by the therapist; professional removal of tooth deposits by scaling, root planing and polishing; and motivational and instruction of the patient in personal plaque removal. Effective plaque control is necessary to the success of all methods.[49]

Under the Michigan Medicaid program, Periodontal Therapy is a benefit for all recipients and requires prior authorization but is severely limited to only:

1. Initial Phase
   (a). periodontal scaling and root planing,

2. Periodontal Surgery
   (i) gingival curretage.

The services of periodontal scaling and root planing in the Michigan medicaid program are separately reimbursable from a **prophylaxis only** when generalized **subgingival** accretions are readily visible on radiographs. This definition is both incorrect and inconsistent with the current practice of modern dentistry in that it is not necessary for the **subgingival** accretions to be visible radiographically in order to initiate scaling and root planing. The definition also fallaciously defines and implies that any removal of **supragingival** calculus by a clinician is a

prophylaxis.

The American Academy of Periodontology defines in their Guidelines for Periodontal Therapy, Treatment Procedures:

> In periodontics, a whole range of therapy exists. No one treatment approach can provide the only means of treating any one, or all, of the diagnostic case type. Further, one treatment plan may be appropriate for one section of the mouth while another therapeutic approach is more suitable elsewhere.

The Academy further defines that in addition to the diagnostic procedures, all plans for active periodontal treatment should include:

> Removal of **supragingival** and accessible **subgingival** calculus by periodontal scaling. Root surface irregularities and root surface altered by periodontal pathosis are treated by the comprehensive services of periodontal root planing. In some instances, these procedures may be incorporated in surgical treatment.

The American Dental Association Council of Dental Care Programs along with the American Academy of Periodontology, clearly has stated in the associations reports JADA Vol. 102. (March 1981) that:

> "Oral prophylaxis applies only to preventive measures used to prevent disease and is not used to treat periodontal disease. These scaling and polishing procedures <u>are not used</u> to treat the periodontal disease found in case type II, III, and IV."[50]

The American Dental Association Council on Dental Care Programs association's report on <u>Reporting periodontal treatment under dental prepayment plans</u> of March 1981 defines Dental Prophylaxis(01110) Adults and Children(01120).

> "Oral prophylaxis is a scaling and polishing procedure performed on dental patients in normal or good periodontal health to remove coronal plaque, calculus, and stains to prevent caries and periodontal disease."[51]

Special Billing Instructions for the Michigan program further define the appropriate procedure code for periodontal scaling and root planning (depending on the number of teeth with calculus that is radiographically evident) that must be used by the dentist. The procedure code selected must be used only **once**, regardless of the number of visits required to

complete the service. If more than one visit is necessary to complete this service, the date of service used on the claim must be the date of the final visit.

Federal Core Component Guidelines used by OTA to evaluate Periodontal Therapy were listed as scaling and curretage and or root planing found under Restorative services; are inaccurate. There may have been some confusion on apart of the staff at OTA when developing the core guidelines by mis-interpreting Health Care Financing Administrations' Table 2, State Medicaid Manual. Table 2 contains EPSDT program guidelines and implements Section 2(a)(43) and 1905(a)(4)(B) of the Act, including revisions enacted by P.O. 97-35, the Omnibus Budget Reconciliation Act of 1981, and P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of `1982."

THE MYSTERY OF GINGIVAL CURETTAGE A SURGICAL PROCEDURE

Dental Survey of America found interesting the procedures defined under Gingival Curretage in the Michigan Manual. Throughout the two year comparative review of 46 medicaid program manuals we have reported striking similarities in procedure definitions found in four States (Michigan, Florida, Massachusetts, and Maine) medicaid dental provider handbooks. These similarities consistent were identical to even including the same technical, spelling and grammatical errors yet each state program director or administrator admitted that their manuals were exclusively designed for their State. Note the procedure definition for gingival curretage for the State of Michigan and Florida.

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This service consists of the stripping of the hyperemic epithelial lining of the cerival* sulcus surrounding a tooth, with the intention of creating appropriate shrinkage of these tissues to approach the original health dimension.

The procedure may be authorized in the presence of soft tissue pockets indicating a minimum depth of 3-4 millimeters, demonstrating an acute inflammatory involvement not including supporting bone.

Special Billing Instructions: The procedure code for the gingival curettage must be used only once, regardless of the number of visits required to complete the service. If more than one visit is necessary to complete

this service, the date of service used on the claim must be the date of the final visit. Periodontal Treatment.

*note spelling error (cervical) corrected in Florida's manual

Florida HRSM 230-22

a. gingival **currettage**** refers to the stripping of the hyperemic epithelial lining of the cervical sulcus surrounding a tooth with the intention of creating appropriate shrinkage of these tissues to approach the original health dimension. This procedure is authorized in the presence of soft tissue pockets indicating a minimum of three to four millimeters depth, demonstrating acute inflammatory involvement not including supporting bone, If the **currettage** of the epithelium is not be be completed, the provider must apply for periodontal scaling instead.

** note spelling error (curettage) corrected in Michigan's manual

FALSIFICATIONS OF MEDICAID MANUALS

On February 27,1982 one of the most celebrated criminal trials of the century came to a close when Wayne Williams was convicted in the Atlanta child murders. The conviction was later reviewed and, in 1983, affirmed by the Georgia Supreme Court. What was most unusual about the Williams case, was the extent to which it turned on purely scientific evidence.[52]

According to Imwinkried a law professor at the University of California, Davis, " In upholding William's conviction, the Georgia Supreme Court approved the use of evidence based on expert comparison of textile fibers found in [William's] environment with fiber discovered on twelve victims bodies. Using a microspectrophotometer and other microscopes, scientist had compared fibers from a green carpet in Williams bedroom with fibers found on the victim's bodies. They traced both sets of fibers to a brand of carpeting produced by the West Point Pepperell company in Dalton, Georgia, and used statistical analysis to show that the odds did not favor such a coincidence. By studying the company's chain of distribution, an expert concluded that only one in every seven thousand seven hundred and ninety-two homes in Atlanta area would likely contain carpeting of that particular color and brand. Other fibers found on the victims' bodies were shown to come from the carpeting of a Chevrolet station wagon- a description that fit the carpeting of only one in every three thousand two hundred and twenty five Atlanta area cars, including Williams."

After reviewing this case Dental Survey of America borrowed a page from the prosecutors handbook and determine that the statistical probability of four States medicaid dental program committees sitting down and independently designing the same incorrect dental policy and procedures right down to the same spelling, grammatical and technical errors are incalculable. On the basis of those odds, Dental Survey of America then determine that no appropriate dental health committees as required by Federal Guidelines and set forth in EPSDT legislation could have ever existed or any document filed with the Federal Government certifying these medicaid dental programs had to be falsified. When one takes into consideration that the Michigan and Maine dental program

manuals are themselves very similar to both Massachusetts and Florida.

THE PEMOVAL PARTIAL DENTURE A CONTINUED PATHWAY TO DESTRUCTION

The removable partial has long been established in the Clinical Dental Profession as the single most useful appliance for the management of space and the restoration of masticatory function (false teeth which cover part of the mouth and allows a person to chew) as the result of early loss of permanent teeth. In adolescent children its presence is necessary for the prevention of hypereruption of opposing teeth into the missing space and the collapsing of the entire dental arch (shifting teeth resulting in spaces between the teeth).[53]

OTA's Core Component guideline refers to the removable prosthetic appliance as a basic dental service required at least when mastication function is impaired or existing prosthesis is unserviceable, including repair and rebasing of the prosthesis. It may include services when the condition interferes with employment training or social development and orthodontic treatment when medically necessary to correct handicapping malocclusion. The. MMDTF ' 88, even recognized in their evaluation that there should be a minimum of 20 teeth (natural and /or artificial) present and functioning properly.

Dental Survey of America found in the Michigan Medicaid Dental Program Manual a policy which designates the accelerated removal of healthy teeth as a remedy for the treatment of dental disease in order for the dental provider to be reimbursed for the placement of a removable prosthetic appliance. Simply put, the dental provider in **Michigan** can be forced by **MEDICAID DENTAL HEALTHCARE POLICY STANDARDS** to remove as much as 10 healthy posterior (back) teeth in order to receive payment from the program for the placement of a removable prosthetic appliances.[54] This type of **DENTAL HEALTHCARE** is both **substandard** and absent of scientific foundation or research found anywhere in the field of Dentistry. Yet as reported by Dental Survey of America in

previous articles, the prevalence of this substandard healthcare policies in the area of the removable prosthetic appliances continues to be **DENTAL HEALTHCARE NORMS** in the Medicaid Programs of Massachusetts, Iowa and Florida.

Michigan the policy reads:

> removable partial are only done where there are **(All RECIPIENTS)** "fewer than six teeth are in occlusion in posterior areas."(false teeth which cover part of the mouth) are done only when there are less than six top and bottom back teeth touching each other

Iowa the policy is:

> " removable partial are only done where there are less than four posterior teeth in occlusion"(false teeth which cover part of the mouth are only done when there are less than four top and bottom teeth touching each other)

In **Florida** it states:

> " removable partial are only done where there are less than eight posterior teeth in occlusion"(false teeth which cover part of the mouth are only done when there are less than eight top and bottom teeth touching each other)

It is clear that these healthcare policies listed are written in a manner where very few children, if any, could ever qualify for a removable prosthetic appliance. They also serve as a paradigm on how State Medicaid Officials uniquely design healthcare policy and procedure guidelines as barriers which makes it impractical and impossible for any dentist to follow when treating a child on medicaid. The failure of Medicaid officials to eliminate these barriers, to children's health care (which are undeniably an **IMMINENT DANGER** to children's health care) bears the legal interpretation of **CRIMINAL NEGLIGENCE**.

Moreover, Michigan Public Health Codes enacted by Public Act 1978, No. 368 effective September 30, 1978 defines **IMMINENT DANGER** as:

> "Imminent danger" means that a condition or practice exists which could reasonably be expected to cause death, disease, or serious physical harm immediately or before the imminence of the danger

can be eliminated through enforcement procedures otherwise provided.

Section 2251 of the annotated Michigan Public Health Codes gives the director of the Department of Public Health the authority to take charge of the administration of laws,

(1) Upon a determination that an imminent danger to the health or lives of individuals affected exists in this state, the director immediately shall inform the individuals affected by the imminent danger and issue an order which shall be delivered to a person authorized to avoid, correct, or remove the imminent danger or be posted at or near the imminent danger....

(2) Upon failure of a person to comply promptly with a department order issued under this section, the department may petition the circuit court having jurisdiction to restrain a condition or practice which the director determines cause the imminent danger or to require action to avoid, correct, or remove the imminent danger.

(3) If the director determines that conditions anywhere in this state constitute a menace to the public health, the director may take full charge of the administration of state and local health laws, rules, regulations and ordinances applicable thereto.

Section 2261 of the annotated Michigan Public Health Codes provides the Criminal penalties of a person who violates the rules or order of the department.

Except as otherwise provided by this code, a person who violates a rule or order of the department is guilty of a misdemeanor punishable by imprisonment for not more than 6 months, or a fine of not more than $200.00, or both.

The illegalities of such partial denture policies were clearly established by the Federal District Court for the State of Texas in the 1983 decision of Mitchell v Johnston. The ruling also upheld in the Federal District Court of Appeals for the fifth Circuit (cite as 701 F.2d 337(1983) pg 349) struck down on point current health policies found under the Michigan, Florida, Iowa medicaid dental programs. Therefore it was determine by both Federal Courts that:

"the elimination of partial dental appliances on posterior teeth was not based on medical necessity but, rather, on the type of condition to be treated, and was wholly unrelated to the accomplishment of the purpose of EPSDT legislation. . Elimination of the appliance could result in periodontal disease, and shifting.

misalignment, and possible destruction of front teeth. Indeed, this cutback, couple with the elimination of posterior root canals, removed all of the basic approaches available to a dentist to deal with diseased or missing posterior(back) teeth. Texas Department of Health and Rehabilitative's refusal to cover root canals for posterior teeth meant that seriously damage teeth would have to be removed. Once removed, however, the posterior teeth could not be replaced with dentures unless the dentist removed more of the child's teeth- including healthy teeth. This is the type evidence that led the district and the experts to the conclusion that the remaining list of allowable procedures was inadequate to meet the needs served by a restorative dental program. Id. at 192-93."[55]

RESTORATIVE DENTISTRY

"**RESTORATIVE TREATMENT** for recipients age 21 and over is limited either to essential prepatory services for dentures or to the essential maintenance of the teeth where there is existing partial denture in active use." Both the Adult and Children dental service program emphasize that "Silicate cement and plastic or composite restoration are benefits only for the 6 anterior teeth in each arch." Futhermore according to Michigan Medicaid Dental Provider manual **Silicate cement an Acrylics** are identified as permanent restorative materials for both Adults and Children on page 4, Appendix F, revised update 5-20-82, as seen below. The mere suggestion of the using **acrylic** and **silicates** restorative materials as permanent restorations would be considered **substandard Dental Health Care** as it has been clearly shown from scientific research that these materials are highly toxic to live tooth tissue.

Under 21	21 and over	
		III. RESTORATIVE
		AMALGAM RESTORATIONS (including polishing)
	*	02110 Amalgam- one surface, deciduous
	*	02120 Amalgam- two surface, deciduous
	*	02130 Amalgam- three or more surface, deciduous

- 02140 Amalgam- one surface, permanent
- 02210 Amalgam- two surfaces, permanent
- 02210 Amalgam- three or more surfaces, permanent
- 02170 Amalgam- pin retained

SILICATE RESTORATION

02210 Silicate cement- per restoration

ACRYLIC OR PLASTIC RESTORATIONS

- 02310 Acrylic or plastic
- 02311 Acrylic or plastic- pin retained
- 02320 Acrylic or plastic (involving incisal angles)
- 02330 Composite resin - one surface
- 02331 Composite resin - two surface
- 02332 Composite resin - three surface
- 02331 Composite or acid etch(includes incisal edge)
- 02399 Not Otherwise classified

CROWNS- SINGLE RESTORATIONS ONLY

- NCB 02710 Plastic (acrylic
- NCB 02711 Plastic-prefabricated
- NCB 02830 Stainless Steel
- NCB 02831 Stainless Steel with window and composite(anterior only)

NCB 02840 Temporary(fractured tooth)

- NCB 02893 Post and core- nonprecious metal (case or steel)
- 02899 Not otherwise classified

OTHER RESTORATIVE SERVICES

- 02910 Recement inlays
- 02920 Recement crowns
- NCB 02940 Fillings(sedative) (under 21)

Silicate cements which are specifically included in the HCFA Guidelines, are excluded from OTA's core components list because most reviewers indicated that silicate cement restorations have been replaced by newer materials. In fact, because the technical errors found in this manual were very similar to the State of Ohio dental providers handbook, we once again employ the exact demonstration model of the Review of the Ohio program published summer 89, Vol 13 Journal of Pedodontics word for word to correct the same inconsistencies found in the Michigan medicaid program.

Once again Dental Survey of America utilized the services of the first year dental school textbook, Principles and Practice of Operative Dentistry, Chapter 12, from 197^ on Conservative Anterior Esthetics Restorations page 284-285 to clarify this discussion:

> The esthetic value of these silicate cements was highly acclaimed. However, some dentist were extremely critical because of pulpal damage and even pulpal death that often appeared to follow the placement of a silicate restoration. A variety of methods began to be employed for pulpal protection. Certain types of cavity liners seemed to reduce the effect of the phosphoric acid liquid on the pulp. Accordingly, the number and severity of pulpal problems diminished. Silicate cements had two factors in its favor. First, it was the only translucent filling material on the market and, second, it was relatively easy to match both the shade and translucency of the tooth being restored. Despite it deficiencies in physical and chemical properties, the dental profession made widespread use of Silicate cements.
>
> In the **1930's**, Germany developed a chemically activated tooth colored resin material. Following World War II, **chemically activated acrylic resins** immediately became popular. It was believed by many, and hoped by all, that at last here was a substitute for silicate cement. However, it was soon observed that these early acrylics materials lacked color stability, had a high degree of shrinkage during(setting) polymerization, and a high coefficient of thermal expansion that resulted in poor margin adaptation(if one ate hot or cold food the filling shrink and fall out). Thus, many Dentist discontinued their use

and turned again to silicate cements.

In 1962 Dr, Ray Bowen at the national Bureau of Standards developed the basic resin fora composite resin system which is now widely used for restoring tooth surfaces where esthetics is important. The composite or filled resin is composed of a continuous reactivated phase that is polymeric in nature and a discontinuous inert phase consisting of ground ceramic particles. The introduction of the ceramic material greatly improved the strength and reduced the coefficient of thermal expansion.

According to the Michigan Medicaid Dental Task Force report of 1988, "The three acrylic or plastic and silicate restoration codes should be removed." Stating that, "recent technological advancements dictate the removal of the three acrylic or plastic restoration codes here and insertion of one code for glass ionomer restoration." To this date these recommendation have not been acted upon. Once again we determined that most programs, including Michigan, that Medicaid Officials have uniquely designed Dental Healthcare policy and procedure definitions that are **substandard**, make no sense, and make it nearly impossible for any dental providers to be reimbursed for their services.

ENDODONTIC SERVICES: A BARRIER TO CARE

Dental Survey of America found overwhelming evidence that medicaid rules had been deliberately changed to save money at the expense of the patients' care and the providers of that care. For the review of the Michigan program we did not assess whether Endodontic policies and procedures were consistent with Dental Health Care policies established in the Federal Core Component Guidelines, Clinical Dental Profession and basic legal principles.[56] Rather we examined whether such policies and procedures represent barriers to the actual delivery of this vital dental healthcare service.

Oral health care providers in every state have always complained that frequent rule changes by local state medicaid officials make some procedure guidelines impractical to utilize in treating a child on

medicaid. In December of 1989 Dr. David Apsey private practicing dentist in Fraizer, Michigan reported to Dental Survey of America the case of John Doe Ellis a 16 year old caucasian male patient who presented 12/16/89 with extreme sensitivity on lower left first molar (#19). Radiographs revealed a large carious lesion and previous access opening initiated two days before by another dentist.

Dr. Apsey stated in his letter, " We referred to the Medicaid manual under Endodontics Services where it reads Molar Root canal Therapy for eligible individuals under 21 requires prior authorization number. Since the patient was in pain, we called for a provisional authorization over the phone and they refused to give a number. The officials said that we would have to initiate the therapy and send a prior authorization in for the treatment. In our experience, when provisional authorizations are refused by phone, the prior authorization is rarely if ever given after that point.

We initiated the root canal regardless but hold out little hope of ever being paid and may never see the patient again because the prior authorization, even if given will be one to two months in processing. By that time, the temporary filling placed after the pulpectomy will most probably have been lost and the tooth will have another abscess formation.

In this way, the next dentist or even our office, when faced with not being able to collect for services performed will be strongly encouraged to extract the tooth. The unnecessary extraction treatment would predisposed and actually cause malocclusion and severe dental problems for this child later in life. This treatment is also one in which provisional authorization would easily be obtained over the phone from the Medicaid Office."

Oral healthcare providers (current and former) who have experienced the medicaid system generally agreed that arbitrary and capricious decisions, often not in the patient's best interest, are made by private (general) dental practitioners or dental hygienists who have little understanding of dental epidemiology in population localities. They are hired mostly on a part-time bases or are on loan to the medicaid program from other State agencies.[57] These individuals act in the capacity as public health dental consultants and much of the time their expertise in

Clinical Dental Epidemiology represent their individual sentiments. Yet in a court room setting these individual sentiments are misinterpreted by juries and judges alike as expert testimony and are not easily challenged.[58]

MICHIGAN MEDICAID
A GUIDE TO SUBSTANDARD CARE

As we have outlined in our introduction and throughout this article, many States including Michigan failed to inform medicaid recipients of the conscious decision to employ sub-standard treatment procedures which imperil dental healthcare. Robert Gittleman JD., and Howard Belkin DDS., JD., practicing attorneys from Southfield, Michigan and nationally recognized prominent dental malpractice law firm have published their guidelines for bringing suit against dentists for dental malpractice in the American Association of Trial lawyer's Journal. This is not and endorsement of the Gittleman law firm or the recognition of the Gittleman Belkin Guidelines for Substandard Dental Care by Dental Survey of America. We simply present their outline, as it seeks to familiarize both an uninformed legal community and general patient population on **substandard dental care**.

> Since the earliest days of medicine the basic obligation of all doctors including dentist has been to do no harm to the patient. Unfortunately though many patients are harmed by their dentist. **Therefore this article will discuss substandard care by dentists; an area patients are usually uninformed about.**
>
> Substandard dental care can cause serious even permanent injuries to your teeth and mouth directly affecting the quality of your life; your physical appearance; your ability to chew and digest nutrients to maintain general health, and the simple enjoyment of eating. In addition, negligent care can injure the muscle, ligaments and bones of your face and jaw causing you severe jaw, face neck and back and shoulder pain. Discomfort can even extend into your arms and fingers. Sometimes dental mistreatment causes arthritis or other injuries requiring surgery.
>
> Inadequate teeth cleaning by your dentist can lead to gum disease teeth loss, disfigurement and the need for extensive mouth surgery. Improper fillings can cause problems ranging from the need for crown to extractions to severe jaw malocclusion. For example, ineptly extracted teeth can cause tongue, lip or chin

numbness and loss of taste sensation or feeling. Unnecessary or improper teeth extraction can also cause serious injuries; some lasting a lifetime. Unnecessary teeth extraction are irreversible losses because adult teeth will not grow back and the supporting surrounding bone structure often become damage by erosion.

Often the patient is not advised of alternatives or risk of a particular treatment that dose in fact result in severe injury. If the patient was adequately informed of the risk before treatment, the patient would have refused the treatment thereby preventing the injury. Dentist are required to inform you in language you understand, the risk, consequences, benefits, alternatives treatment and expected results. In many situations a referral to a specialist for full or partial treatment is indicated. Violating these standards can result in severe injury to the patient, entitling the Plaintiff to compensation.

If you suspect you are an injured victim of a negligent dentist, you should consult with GITTLEMAN, PASKEL, TASHMAN, & BLUMBERG, P.C., Attorneys to determine if your treatment conforms to current techniques to prevent treatment caused injuries.

When one applies the Gittleman/Belkin Guidelines for Substandard Dental Care to any State run Federally Funded Medicaid program including Michigan's, any dental provider who accepts assignment on a recipient of medicaid becomes culpable for malpractice.

This contemptuous disregard for Poor Americans by State Medicaid officials has connotations far beyond the borders of the United Sates. The prohibition of torture, cruel inhumane or **degrading treatment** or punishment appears as an early article in the United Nations General Assembly's Declaration of Human Rights. It recurs in all the other principal international and regional conventions establishing civil and political rights, and the United Nations has maintained a continuing interest in the subject.

The International Covenant on Civil and Political Rights of 1966 extends the prohibition to include **subjection, without free consent, to " medical or scientific experimentation'** and in 1975 the United Nation's General Assembly adopted a Declaration on the protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

WHY NOTHING GETS DONE

" The most compelling issue," stated Daryl E. Williams (DSA) when he confronted the Director Office of Prior Authorization of Michigan Medicaid, Bruce Huckaby on a highly respected Detroit television talk show, " is how high up in the level of hierarchy, of true decision making process about the policies that are eventually formatted, does dentistry participates and when they stops their participation, how many steps are there."[59] Dental Survey of America examined the levels of final decision making and found dental expertise to be lacking.

THE MEDICAL SERVICES ADMINISTRATION

CONTAINS: 4 Bureaus and 2 offices, which are listed as follows:

1) Vernon K. Smith, Ph.D., Director
   Bureau of Program Policy
2) Dr. Levine- Director
   Bureau of Health Services Review
3) Richard Mahavan-Director
   Bureau of Medical Fiscal Review
4) Keith Cole- Director
   Bureau of Medicaid Operation

   A) Dennis Duccap- Director
      Office of Support Services
   B) Bruce Huckaby- Director
      Office of Prior Authorization

Vernon K. Smith, Ph.D., Director
Bureau of Program Policy — No Dental Background

Donald R. VeCasey, Director
Medical Services Policy Division
Bureau of Program Policy — No Dental Background

Ronald G. Eggleston, Ph.D., Manager Institutional and Alternative Long Term Care Policy Section Bureau of Program Policy	No Dental Background
William J. Keller, Ph.D., Manager Special Program Section Medical Services Policy Division Bureau of Program Policy	No Dental Background
Carl A. Ramroth, Manager Ambulatory Policy Section medical Service policy Division Bureau of Program Policy	No Dental Background
Richard G. Wilkie, Director Medicaid information Division Bureau of Program Policy	No Dental Background
Ernie A. Bueschlen, Manager Provider and Citizens Services Section Medicaid Information Division Bureau of Program Policy	No Dental Background
Warren C. Roost, Manager Provider and Citizens Information Section Medicaid Information Division Bureau of Program Policy	No Dental Background
Eileen R. Ellis, Acting Director Institutional Reimbursement Policy Division Bureau of Program Policy	No Dental Background
Blair Dean, Policy Analyst for the Medicaid Dental Program " responsibilities is to coordinate and prepare drafts of the dental manual"[60]	No Dental Background

This is indicative of the way the entire program is being conducted, monitored and staffed.

In enacting EPSDT legislation and guidelines the Congress has given the state the right to design and operate the medicaid program under specific Federal rules and regulations to which all States must adhere. The federal courts have affirmed the intent of Congress and the Federal Government to provide quality Dental care to poor children under 21. The findings of the 5th Circuit Federal District Court of Texas, as affirmed by the Federal Appeals Court were so broad and so sweeping they made comprehensive dental services including Orthodontia available to poor Americans, this made it impossible for any State to avoid, frustrate or cut in any form or fashion federally mandated orders as intended by the will of the Congress of the United States of America to make such services available under EPSDT.[61]

The case of French v. Pan Am Express, 57 LW 2509, 3/14/89 decided by the Court of Appeals for the Second Circuit is a case that puts state laws as well as drugs to the test. The case involves an airline pilot suspected of using marijuana while off duty. He refused a drug test citing the Rhode Island law gave him the right to refuse and Rhode Island did have a law restricting blood and urine testing of employees. The pilot (French) was fired, and he sued the airline using the state law as foundation for his lawsuit. The question for the court was when federal and state law are on collision course which wins.[62]

The court noted the Secretary of Transportation as charged with the duty to promulgate reasonable rules and regulations related to safety and security in the air and this delegation of power is as quoted **"as deep as it is wide."** The court said no pilot can fly without an Airman's Certificate which can only be issued to those with proper qualifications and who are physically able to perform a pilot's duties. The court said this intricate web of federal statutory authority affords no room for the imposition of state law criteria, vis a vis pilot suitability and federal preemption is implied which in plain English means, Rhode Island laws as they affect qualifications for pilot's are going nowhere. The court concluded that there is no question but that Congress has decided to fully

occupy the field and when Congress is on the field you can't even see Rhode Island.[63]

The decision handed down in French v Pan Am Express by the Court of Appeals for the Second Circuit is on point with any previous arguments we have made by **Dental Survey of America** et al. Moreover the Congress when enacting EPSDT legislation fully occupies the field and when Congress is on the field it doesn't see Florida either. Furthermore the Appeals Court in **Mitchell v Johnston** at paragraph 8 page 347 noted in its summary the concerns which lead the Congress to occupy the field in 1972. Quote, "with participating states' apparent refusal to adequately assure that eligible children knew of and obtained the services provided by the applicable law, Congress added certain state administrative performance requirements. 42 U.S.C. at 603(g), as added by Pub.L. 92-603, at 299F. States were required to inform all families... of availability of child health screening service under.... Title XIX..." and to affirmatively arrange for screening and the necessary treatment of detected dental problems." Id."

The Appeals Court (Mitchell v Johnston) continued, " In 1981 these outreach and performance standards became conditions of federal funding under the Medicaid program. As noted, the Secretary of HEW was delegated authority to establish the contours of the federal program. 42 U.S.C. at 1396 (a)(4)(B) specifically provides for "such [EPSDT services] as may be provided in the regulations of the Secretary." The regulations subsequently promulgated by the Secretary of HEW lead the Appeals Court to conclude that the district court did not err in its conclusion that " the program aimed at reducing future Medicaid expense by detecting and remedying incipient dental problems with children who could reasonably be anticipated to become adult Medicaid recipients." The Secretary's regulations are "entitled to more than mere deference." Schweiker v Gray Panthers, 453 U.S. 34, 101 S.Ct. 26633, 2640, 69 L.Ed.2d 460 (1981). The regulations promulgated by the Secretary leave little doubt as to the purposes of the EPSDT program."

By disclaiming Dental Survey of Americas et al use of Mitchell v Johnson, Medicaid officials hope to nullify their responsibility and the role of the States (in this case the States' Statues), which must adhere

to the laws of the Federal Government. Dental Survey of America et al have clearly pointed out that Medicaid Officials claims that providers have been violating State Statues are going nowhere. Since it is the States medicaid programs that are in absolute violation of Federal Statues, Federal court orders, and rules and regulations are promulgated by the Secretary of the Department of Health and Human Service whose delegation of power is " as deep as it is wide."

WHAT CHANGES NEED TO BE MADE AND WHAT MUST BE DONE

There are a multitude of problems with the Michigan Medicaid Dental program which ultimately lead to substandard care and discourage dental providers from participating in the program. Among them are frequent changes in the rules which make guidelines impractical and low fees that any provider should deserve a medal when he/she elects to treat recipients of medicaid. Yet the pervasive attitude among Medicaid Official is that all health care providers seemingly are crooks. No matter how honest an individual is in his/her practice, there is always the chances that medicaid at a later can arbitrarily place wrongful judgement on a provider.

The easiest way to begin changes in the Michigan Medicaid Dental Program would be for state medicaid officials to obtain a copy of the Guide to Dental Care, EPSDT-Medicaid, Pub. No. HCFA 24515 and read and follow. Unless this is done, then the State of Michigan's program is guaranteed for continued failure. Hapless mismanagement by Michigan Medicaid Officials many of whom are non dentists in their zeal to prosecute oral health care providers will only further serve to keep basic dental services token and health care delivery to the medicaid recipient substandard. Indictments have been made for even on the most minuscule of error including errors admittedly caused by the local state run medicaid agency.

The hopes that local dental organizations and boards of dentistry can provide input into the Michigan program to the standard care of

dentistry may have long passed. Some of Michigan's medicaid officials have become so indifferent to the practice of dentistry as it relates to federal guidelines and the rampant corruption in the administration of the program that the only way to effectively resolve this crisis is through criminal prosecution:

1. ON THE FEDERAL LEVEL-

Congressional Oversight and Investigation which must then be followed by indictments and vigorous criminal prosecution of these local state medicaid officials by a Special Prosecutor assigned from the United States Justice Department.

2. ON THE PART OF STATES BOARDS OF DENTISTRY,

It is incumbent that the Michigan Department of Professional Licensing and Regulation through their Boards of Dentistry get control of the Medicaid dental program.

3. ***STATE LEGISLATURES MUST EMPOWER BOARDS OF DENTISTRY*** to require that Medicaid dental policies and procedures be written by dentists knowledgeable in various specialties of dentistry and not by lay-persons or part-time dental consultants. That all dental programs private insurance, federal, state, local, policies and procedure be continually updated and consistent with the current practice standards of dentistry.

4. Boards need to take drastic action such as unilateral implementation of *Emergency Orders* prohibiting all licensed practitioners from participating or seeing Medicaid clients until this program has been thoroughly overhauled and updated to meet the minimum practice of dentistry in these individual *states*.

5. That if necessary some state programs which continue to fail to clean up their act in 90 days be taken over by the Federal courts and appointed a trustee for a period of two years in order to comply

with the current standard practice of dentistry.

CONCLUSION

Until recently Medicaid Official across the country including Michigan have been very effective at discrediting healthcare providers, holding them in disdain with the public by the use of the words, " Medicaid Fraud." What Dental Survey of America has been able to demonstrate, through research supported by clinical data, scientific literature and with help from many distinguish scholars in Dentistry, Law, and various other fields that it is the medicaid program which has become a fraud. The real issues in Michigan as with other program has been medicaid policies and procedures that are counter productive to the practice of Human Health Care, Dentistry specifically and medicine in general.

Correcting these substandard medicaid dental health care policy and procedures through legal remedies has itself become an additional burden on the modern health care provider. The Attorney(s), lacking knowledge of basic sciences(which they must have) are unable to make an integrated analysis of the Clinical Dental Profession as it pertains to the constructs of medicaid dental manuals with legal principles. It is this failure to comprehend Clinical Dental Science which significantly alters legal counsels ability to adequately litigate these cases. The Clinical Dental Profession, has been forced to compromise its integrity and standards to errant, illegal, illogical medicaid dental health care policies through settlements negotiated by unknowledgable Attorneys. These settlements are then reenforced by fines and or imprisonment from Circuit Court Judges or Administrative Court Judges; medicaid recipients are then subject to dental practices which are a **IMMINENT** danger to their well being.

The other nagging questions amongst health care providers has been, in whose interest are these negotiated settlements? Negotiated settlements are between Attorneys and not between healthcare providers, **the Attorneys seems to win all the time.** In the opinion of most medicaid providers any imposition of fines amount to judicial extortion, in which the doctor must elect to go along, just to get along. The

Attorneys have become Vultures preying upon the slain carcass of the health care providers who have run afoul with archaic policies and procedures of medicaid. In the final analysis the fines and court cost, media attention destroys an otherwise innocent health care providers practice. This legal maze also works to the advantage of Medicaid as it is intended to discourage other health care providers from participating in the program. In the end Poor Americans are deprived of medical and dental care and the Medicaid System saves money. Ordinary decent citizens, **the health care providers are made criminals**.

Certainly, there are very few individual Medical and Dental practices that could afford the million or so dollars to take on the Medicaid Health Care Power Structure in court. Thus Medicaid programs across the country and including Michigan have protected their errant policies and procedures by taking advantage of the cumbersome legal process of motions, discovery and counter motions which assures that the merits of these cases;

1. Forcing healthcare provider's to adhere to outdated, outmoded medicaid policies.

2. Forcing medicaid recipients to receive substandard care.

will never get to trial while **Substandard Dental Care** is guaranteed.

ENDNOTES

1. **The Michigan Medicaid Dental Task Force Report, Review of Dental Services Available Under the Medical Assistance Program 1988, August 1988, Page 5.**

2. **MICHIGAN DEPARTMENT OF SOCIAL SERVICES, COMPARATIVE REVIEW OF THE STATE OF MICHIGAN MEDICAID DENTAL PROGRAM BY DENTAL SURVEY OF AMERICA**, Norman J. Clement DDS, Daryl E. Williams DDS., MS. May 1989 unfinished to be submitted into publication fall 89.

3. United States General Accounting Offices, GAO/HRD-87-12FS, October 1986, Page 6.

4. Health Children Investing in the Future Congress of the United States, Office of Technology Assessment, February 1988, **Medicaid: Features that Pose Barriers to Access**, page 60 (OTA-H-345).

5. The affirmative action requirement of the Medicaid EPSDT program was originally added to the **Social Security Act in 1972** in response to growing Congressional concern over states' failure to implement EPSDT. Federal law requires under 42 CDF Section 441.56 (c) (2)

6. **42 USC Section 1396(a) (10); 1396d(a) 1985. Enacted by Congress in 1967,** EPSDT(Early and Periodic Screening Diagnosis and Treatment) is a program which finances health care for certain groups of persons determined by state and federal regulation to be eligible. EPSDT is distinct in that it requires the state to not only pay for services but to assure the delivery of those services. States are required to provide well-child examinations in accordance with a reasonable timetable to diagnose adverse health conditions, and to appropriate treatment services to all Medicaid-eligible children from birth to 21 years.

7. IBID, page 61 (OTA-H-345).

8. A GUIDE TO DENTAL CARE EPSDT-MEDICAID, BY Roy L. Lindahl DDS, MS., Wesley O. Young, DMD, MPH., prepared by the American Society of Dentistry for Children and the American Academy of Pedodontics under Contract SRS- 73-49, Social Rehabilitation Service, U.S. Department of Health, Education, and Welfare, page 5-6.

9. **42 USC Section 602(g) (1972).** The affirmative action requirement of the Medicaid EPSDT program was originally added to the **Social Security Act in 1972** in response to growing Congressional

concern over states' failure to implement EPSDT. The original provision withheld one percent of federal AFDC payments otherwise due from any state that failed to inform screen and treat eligible children. See **42 USC Section 602(g) (1972).** In 1981 the so-called penalty provision was removed and the Medicaid statute was amended to incorporate these affirmative action provisions as a state plan requirement. **Section 2181 of Pub.L. 97-35, 95 Stat. 357(1981), codified at 42 USC Section 1396a(a)(44) (1982).**

10. IBID.

11. Moreover in March 1983 the Federal District Court of Appeals for the fifth Circuit upheld in Mitchell v Johnston cite as 701 F.2d 337(1983) pg 338, that:

"When state voluntarily and knowingly accepted terms of Federal-state "contract", state is required to fulfill it Mandatory obligation under the contact."

As has been stated earlier that the Health Care Financing Adminstration has broadly interpreted these requirements(Guide to Dental Care, EPSDT-Medicaid, Pub. No. HCFA 24515), and a federal court affirmed the broad intent of this language (Mitchell v Johnston 701 F 2d 337, 5th Cir, 1983). "

12. Early Periodic Screening Diagnosis and Treatment(EPSDT) Regulations. Transmittal Notice To: All State Medicaid Directors and EPSDT Coordinators. (May 9, 1985.)
The EPSDT regulation **(effective January 29, 1985) at 42 CFR 441.56(c)(2)** require, just as the previous regulations did **(42 CFR 441.56(b)(2))**, that States provide for "Dental Care ...needed for the relief of pain and infections, restoration of teeth and maintenance of dental health.," States will be cited as out of compliance with the regulation at **CFR 441.56(c)(2)** unless this service is made available to children (through EPSDT) **by July 1, 1985.**

13. **ICF/MR Operation Requirements. Area: Programs and Services. Sub -Area: Dental Services. FAC 10D-38. 13(1-6), (8-9).** Chart of State and Federal standards in the above area.

14. **42 CFR Section 440.230(b) 1985.**

15. **Early Periodic Screening Diagnosis and Treatment(EPSDT) Regulations. Transmittal(MCD-18-85 (PO) May 9, 1985.** Notice To: All State Medicaid Directors and EPSDT Coordinators. The EPSDT regulation **(effective January 29, 1985) at 42 CFR 441.56(c)(2)** require, just as the previous regulations did **(42 CFR 441.56(b)(2))**, that States provide for "Dental Care ...needed for the relief of pain and infections, restoration of teeth and maintenance of dental health.," States will be cited as out of compliance with the regulation at **CFR 441.56(c)(2)** unless this service is made available to children (through EPSDT) **by July 1, 1985.....** from George R. Holland, Regional Administrator, Health Care Financing Administration.

16. **42 CFR Section 441.56(c)(2) 1985.**

17. Early Periodic Screening Diagnosis and Treatment(EPSDT) Regulations. Transmittal Notice To: All State Medicaid Directors and EPSDT Coordinators. (May 9, 1985.)
The EPSDT regulation **(effective January 29, 1985) at 42 CFR 441.56(c)(2)** require, just as the previous regulations did **(42 CFR 441.56(b)(2))**, that States provide for "Dental Care ...needed for the relief of pain and infections, restoration of teeth and maintenance of dental health.," States will be cited as out of compliance with the regulation at **CFR 441.56(c)(2)** unless this service is made available to children (through EPSDT) **by July 1, 1985.**

18. Regulation at **CFR 441.56(c)(2)** which states "all Dental Care as early an age as necessary which is needed for the relief of pain and infections, restoration of teeth and maintenance of dental health."

19.Maximizing Dental Coverage Under EPSDT, by Kay Johnston, MPH, MEd., Senior Health Specialist, Childrens Defense Fund, 1983.

20. Kay Johnson, MPH, MEd. Senior Health Specialist letter to Norman J. Clement DDS of Tallahassee Florida, July 15, 1988.

21. The Special House Committee To Investigate The Michigan Medicaid Program: Report of Representative Jelt Sietsema, Chair, Michigan House of Representatives 83rd Legislature Regular Session of 1986, released September 1986, page 53.

22. William, D.E.,: Panel discussion, The Toothgate Scandal: TV 62- "Strictly Speaking" Detroit, Mi. 13:34 minutes in videotape, July 12, 1989.

23. The Michigan Medicaid Dental Task Force Report, Review of Dental Services Available Under the Medical Assistance Program 1988, August 1988, Page 5.

24.Maximizing Dental Coverage Under EPSDT, by Kay Johnston, MPH, MEd., Senior Health Specialist, Childrens Defense Fund, 1983.

25. Kay Johnson, MPH, MEd. Senior Health Specialist letter to Norman J. Clement DDS of Tallahassee Florida, July 15, 1988.

26. IBID

27. IBID

28. Aspey, D. E., : Interview with Dental Survey of America, January 7, 1989.

29. The Michigan Medicaid Dental Task Force Report, Review of Dental Services Available Under the Medical Assistance Program 1988, August 1988, Page 5.

30. The Michigan Medicaid Dental Task Force Report, Review of Dental Services Available Under the Medical Assistance Program 1988, August 1988, Page 5.

31. The Michigan Medicaid Dental Task Force Report, Review of Dental Services Available Under the Medical Assistance Program 1988, August 1988, Page 5.

32. 42 CFR Section 440.230 (b) 1985)

33. Maximizing The Use of the EPDST Program in the Delivery of Dental Care to Low-Income Children by Kay A. Johnson, M.P.H., M.Ed. of the Children's Defense Fund, 122 C Street N. W., 4th Floor, Washington D. C. , 20001. A paper prepared for the American Public Health Association Annual Meeting in Las Vegas, 1986.

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35.Maximizing Dental Coverage Under EPSDT. by Kay Johnston, MPH, MEd., Senior Health Specialist, Childrens Defense Fund, 1983.

36. Kay Johnson, MPH, MEd. Senior Health Specialist letter to Norman J. Clement DDS of Tallahassee Florida, July 15, 1988.

37. Kakehashi and Parakkal: Proceedings from the State of the Art Workshop: J. Periodontology 53: 490, 1982.

38. Kakehashi and Parakkal: Preface, Proceedings from the State of the Art Workshop: J. Periodontology 53: 476, 1982.

39. The Michigan Medicaid Dental Task Force Report, Review of Dental Services Available Under the Medical Assistance Program 1988, August 1988, Page 5.

40. The Michigan Medicaid Dental Task Force Report, Review of Dental Services Available Under the Medical Assistance Program 1988, August 1988, Page 5.

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48. Kakehashi and Parakkal: Proceedings from the State of the Art Workshop: J. Periodontology 53: 483, 1982.

49. Kakehashi and Parakkal: Proceedings from the State of the Art Workshop: J. Periodontology 53: 488, 1982.

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54. IBID

55. Mitchell v Johnston cite as 701 F.2d 337(1983) pg 349-350, The Federal District Court of Appeals for the fifth Circuit.

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57. State of Florida v Norman J. Clement, : Deposition of Ed Younglood: Journal of Pedodontics 14: 7, 1989.

58. IBID, pg.8

59. William, D.E.,: Panel discussion, The Toothgate Scandal: TV 62- "Strictly Speaking" Detroit, Mi. 13:34 minutes in videotape, July 12, 1989.

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61. Toothgate: How the medicaid dental program in America is a national disgrace. Journal of Pedodontics Vol 13, No.2, pg 175, Winter 1989, Norman J, Clement et al.

62. From Neal Chayet: Looking at the Law: Boston, Mass. April1988.

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STATEMENT OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS (NACHRI)

ROBERT H. SWEENEY, PRESIDENT

NACHRI—the National Association of Children's Hospitals and Related Institutions—appreciates the opportunity provided by the Subcommittee on Health for Families and the Uninsured to submit this statement for inclusion in the record of the July 23, 1990, hearing on "Care for the Uninsured."

NACHRI is the only national, voluntary association of children's hospitals. It represents more than 100 institutions in the United States and Canada, including The Children's Mercy Hospital in Kansas City, MO, whose President and Chief Executive Officer Lawrence A. McAndrews testified during the July 23 hearing. Virtually all of NACHRI's members are teaching hospitals and involved in conducting research. Most are also regional medical centers receiving referrals from larger geographic regions in the U.S. and from around the world.

Children's hospitals care for very sick children including infants, children with special health care needs, and children of families with low incomes. On average, more than a third of the care provided by a children's hospital is for children of families lacking both private health insurance and personal resources to pay for care. These families depend on public assistance or charity when their children are too sick to postpone seeking care.

Our purpose is to build on Children's Mercy Hospital's testimony to demonstrate the experience of children's hospitals nationwide by: (1) describing the results of a one-month study of children who were uninsured at the time of admission to children's hospitals and (2) summarizing the financial experience of children's hospitals with uncompensated care.

SNAPSHOT OF THE UNINSURED CHILD

In the fall of 1989, NACHRI took a "snapshot" of children's hospitals' experience with uninsured children. For one month, 22 member hospitals throughout the country interviewed the families of every child who was uninsured at the time of admission to the hospital for care.

From this study, we can draw the key features of the children admitted without insurance to children's hospitals. This one month snapshot is not a perfect picture—a longer survey including more hospitals would give us a sharper image, and a comparison of these children with the insured children admitted to the hospitals at the same time also would put the picture into fuller perspective. Nonetheless, the survey does begin to bring into focus the circumstances of uninsured children and their families who come to a significant number of children's hospitals. Using this survey, we see the following picture:

Typically, a child who is uninsured at the time of admission to a children's hospital is very young and has few siblings. At least one parent is employed, often for a small firm and in either the service or the construction industry. Usually, the parent cannot obtain health insurance through the employer, and the family's low income makes private insurance unaffordable. It is not unusual for the child to need immediate hospitalization for emergent or urgent care.

In particular, we found:

- *The uninsured child is pre-school age.* Children under 5 years of age accounted for nearly 70% of the children who were uninsured when admitted to children's hospitals.
- *The family of the uninsured child generally has only one or two children.* Most—63%—of the children who were uninsured when they were admitted to children's hospitals lived in families where they were either one of two children or the only child.
- *The uninsured child usually lives with two parents.* Two parents lived in nearly 60% of the households of the children who were uninsured when admitted to children's hospitals.
- *The uninsured child's parents often are employed.* In over 85% of the families with two parents at least one of the uninsured child's parents was working. The father was the sole working parent in 67% of these two parent, employed families, while in one quarter both parents worked.
- *The uninsured child's family is often poor, even though an adult member is employed.* Among households of the children who were uninsured when admitted to children's hospitals with at least one adult working, many had low incomes. Nearly one third—31.7%—of these households reported a present income less than an annual amount of $10,000, which is the Federal government's definition of poverty

for a family of three. The reported incomes of over 40% of these families were below an annual amount of $12,000.

• *Working parents are often unable to obtain health insurance through their employers.* Nearly 60% of the adults working at least 35 hours weekly indicated they were unable to obtain health insurance through their employers—even if they could afford to pay for it—either because the employer did not offer it or because the employee had to be employed longer in order to be eligible for health care coverage.

• *Working parents often are employed by small firms, and the majority work in the service and construction industries.* Sixty-four percent of the adults working full-time who could not obtain health insurance through their employers were employed in either the service or construction industries. Over half—53%—worked in firms with less than 26 employees.

• *An uninsured child may need immediate hospitalization for emergent or urgent care when admitted to a children's hospital.* More than 53% of the cases of the children who were uninsured at the time of admission were defined by the admitting hospitals as "emergency."

• *Uninsured children incur significant hospital expenses.* A follow-up study of the charges recorded for each uninsured child identified an average charge per admission of $13,383. The average charge per emergency admission was $14,486.

• *Medicaid has the potential to be an important source of assistance for uninsured children, but many are ineligible.* More than 70% of the families of the uninsured children were applying for Medicaid assistance. A subsequent attempt to assess eventual payer status of the uninsured children found that nearly half of all of the uninsured children—48.4%—eventually did receive Medicaid assistance. However, for an additional 41.8%, payment neither had been made nor was expected by the hospitals.

UNCOMPENSATED CARE

Children who were uninsured at the time of admission represent two different but related problems of uncompensated care. For the more than 41% who had no source of payment, the hospitals could expect to receive no compensation. And for the nearly 50% who were successful in obtaining Medicaid assistance, the hospitals could expect to receive reimbursement substantially less than the cost of care. A special NACHRI study of children's hospitals' experience with Medicaid assistance for children in 1987 found that on average, a hospital received only 75 cents in reimbursement for every $1.00 of actual expense incurred in caring for a child.

NACHRI's analysis of the responses of freestanding, acute care children's hospitals, such as The Children's Mercy Hospital, to the 1989 American Hospital Association Annual Survey of Hospitals provides a more recent picture of the financial impact of uncompensated care and under-compensated care.

In recent years, the volume of care provided by children's hospitals to patients assisted by Medicaid has grown while already inadequate Medicaid reimbursement has deteriorated:

• Since 1987, the proportion of Medicaid patient days to total patients days for 40 responding hospitals rose from 30.8% in 1987 to 36.3%.

• However, for the 20 responding hospitals that also reported financial data for three years, Medicaid net revenue as a percent of estimated Medicaid expenses dropped from 78.4% in 1987 to 73.4% in 1989.

In other words, for more than a third of the care they provided in 1989, these children's hospitals lost over 26 cents for every $1.00 they spent to care for children under Medicaid. These losses are in addition to the losses resulting from bad debt and charity, which accounted for an additional 8%, on average, of the care provided by these hospitals.

This indicates that these free-standing acute care children's hospitals were not recovering their costs of care on about 40% of the care they provided. As Mr. McAndrews described in his testimony, the financial burden of uncompensated care due to uninsured and Medicaid patients places significant pressures on the hospitals: to shift costs to other payers, where possible; to raise revenues from alternative sources, including charitable contributions as well as commitment of endowement incomes by postponing necessary expenditures or not funding depreciation; and to re-evaluate continually how to meet the service needs of children.

RECOMMENDATIONS

The combined problems of significant numbers of uninsured patients and inadequate reimbursement for Medicaid patients have led children's hospitals, through

NACHRI, to advocate both short term, incremental Medicaid reform for children and long term, comprehensive reform to ensure financial access to health care for all Americans.

Universal Access NACHRI has developed a set of principles for universal financial access for health care. In summary, we believe national health policy should:

- provide financial access to health care for all Americans, beginning with pregnant women and children;
- build upon the existing system of publicly and privately funded health insurance plus direct public funding;
- incorporate quality assurance and cost containment, which includes consumer cost sharing;
- incorporate basic health service benefits meeting minimum national standards;
- provide for reimbursement reflective of the costs of providing care.

NACHRI has been encouraged by the efforts of many members of Congress, including the work of Senator Riegle and his colleagues in the Bi-committee, Bi-partisan Senate Working Group on Universal Access, to explore the need for guaranteeing universal access and to develop proposals to fill this need. We believe that Senator Riegle is correct in pointing out that the problems of uncompensated care ultimately threaten the ability of all people to obtain access to care, not just individuals with low incomes. Comprehensive reform to provide universal access is essential.

We also recognize that precisely because of the magnitude of the problem, the complexity of potential solutions, and the size of their costs that no Congressional action on universal access may not occur for at least another year while the Congress grapples with the Federal deficit. At the same time, we also recognize that for children—for whom lack of health care access today can have life-long consequences—comprehensive health care reform can come a generation too late. Or, as we put it earlier this year, on buttons worn by representatives of children's hospitals visiting their Members of Congress, "Kids Can't Wait While Adults Debate."

Medicaid Reform For this reason, NACHRI also urges Congress to continue to pursue short term, incremental reforms of Medicaid to benefit pregnant women and children of low income families. In particular, we have recommended reforms that would reduce the four obstacles to children's gaining access to care under Medicaid: (1) restrictive eligibility standards, (2) burdensome enrollment processes, (3) limited benefits, and (4) inadequate reimbursement.

We strongly support enactment this year of S. 2459, the "Medicaid Child Health Act," by Senators Bentsen, Riegle, and Chafee, which has been co-sponsored by a majority of the members of the Finance Committee. This bill includes modest proposals that on an incremental, low cost basis seek to reduce each of the four barriers to access to care.

We believe this legislation enjoys strong, bipartisan support, because it represents a low cost, high return investment not only in the health of children today but also the health and welfare of the nation tomorrow. Surely it makes no sense as Congress seeks to bring the Federal deficit under control to ignore the need to invest now in the health of our children whom we will expect to shoulder the burden of paying off the national debt when they become adults.

CONCLUSION

NACHRI commends the Subcommittee for drawing attention to the impact of uncompensated care on the ability of providers to serve all patients, not just low income patients. We think the record of this hearing clearly demonstrates the need for long term, comprehensive health care reform to which Senator Riegle is committed, as well as immediate, short term improvements in Medicaid assistance for children.

If NACHRI might be of further assistance to the work of this Subcommittee, please call upon us.

The Presbyterian Hospital in the City of New York
Allen Pavilion, 5141 Broadway, New York NY 10034-1159

Kevin W. Dahill
Vice President
(212) 932-5000

August 1, 1990

I have been an administrator at the Presbyterian Hospital in the City of New York for the past twenty years. I have witnessed first-hand, erosion in the general availability and quality of health services throughout this Country brought on by continuous budget cuts and serious flaws in reimbursement methodology. Presbyterian Hospital in the City of New York is one of the largest voluntary teaching hospitals in the United States and has always prided itself on its commitment to providing free care to the medically indigent population. As a matter of fact, for the past five years Presbyterian Hospital has provided more free care than any of the institutions within New York City's Health and Hospitals Corporation. During the first quarter of 1990, Presbyterian Hospital's total bad debt and charity care reached an astounding $16,088,754.

We are faced with a looming crisis caused by a serious imbalance between the demands placed upon the health care system and the resources available to meet those demands. It is unrealistic for the Government to presume that the private sector can continue to carry the burden of providing health care to the uninsured. Hospitals today increasingly serve as the social service agency of last resort. Serious social problems which society has failed to deal with arrive ultimately on the doorsteps of hospital emergency rooms. AIDS is straining hospital services in metropolitan areas, and the problems of homelessness, drug and alcohol addiction, and mental illness have an equally devastating impact on both urban and rural hospitals. Losses for providing health care to the uninsured population can be projected to reach $65,000,000 at Presbyterian Hospital for the year 1990. Presbyterian Hospital's total operating loss for

the year 1989 was $50,000,000. It is clear that this institution has reached its limit. We cannot deliver quality health care if we cannot meet our payroll, or pay our vendors for the drugs and medical supplies required. The chronic underfinancing of the health care system at both the State and Federal levels has created the current situation which will only worsen. Financial losses will deepen; services, particularly in the outpatient area, may be reduced or eliminated; additional staff layoffs may be necessary for cost reduction even in a time of high utilization; biomedical research may continue to decline in a depressed health care system; and the recruitment and retention of high quality physician, nursing and other technical staff may be increasingly difficult without funding for competitive salaries.

The viability of the health care system in the United States requires a long term evolutionary approach. A continuum of care has yet to be adequately built and the private sector can no longer be relied upon to take responsibility for the medically indigent. Lack of preventive and primary services are revealed as patient's only access point to medical care becomes the emergency room. Lack of long-term care, home care, and other social supports leave patients in hospitals or on their own with no follow-up services.

I am pleased that the Senate Finance Subcommittee on Health For Families and the Uninsured is addressing the impact of uncompensated care on the financial status of hospitals and other health care providers. For the immediate future, hospitals must have improved reimbursement to cover operating and capital expenses. An immediate response to providing coverage for those who cannot afford hospital insurance must be found. I urge your Committee to analyze the very real health crisis which exists in our country and draft legislation which will appropriately restructure the delivery of health services.

Thank you for the opportunity to offer my comments on this important subject.

Kevin W. Dahill
Senior Vice President and
General Manager

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