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THE ROLE OF MEDICAL PROFESSIONALS AS SMALL BUSINESS OWNERS

FIELD HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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THE ROLE OF MEDICAL PROFESSIONALS AS SMALL BUSINESS OWNERS

MONDAY, JULY 14, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Frederick, MD

The Committee met, pursuant to call, at 2:08 p.m., at Winchester Hall in the 1st floor Hearing Room, 12 East Church Street, Frederick, Maryland. Hon. Donald A. Manzullo [Chair of the Committee] presiding.

Present: Representatives Bartlett and Christensen.

Chairman MANZULLO. Okay. Good afternoon and welcome to the Small Business Committee field hearing here in Frederick, Maryland. We will be looking at the issue of doctors as small businesses.

We are in the midst of a health care crisis as the doctors are fleeing medicine because they spend less and less time with their patients and more time dealing with government regulations, excessive paperwork, inadequate reimbursement rates, and escalating malpractice insurance. It is little wonder that when doctors are forced to deal with all of these complications, that they feel they have too little time for their patients and their craft. Surveys have shown that doctors are doing over an hour of Medicare paperwork for every one to four hours they spend with their patients.

Insurance companies require more and more paperwork from doctors' offices before reimbursing them, add to that Medicare reimbursement rates frequently do not cover the cost of Medicare procedures. Rising malpractice premiums have not only driven up the cost of health care, they are driving doctors from their practice. Doctors across the country are upset with malpractice premiums and some have even gone on strike.

Last year, I had a field hearing in my home State of Illinois to hear from doctors about problems we are encountering. An OB/GYN testified to the state of a practice with her three colleagues. She explained that after paying malpractice insurance of $440,000 a year for four physicians, she and another physician made $50,000, a third doctor made $60,000, the last doctor made $70,000, and their office manager made more then all of them $75,000. Before becoming a doctor, she was a pharmacist. She was pursuing pharmaceutical jobs because she could make over $100,000 as a pharmacist and didn't have to worry about medical malpractice insurance or being sued or testifying before congressional committees either.

We are facing a nationwide crisis today in the delivery of medical services.

[Mr. Manzullo's statement may be found in the appendix.]

I look forward to the hearing from our colleague, Roscoe Bartlett, who is doing a tremendous job. Roscoe and I were elected in the 103rd Congress. Roscoe, we look forward to your opening statement.

Mr. BARTLETT. Thank you very much. Frederick is my home town, in addition to being part of the 6th District of Maryland. I am very pleased to welcome my colleagues to Frederick, Maryland. Congressman Don Manzullo, and this will be an understatement, from Illinois is the Chairman of the House Small Business Committee, and he is the most vigorous champion of small business in the Congress. Congresswoman Donna Christensen is from the Virgin Islands. Congresswoman Christensen is also a physician, in addition to her conscientious work as an advocate for small business owners and the House Small Business Committee.

We are here today as Representatives of the Congress to examine the role of doctors as small business owners and to learn whether the Federal Government helps or hurts them.

We have two panels of witnesses combined here into one. The first panel of witnesses features doctors and private practice managers from the local region who will share their personal experience as they work to take care of sick people and provide a living for themselves and their families.

No one ever wants to be sick. However, illness and accidents are a part of life. As we sit in this room there is a growing epidemic spreading across America. I am not talking about SARS or any other contagious disease. We all hope that if an when we become sick, there will be a skilled, trained and compassionate person to take care of us. When it is beyond the capability of ourselves and family members, we turn to doctors. A web of Federal regulations, reimbursement cost shifting and malpractice lawsuits are combining to make it more difficult for doctors in the United States to do what they want to do and what we expect them to do, to take care of us when we are sick.

There are two big lies that are contributing to a growing national shortage in private practice physicians in the United States.

The first big lie is the check is in the mail. When was the last time any of us went to a doctor and paid them for their work? Many of us with insurance or an HMO are required to pay between $5 and $30 that is a co-payment or partial payment. What happens to the rest of the cost? I wonder. Months later I receive one of these notices from my insurance carrier marked "Explanation of Benefits—this is NOT a bill." these complex documents usually list an amount billed by the doctor. Another line will have the "allowable" amount. What is that? It is always significantly lower than the billed amount. Then there might be a line for the co-pay I remember giving the doctor at the appointment. Sometimes there is a line labeled "disallowed" on the form with an impenetrable footnote. "amount of deductible satisfied." finally, at the bottom there might be a line "patient's responsibility." occasionally, I do receive a bill from a doctor that I promptly pay. None of this paperwork makes any sense me as a patient or Member of Congress. What does it mean to the doctors who care for me?

We will learn today that in addition to the receptionist who greets us and nurse we see in the examining rooms, doctors must employ practice managers and accountants and other assistants. We do not see these people and they do not provide any health care to patients. However, private practice doctors would not be in business without them. These employees of solo and small group medical practices spend all of their fighting with third-party payers to reimburse the doctors. These third-party payers are Medicare and Medicaid in the public sector or government. In the private sector, it is the insurance companies or HMOs that are the third-party payers. Whether private or public, these gigantic bureaucracies operate to achieve one purpose, to deny or delay paying doctors for the work they do in caring for me. None of this makes any sense to me. Does it make sense to doctors? We will listen to their experiences today.

There is a second big lie. That is I am from the Federal Government and I am here to help you. The Federal Government is supposed to improve old people's health through Medicare and provide health care through Medicaid. There are now thousands of pages of Federal regulations under Medicaid and Medicare. Do these Federal Government regulations help or hurt the ability of doctors to treat our old and our poor when they are sick?

To quote from a popular book title, American society and culture used to accept the fact that "bad things happen to good people." this acceptance has been replaced with the expectation if something bad happens, it must be because someone made a mistake. Now, there is the unreasonable expectation that a doctor can and must save or improve our lives, and if that doesn't happen, it is because the doctor made a mistake. And if the doctor made a mistake, then they owe us for this failure.

This is how one doctor in Frederick described what he faces every day in an e-mail to me.

"I have grown weary of feeling every patient that I see is a potential lawsuit. I work very hard. I try very hard to do my best. I am always concerned for the well-being of my patients. I don't know of any other profession that is exposed to the liability physicians have. I feel that I am caught between the proverbial rock and a hard place—patients whose expectations are absolute answers to their concerns (which are often not possible), but require many tests to evaluate and economic pressures to control medical cost. Where does it end? As physicians we take the information that patients give us and try make sense of it, but this does not always work out. It doesn't mean that there was a mistake. Sometimes bad things happen because they happen." and this was the end of his e-mail.

The June 9 issue of Time magazine included a 12-page feature entitled "The Doctor Won't See You Now." it noted, "the soaring cost of malpractice insurance is becoming a worry for everyone, especially patients who see their doctors move away, change specialties or quit medicine altogether." this hearing offers an opportunity to explore the impact of medical malpractice lawsuits and insurance costs on the ability of doctors to care for sick people.

Regulations. Reimbursement. Lawsuits. Up until recently, being a doctor used to be a noble and well-paid profession. Today the obstacles that a doctor faces should make us all sick.

Our second panel of witnesses, combined with the first, has the unenviable task of examining the mess that we have got and trying to provide recommendations for improvement.

Welcome to the hearing today.

[Mr. Bartlett's statement may be found in the appendix.]

Chairman MANZULLO. Dr. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. And it is a pleasure to be here with you for the hearing. I want thank you, particularly, for holding this very important hearing and for giving me the opportunity to have a representative from the National Medical Association, who I will introduce later, join us on the panel. I think any time that we have the opportunity to hear from our physician community, it is really important to have as broad and as full a picture as possible. So I want to both thank you and Chairman Bartlett for making this possible.

Also, glad to see the Office of Advocacy here with us today. This Committee and the Office of Advocacy has had a very good working relationship. I think we have been able to make some changes in CMSS, and I look forward to having the Committee work with you on some even further issues.

My particular interest today, and I am sure there they will be covered by our panelists, provider payments, HIPAA, malpractice and the impact of the uninsured, all of which are creating calamity in the provider community and threatens a real catastrophe for the entire health care delivery system. One of the reasons I felt it was important for Dr. Thomas to be here is that African-American physicians and other physicians of color are even more severely being impacted. And you would think that in a physician community we—there is a saying that "when the majority in a community gets a cold, people of color get pneumonia." you would think the physician community would be immune from that, but they are not. So they are really being severely impacted. I just want to look forward to everybody's testimony and to the guidance that you will, hopefully, leave with us as we move on from here to tackle some of the important issues on which you will touch.

So I want to welcome everyone, and I thank you, again, for the opportunity to be at this hearing.

Chairman MANZULLO. Thank you. The rules are—we don't have a time clock in front of us, but it is five minutes on testimony. And there is a reason for that, because we do have votes later on this afternoon, plus, we want to move it and get lots of questions going now.

When Piper raises this, that is four minutes have expired. That means you got to finish in a minute. So what I would suggest is we all know that you are glad to be here, but you don't have to make that part of your testimony. Get immediately to the meat of your testimony, and don't waste time, like the politicians before you have, getting this started.

So I would first turn to first witness is Donalda Toro, and we look forward to her testimony. We you want to talk into the mike right there.

STATEMENT OF DONALDA TORO, PRACTICE MANAGER, FREDERICK NEUROLOGY, LLC, FREDERICK, MD

Ms. TORO. Today the entire medical establishment is in crisis. Working as a physician in private practice is nothing short of abuse. As the wife of a physician and working as a practice manager, I speak from both a professional and personal perspective. I am responsible for negotiating insurance contracts, billing, posting payments, collections and accounts receivable and human resources. I manage the business as well as the family.

My husband has built a very successful neurology practice with over 4,000 patients. His schedule, as well as that of his associates, are booked two months in advance. Dr. Toro is well-respected throughout the community by his peers and patients. However, from a financial point of view, our business looks sluggish to grim. Commercial insurance companies and Medicare reimburse 20 to 50 percent of the bill charges; that is our charges. The RBRVS system, which is a resource-based relative-value scale, an algorithm used to assess value of work in units of medical care such as procedures and interventions, is totally ignored by the insurance companies. Therefore, physicians are only paid a small percentage for the work they do. There is not a billing code for consulting with family of a patient, doing the patient billing, long distance calls, calling in prescriptions, time spent coordinating patient care with other physicians, telephone consults with patients. On an hourly rate, my husband makes about as much as a ditch digger. I mean, a lot of people are shocked by this, but it is the truth.

Commercial insurance companies refuse to pay more than Medicare rates because insurance companies consider Medicare rates the standard. In fact, some pay—many of them pay less; Aetna pays less than Medicare. Insurance companies take their time in paying the claims, or they deny they received the claims or they refuse the pay the claim. Once a claim is denied for payment, I must pull the records and write an appeal for payment. I spend most of my time writing appeals more than I do billing. Once I submit an appeal, it takes four to six weeks before I receive a response. I have appeals that have been overturned to be paid by Blue Cross and Blue Shield of Maryland, but they haven't been paid in over two years, and I will still continue to follow up on them. If the insurance company overpays a claim, they quickly demand payment in full or the payment will be deducted from their next member or the next, if it is Blue Cross and Blue Shield, the next patient.

It takes a great deal of intelligence to become a physician, however, it takes a very different type of intelligence to successfully manage a business. Physicians are not business people. In fact, the psychological makeup of a physician is contrary to that of a business executive. Physicians are more concerned with saving the patient's life or improving their quality of life. A business executive is really just concerned about the survival of the business and receiving payment in full before the services are rendered. If a physician had earned an MBA after medical school, business school would teach them to practice medicine on a volunteer basis and choose a more lucrative business to make their living and repay their school loans.

In order for a small practice to survive today, the commercial insurance products must be limited, and under no circumstances can a provider accept an HMO or Workers' Compensation. These products are sudden death to a practice. A physician with business savvy would not accept commercial insurance, only fee for service. In other words, payment in full would be expected at the time of service. Medicare rates are a pittance and it would make sense to not participate with Medicare, but the physician could accept the Medicare rate plus 5 percent and the office would send the claim directly to Medicare for the patient to be reimbursed. However, if a provider does not participate with Medicare, he would not be permitted to be on staff at the hospital, which is really to their advantage because the hospital is where the physicians incur most of the bad debt. A physician in our community uses the business model I just described and seems quite happy practicing medicine.

Chairman MANZULLO. You have one minute.

Ms. TORO. Practicing medicine seems to fit the definition of a minister rather than a business. I don't know any other small business that can function without payment when a service is rendered.

It is hard to picture going to the grocery store with a cart full of groceries and meeting a third-party at the check-out counter as you observe them negotiating payment of 20 to 50 percent of what the groceries are worth, or possibly going to a restaurant and walking out without paying their bill and letting the manager know you will be happy to send them $5 a month until the bill is paid. That being the case, a small business would not survive or telling the manager, you have been stiffed again, and I have no intention of ever paying your bill.

Today I ask you to take small practices and give them a nonprofit status instead of a for-profit status that we currently have. After all, CareFirst and Blue Shield of Maryland have a nonprofit status. And according to an article in the Saturday May 17th issue of the Frederick Post, the nonprofit health care company reported in the first quarter——.

Chairman MANZULLO. It is not necessary to read your report. Your complete statements will be made part of the record. And, I mean, you are here because you got some problems and some big problems. Just speak from your heart. It is not necessary.

Ms. TORO. So many of them, it is hard to narrow it down. It really is.

Chairman MANZULLO. You are in a very unique position.

[Mrs. Toro's statement may be found in the appendix.]

Chairman MANZULLO. Our next witness is Dr. Camilo Toro, neurologist. And we look forward to your testimony.

STATEMENT OF CAMILO TORO, M.D., FREDERICK NEUROLOGY, LLC, FREDERICK, MD

Dr. TORO. Thank you. Most of my testimony has been summarized by my wife and Congressman Bartlett, but I want to basically express my feeling of frustration with the medical system and how that feeling is universal.

When I speak to my colleagues in the hospital and other physicians, it is a universal feeling that the medical community at large

is extremely frustrated and disenchanted with the practice of medicine. I like to use the analogy of what physicians do by making the case of the health care system kind of akin to the space program. You know, we are like the engineers that create these incredible projects of taking our citizens from birth to their death, and our mission is to really take our citizens through the journey in a way that is healthy and happy. And there are many professionals involved in delivering this mission, but physicians remain, really, the main engineers that handle the knobs and controls in this giant vessel.

One would think that in kind, society would compensate their committed professionals with recognition, respect and, to some degree, financial stability. In reality, that has changed. At this point, these aims of society have been changed by constant financial uncertainty, incredible personal and family hardship, and a constant fear of litigation that undermines, really, the financial objective of the practice of medicine.

The American Academy of Neurology, to whom I am a member, estimates that in the year 2000, the mean salary for neurologist was in the order of $160,000 a year. I find that figure, actually, personally, pretty hard to believe. I certainly make much less than that. I don't believe that I can work any harder than I am already working, unless I begin to practice bad medicine, fast medicine, or some form of illegal practice of medicine. In the end, a salary of $160,000, when it is placed into perspective as to the number of hours worked per day, the amount of weekend and nights on call, four years of college, four years of medical school, and four years of neurology training, and most likely two years of fellowship, in total 14 years of medical training, plus whatever experience, it comes to a salary that is in the range of $50 an hour.

A very ominous sign of how medicine is evolving can be gauged by the content of the medical society meetings. Medical society meetings are conceived to be the instrument of providing updates and to bring their physicians up to speed with new advances in technology. Turns out that in the last five years or so, most of the medical society meetings have begun to be inundated with a number of conferences and topics that now have become continuing medical education whose titles will mimic what I am going to say: Surviving a Medicare Audit, Coping With Litigation, 10 Most Frequent HIPAA Pitfalls, Getting Paid, Collecting on Insurance, et cetera, et cetera. So many of these societies have introduced these topics as part of their curriculum simply with the purpose of allowing this practice to survive but no longer have any relevance to actually the practice of medicine.

The reduction in physician reimbursement has probably very little impact in the skyrocketing cost of health care. I propose that a demoralized, underpaid, overworked and motivated physician fearing litigation is much more likely to practice defensive medicine, overutilize expensive, necessary services compared to a physician that feels that his work is remunerated in a commensurate way to his skill and effort. I hope that with this meeting we can provide some answers to these questions.

[Dr. Toro's statement may be found in the appendix.]

[Additional material submitted by Dr. Toro for the record is retained in the Committee's file.]

Chairman MANZULLO. Doctor, the purpose of these field hearings is to create public policy. It is to educate not only Members of Congress, but the public as a whole, that the medical profession needs tremendous assistance and that things in this country are going to change dramatically unless we address those issues. So we really appreciate you taking the time.

Our next witness is Mrs. Elizabeth Chung who is a practice administrator, and we look forward to your testimony.

STATEMENT OF ELIZABETH CHUNG, PRACTICE ADMINISTRATOR FOR STANLEY CHUNG, M.D., FREDERICK, MD

Mrs. CHUNG. Thank you, Mr. Chairman. Good afternoon. I will just use one minute, I hope, to summarize my write-up, but at the same time, I will use four minutes to speak from my heart as the wife of a physician that has so many of the issues that have been addressed.

As an orthopedic doctor, first of all, this is my husband's second career. He was working in engineering and changed his mind. He wanted to be a good old country doctor and get away from politics, but he was dead wrong after only one year.

The first problem is in terms of public policy, probably should look into helping us in terms of running a small business is the first thing, because we really have to find a way to find any kind of services that could help to us start a new business, but again, it costs very much to do so.

The issues that I have are five: One is cost schedules. My husband works 10 to 11 days a month on call out of which five to six days are in the emergency room at the Frederick Memorial Hospital, which means that we are seeing 20 percent of the orthopedic patients who went through the emergency room in each month. And why is it important? Because out of the ER, we have a lot of uncompensated care. The uncompensated care came from indigenous patients and comes from uninsured patients, comes from Worker's Comp sometimes the employer did not want to pay because they argue with the employer and employees. And also we have contract and labor, which is very important issue to look at because they work on the job, they get hurt, they went to emergency room, we treat them and then we never see them again. And also the other thing, medical assistance patient, again we don't just treat patient from Frederick County, we treat patients from Prince George's County, everywhere because they know that there is a good doctor in the ER that can take care of them. Frankly, that is the only way sometime for our indigenous and also uninsured patient to get medical care.

The other one is the automobile with the liability, they got the money, they put the money in the pocket, and they said they deserve the money, they don't want to pay the doctor. They file bankruptcies.

So the major issue, besides the uncompensated care, is also our out-of-pocket care. My husband never look at whether they get paid, whether he has insurance or no insurance to take care of patient. So we treat them. We operated on them. And yet what hap-

pened? If they call the office, we see them. We see them. We treat them well until they are clean bill, really. So what does that mean? Casts, crutches, X-ray, all kinds of material. We have out of pocket. So it is not just we are not getting paid for his professional time, expertise, we are taking money out, hundred and hundred and hundred of dollars to cover care for those who need help. That is one thing that my husband said, make sure, let the Congress hear about that. We are also providing, subsidizing the medical care to our needy elderly.

The administrative nightmare that I won't to go into a lot of detail because I have ten different items, but several things I want to bring up. And one is that we have unqualified staff at the company, insurance company, to tell us that the doctor should not do this or doctor should not do that. And this is very ridiculous. This is individualized. We have to make the best decision, what is good for the patient. Is it better to take the patient back three or four times so we can send our claim in three our four times separately? So we can get paid more? No. We need to be conscientious, we need to be ethical about that.

Second thing is the bundling of claims, packing the claims so they can reduce a payment. And we tell them this is a distinctly procedure hoping that we can get paid at least 100 percent, but they still come back discounted. They have all kind of games. If you don't know the rules, don't know the game, you can't play with them. One thing that is ridiculous. I will show it to you. My son was hurt four and a half years ago. Fractured his leg. Daddy took care of him with an X-ray, it is true and real. And four and a half years later, last Friday, I got a bill from my insurance company requesting money back from the doctor, who is his daddy. Okay. And basically, to have a job this is ridiculous. I guess it is to take my son to the emergency room would be better.

Medicare. Medicare patient is very important to us. It is growing 18 percent of the population, 25 percent of ER patient, and yet, do you know that Frederick, many of the primary care physicians are not taking new patient anymore? They are not taking Medicare patient. They go into the emergency room for a simple condition.

So this is the Tom Brokaw greatest generation, folks. So when you take care of them, the small business people, how can they take care of them when they cannot even afford a business manager, a biller? I do practically a lot of things for my husband's office. My husband work, my husband work more than 80 hours a week. I am a single mom, and my husband went through litigation at one time, and you don't want to see it, five days in the court room, 140 degree temperatures. We lost the case. I was so afraid he might commit suicide literally. You know, this is ridiculous because premeditated, the lawsuit is in the run with a lot of situations in here. Do you want my son to be a doctor? Do you think I want him for a doctor? I am afraid, you know. So we have two doctors in our practice and other associate, Yale graduate. Now, they went to Wall Street. They went to law school. That is where the children went to after putting them through orthopedic training and medical school. So I am asking that please if you can help out the saving and loan bank, help out the airline industry, why not help us too? We need some tax relief. That's what I am asking.

Tax relief. Give me some, a few thousand dollars so I can write them off, so I can, you know, do something. I can give it to my community organization because that is where my passion is. I want to help the poor, but I want to make sure the money is in the right places.

Thank you very much.

Chairman MANZULLO. We thank you for your passion. It is obvious that you live this 24/7. We appreciate that very much.

[Ms. Chung's statement may be found in the appendix.]

Chairman MANZULLO. Congresswoman did you want to the introduce the next witness?

Mrs. CHRISTENSEN. Thank you. We often have the opportunity if we have a special relationship with a witness, to be able to introduce them. I am pleased to introduce Dr. Michelle Denise Thomas. As a former board member and Regional Chair of the National Medical Association, it is especially an honor, as she is the President of the Maryland NMA State affiliate, and she practices intensive care and critical care medicine in Maryland. She is a graduate of Vassar College, received her M.D. from Rutgers Medical School. She holds many board certificates, including she is a Diplomat of the American Board of Surgery, and she is a producer and host of Health Access on Public TV channel 76 and a Health Correspondent on the news for Channel 76. So it is a pleasure. I am glad you are able to come on such short notice.

STATEMENT OF MICHELLE D. THOMAS, M.D., ON BEHALF OF THE NATIONAL MEDICAL ASSOCIATION (NMA)

Dr. THOMAS. Thank you. Good afternoon.

I have been asked by Dr. L. Natalie Carroll, President of the National Medical Association to represent the concerns of her constituents and 25,000 African-American physicians and the patients they serve. I am the President of Maryland State NMA affiliate organization. I am a surgeon and critical care medicine specialist. I have a small surgical practice.

I am a member of a five-physician critical care group organized as an LLC, I a do critical care. With respect to Tort Reform, the National Medical Association is committed to quality health care, the elimination of health disparities and access for all citizens and immigrants communities to health. We believe that if an individual patient is injured or victimized by a negligent physician, there should be legal redress and compensation. We do believe that Tort Reform is necessary to preserve the economic viability of physician practice. I have, over the past 12 years, worked in hospitals and communities throughout Maryland including Cumberland, Hagerstown, Carroll County, Baltimore County, Baltimore City, Prince George's County, Montgomery County, Anne Arundel County, as well as our Nation's capital, the District of Columbia.

I am in contact with physicians in urban and suburban and rural areas of Maryland and the national crisis in medical liability is taking its toll on health care providers both professionally and personally. There is no high-risk obstetric care on the Eastern Shore of Maryland due to the high cost of malpractice insurance. In 1995, there were 14 companies underwriting medical malpractice insurance. In Maryland today, there are three companies providing in-

surance, Medical Mutual Liability Insurance, Society of Maryland, covering the majority of physicians. Please see Attachment A it is a copy of the Maryland OB/GYN Society Survey on Professional Liability, conducted in February 2003, which in brief states: If malpractice premiums increase by 25 percent, 34 percent of the surveyed respondents could stop practicing medicine all together. The worsening professional liability environment, coupled with declining reimbursement for service, suggests that the impact on women's and infants' health outcomes will be negatively impacted. This will be across the board in other medical specialties. Med Mutual Insurance informed on July 2, 2003, that it filed with the Maryland Insurance Administration a proposed rate increase of 28 percent. The National Medical Association endorses Tort Reform policy with emphasis on: Collateral source rule, contingency fees for plaintiffs attorney, periodic payments, limits on noneconomic damages, limits on statute of limitations and qualification of expert witnesses.

Attachment B is our health policy brief on medical liability reform.

To speak about bureaucracy, bureaucracy is defined as a system of administrations marked by officialism, red tape and proliferation according to Webster's. Physicians, whether they are employed by hospitals, managed care organizations, or self-employment in small or large medical practices, must traverse nongovernmental and Federal and State bureaucracies.

Medicine is a highly regulated industry. We are licensed, credentialed, insured and monitored. The time spent on administrative paperwork is approaching 40 to 50 percent of the workday for small practices. The Health Insurance Portability Act, HIPAA, does feel like an 8,000-pound hippopotamus to me. There has been a deluge of HIPAA compliance information services, compliance products which have just added another expense item to the cost of medical practice. We do believe there is some value to HIPAA in the long term, but the spectre of penalties and large fines and imprisonments for violations has small practices and particularly minority physicians concerned that they will be unfairly targeted. This is partly due to the individual experiences with the correct coding initiatives, and audits.

The Health and Human Services Order 13166, which requires health providers to offer translating services to non-English-speaking patients, is unaffordable for small practice. We all would like to provide that, but it is unaffordable. There are some examples listed here in terms of our frustrations with government, private insurance, and managed care corporations in obtaining authorization and treatment reimbursement.

Profitability and solvency of small medical practice. The value of health, that is being of sound mind, body, and spirit, free of disease, is dear to us all. The art and science of medicine once was a noble profession. Today many struggle to sustain their medical practice. Personally, I can say my small search for practice is not profitable and barely solvent. Antitrust regulations prohibit me from joining other small practice groups to negotiate fees——.

Chairman MANZULLO. You have a minute.

Dr. THOMAS. It is difficult to obtain fee information, profiles. My initial fee schedule for medical service was established in 1993

based on a geographic adjustments factor in Hagerstown. When I moved it Prince George's, that was adjusted up to 1.042. Today my, reimbursement is 30 to 40 percent of my fee schedule set in Hagerstown in 1993.

I and a majority of NMA physicians' constituency accept Medicare and Medicaid patients in addition to a large proportion of uninsured patients. This health care disparity exists in the country and the general health of our Nation will worsen if small medical practices are not profitable.

Chairman MANZULLO. You have a shortage of time, Doctor.

Dr. THOMAS. One last statement please. The impact of the uninsured on small medical practices. There are 41 million uninsured individuals in the United States. Not all uninsured are poor. However, the majority of uninsured are of modest to low income, especially among those of African American, Hispanic and minority communities. According to the latest figures released by the U.S. Census Bureau, over half of all uninsured are Asian, African American, or Hispanic. More than 6.5 percent of Hispanic and African Americans report they have unmet medical needs compared to 5.6 percent of Caucasian Americans. The Department of Health and Human Services report that communities of color experience serious disparities in health care access and outcomes in six areas: Stroke, heart disease, diabetes, infant mortality, cancer, and HIV/AIDS.

Insurance coverage income and available safety net services contribute to the health care disparities.

A small medical practice's costs shift when they provide uncompensated care. Charitable care becomes more burdensome for physicians as third-party reimbursement rates remain low and practice expenses increase.

Chairman MANZULLO. I will have to——.

Dr. THOMAS. I just have two sentences.

Chairman MANZULLO. But I really—I want to get through the witnesses because we have to have time——.

Dr. THOMAS. I have two sentences, Congressman, if I am allowed to.

Chairman MANZULLO. Okay.

Dr. THOMAS. If my panelists would allow me.

Chairman MANZULLO. I really have to push you because I want——

Dr. THOMAS. I will.

Chairman MANZULLO [continuing]. to get through with the testimony and have time for questions. Then we have to leave to get back to vote.

Dr. THOMAS. I understand, and I appreciate the privilege. Prevention services are cost saving for both children and adults. Expanding insurance would do more to improve access for the uninsured across all communities. For the small and large medical practice, hospital, or clinic, something is better than nothing. The fundamental truth about health care industry is that it is difficult to profit on delivery of health care to people who are ill.

I thank you for the privilege.

[Dr. Thomas's statement may be found in the appendix.]

[Additional material submitted by Dr. Thomas for the record is retained in the Committee's file.]

Chairman MANZULLO. I am going to have to insist on the five-minute clock. There is a reason for that because I have got a chairman's meeting back in Washington. We have leave time for questioning. Your testimony is all made part of the record. And what I would suggest is take the highlights of your testimony, tell us your story. Because we will read everything, and it will be part of the record. It will be published.

Our next witness is—and thank you for your testimony, Doctor. Our next witness is Dr. James Pendleton with the association of American Physicians and Surgeons. I look forward to your testimony.

STATEMENT OF JAMES L. PENDLETON, M.D., EMERITUS, PSYCHIATRIC STAFF, ABINGTON MEMORIAL HOSPITAL AND MEMBER, BOARD OF DIRECTORS, THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Dr. PENDLETON. Thank you, Mr. Chairman.

In 1965, health care cost 5.9 percent of the gross national product. The poor saw physicians slightly less often but were hospitalized slightly more days than the middle-class and the wealthy. Blue collar families could pay for appendectomies, hysterectomies, deliveries, and most other surgery. The Kerr Mills Act had been passed in 1960 to pay for the elderly poor. Reportedly the average doctor contributed about 20 percent of his time to caring for people who could not pay part or the full fee.

My father-in-law, a general practitioner in Akron Ohio, saw his first—the initial patient visit was an hour and subsequent visits were 20 minutes. I understand the time now is seven and a half minutes. Let me show the first of these slides. And things were good enough at that time that when the Medicare/Medicaid Act was passed, the Congress said the following in other words: That there would be no control over the practice of medicine, the finances, the administration, or anything. And actually, what is the case now is that laws are all over our practices from start to finish. And one of the controls, of course, is essentially price controls with Medicare, not Medicaid, but the managed care and the Blue Shield. I won't go into what is going on except to say my area of southeastern Pennsylvania is one of the hardest hit areas. I suffered a serious accident on a bicycle and was admitted in Trenton, New Jersey because the trauma unit in Langhorne at St. Mary's Medical Center was closed because they had no neurosurgical coverage for the weekend. If there had been bleeding in the brain, there could have been death or extensive neurological damage.

The number of applicants to medical school has been decreasing steadily for the last several years. And as one college counselor said, the best students are no longer going into medicine. Counsel for AAPS, the organization for which I work, on which I am an unpaid member of the board of directors, our counsel, Andrew Schlafly has admitted, submitted written testimony along with mine, that I can't cover either of them but his case histories are very interesting and important as to prosecutorial abuse of physi-

cians. It is amazing some of the things that those people who are looking to make a name for themselves do and get away with.

Between 1965 and 2003 about which have you been hearing, the doctor—planners wrote repeatedly that the doctor, not the patient, was the consumer. That the market couldn't work in medical care because of insurance. That the patient couldn't make the complex decisions required of medical care to balance quality—value and cost to themselves. Although none of this was true, patient money was almost entirely removed by lower-dollar coverage and the billing of the doctor was hidden from the patient. Those situations have created a tremendous lack of accountability. And insurance and government inspectors can't match what a patient with money in his or her hands will do in inspecting the doctor, and they are not identified, and they don't warn you that they are coming in. I would say that more than half of my practice certainly—and I was a psychiatrist—would know quite well what was happening with their money if their money was involved.

Chairman MANZULLO. We have a minute left.

Mr. PENDLETON. Wow. Okay. Not much time, is there? This shows, these statistics are from 1946 to 1976. That shows the increase of a hospital stay going up from 1966 where Medicare came into effect. I used the same principle, these data are—the green line is the projection from 1950, not shown here, to 1991. That level is 8.9 percent of the gross national product. The actual level at that time was 13 percent. I calculated very roughly the amount between the red reality lines and the projected line from 1950 to 1966, and that represents $1 trillion, $225 billion difference in the projection from before the time of the entrance of Medicare, Medicaid, and low-dollar coverage. I won't have time to go into that. And I won't bother with that.

What I would say in what should be done, the most important thing that Congress could do is to—and the House did this—is to remove the crippling restrictions from tax deferred medical savings accounts and make them permanent. We have to bring the patients' money back so they become the inspector, not someone from a bureau or somebody from an insurance company. The doctor has a lot more trouble, emotionally and practically, cheating his patient than when they try to do it with the insurance company. I have about three things to say.

Chairman MANZULLO. I know. How are you doing on time?

Mr. PENDLETON. You are trying to remove the regulations and I am really appreciative. I don't think you can do that until you bring money and the market back into the patients' hands so they have an account and they are paying and they are watching. We are going one of two ways toward total government control, more of this same or back to the market. I hope you will go that direction. Health insurance should be selected and owned by patients and noncancellable except for failure to pay the premium.

Tort Reform companies are a necessity in our State. It looks like that won't happen for at least 10 years. Abuse of physicians by prosecutors should be reigned in by Congress. The FDA should evaluate safety only, which would cause far less delay because clinicians would soon find the efficacy without significant cost.

Dissatisfaction with managed care, as I mentioned, means that we are at a crossroads. I hope we take the direction back to trust the patient. They can understand. I saw two psychiatrists lose their practices because they didn't give the care that they should have to the patient. They didn't cheat them, but it was not—and one made his home with the hospital and the other made his home with first one managed care and then another. The patients are smart. They run the whole rest of the economy. They are enough of them to keep us under discipline.

Thank you very much.

[Dr. Pendleton's statement may be found in the appendix.]

[Additional material submitted by Dr. Pendleton for the record is retained in the Committee's file.]

Chairman MANZULLO. It is not hard to realize that Dr. Pendleton has a minor in political science at the University of Pennsylvania in 1953. I thought that was interesting you go from political science undergraduate to an M.D.

Mr. PENDLETON. I am a slow learner. I went into premed later but I took philosophy and hard science.

Chairman MANZULLO. Our next witness is Greg Scandlen. He is the Director for Consumer Driven Health Care at the Galen Institute. And we look forward to your testimony.

STATEMENT OF GREG SCANDLEN, DIRECTOR, CENTER FOR CONSUMER DRIVEN HEALTH CARE, GALEN INSTITUTE

Mr. SCANDLEN. Thank you.

Dr. Pendleton gave me a wonderful segueway into my own views which are essentially that health care has got to be about the patient. The hospitals, physicians, nurses, insurance companies, all the rest should be measured only on how well they serve the patient. If they don't do a very good job, they should be forced out of business. If they do a good job, they should prosper. But only the patients can ultimately express their views. How well a patient is served is ultimately the judgment of the patient. Unfortunately, in today's health care system, patients control only 15 percent of total national health expenditure, total health spending. That goes down every year. In 1965, it was about 56 percent, and are we seeing a growing drop-off of the influence of patients over controlling their own resources.

Now, I polled a number of physicians before coming here, and they told me there are four issues, which won't surprise any of you: Inadequate reimbursement, excessive regulation, administrative burdens and a tort system that is completely out of control. Virtually all the physicians I talk to say that that is what is plaguing them in today's health care system.

It seems to me that these problems can be addressed in two ways. You could roll back some regulations, you could increase reimbursement, you could do some tort reforms and that would be a very good thing. However, the next Congress or the next administration will be right back to the same old place cutting payment, increasing regulations. So it will be an endless tug of war between the regulators and the deregulators, between the thrifty appropriators and the generous appropriators, and it strikes me that that is not the most effective way of going.

And I would come back to what Jim was saying where if you want permanent change in the system, you have to re-empower the patient. You got to put the resources and the decision-making authority back in the hands of the patient. You have already taken some steps in this direction: In 1996, medical savings accounts, which were just a very little baby step, but it was important nonetheless. The Internal Revenue Service put out guidance on health reimbursement arrangements a year ago. The President has proposed tax credits in association health plans. Those would be good steps in the right direction. The self-employed are already allowed to deduct 100 percent of their premiums. Again, that is a small step, but an important one in the right direction. There is health savings accounts, which are basically an expansion of the medical savings accounts in the House Medicare bill currently. That would be valuable.

At the same time that Congress and the administration are working on these developments, the private sector is absolutely booming with consumer-driven health care. The level of innovation and new ideas that are happening in corporate America and within the insurance industry trying to put more control in the hands of patients is astonishing, and the medical profession is also moving in that direction. Increasingly physicians are refusing to take managed care payments, and they are refusing to enroll in managed care. They are not taking new Medicare patients, or they are dropping out of the Medicare program entirely. They are creating programs like SimpleCare, which operates on a cash only basis. The patient comes in, pays cash for the service, and the patient can bill his insurance company if he has coverage. There is boutique medicine. There is so much happening out in the community, and I hope to God that Congress will stay in touch and stay aware of all of these developments and help facilitate them rather than getting in the way.

The four issues of most concern to physicians and how that will be affected by more empowering patients, first of all, on the reimbursement side, one of the horrible things we are paying is that all docs get paid the same regardless of how good they are. The kid right out of medical school gets the same level of payment as Dr. Pendleton would. It makes no sense to do it that way. We talk a lot about quality, but we are not willing to pay for it. If patients controlled their own resources, they would be willing to pay more to get the very best quality service and less for mediocre service.

Excessive regulations. Most of the regulations are aimed at correcting the problems created by a third-party payment system.

Administrative burdens. If we could move more of the payment system into a cash basis and process less through third-party payment mechanisms, it will be far more efficient and less burdensome for doctors.

And malpractice. We have got to restore the level of trust between physicians and patients. The only way to do that is to restore the patients to a position of power in their relationships with their doctor. I think malpractice would quickly go away even without tort reform if we did that.

And then finally, I think the system would be self-correcting with empowered patients. We wouldn't need to come back and write new

laws every year. New services, new ideas could be paid for or not depending on the wishes of the patient. And I would encourage you to move further in that direction. You have already started, and it is very encouraging to see that activity, and I thank you for your time.

Chairman MANZULLO. Thank you very much.

[Mr. Scandlen's statement may be found in the appendix.]

Chairman MANZULLO. Our next witness is Linwood Rayford, with the general counsel of the Small Business Office of Advocacy, and look forward to your testimony.

STATEMENT OF LINWOOD RAYFORD, ASSISTANT CHIEF COUNSEL FOR FOOD, DRUG AND HEALTH POLICY, OFFICE OF ADVOCACY, SMALL BUSINESS ADMINISTRATION

Mr. RAYFORD. Thank you, Chairman Manzullo, Representative Bartlett, Representative Christensen for your ongoing support of the Office of Advocacy. The committee asked me to discuss the Office of Advocacy's review of government regulations and how our review of health care regulations reduces the burden on small doctors' offices.

One of the agencies that Advocacy is responsible for monitoring is the Department of Health and Human Services, more commonly referred to as HHS. The primary agency within HHS that is charged with promulgating rules that govern physicians' care of patients and physicians' reimbursement under Medicare/Medicaid is the Center for Medicaid and Medicare Services, CMS.

Pursuant to the U.S. Small Business Administration size standards, the vast majority of practicing physicians are considered small businesses. Recent studies have shown that physicians are spending more time on administrative paperwork and less time on patient care. Therefore, it has been one of Advocacy's goals to have CMS more fully consider the consequences of their regulatory actions on small health care providers prior to finalizing their rules. This is, after all, the primary tenet of the Regulatory Flexibility Act.

How does Advocacy fulfill its mandate under the Regulatory Flexibility Act? Historically Advocacy monitors CMS compliance with the RFA by reviewing rules that the Agency published in the Federal Register or because of requests from a small health care business or health care association that asks us to review the rule that was particularly burdensome. The problem with this method of regulatory review is that once the rule was published in the Federal Register or had come to the attention of industry, it was often too late for Advocacy to encourage CMS to consider less burdensome alternatives.

Advocacy realizes that the best way to have meaningful or full effect on CMS rule-makings was to become involved in the process much earlier prior to the proposed rule or final rule being published in the Federal Register. Three recent developments have helped Advocacy become involved in CMS rule-making earlier. First, the President signed Executive Order 13272, which requires Federal agencies to implement policies protecting small entities from writing new rules and regulations. That ensures the regu-

latory agencies will work more closely with the Office of Advocacy during the regulating writing process.

Second, in large measure because of the influence of this committee, CMS agreed to increase its dialogue with my office during the rural development process.

Third, Advocacy signed a memorandum of understanding with the Office of Information and Regulatory Affairs at the Office of Management and Budget. Agencies are required to submit significant rules to OMB for review before publishing them in the Federal Register. OMB and Advocacy have agreed to communicate more closely on rules that are expected to have a significant small business impact.

Some examples of how advocacy has influenced CMS rule-making: Advocacy was involved in reviewing CMS's Health Insurance Portability and Accountability Act, more commonly referred to as HIPPA. Under HIPPA, CMS promulgated the privacy rule. On April 14, 2003, the privacy rule became effective. The privacy rule was intended to provide standards for preventing unauthorized disclosure of individually identifiable health information maintained or transmitted electronically by health care providers. Advocacy was intimately involved with the rule during each stage of its promulgation. While concerned with many aspects of the rule, which we still are, Advocacy fought to provide an extended time period for small business to comply with such a complex regulation. As a result, small entities covered by the regulation had an additional year to comply with its provisions.

Advocacy is aware that this regulation continues to be a source of great concern to physicians, and Advocacy is having ongoing discussions with CMS to make the provisions of the rule more easily understood by health care providers through the use of a small business compliance guide. We want CMS to focus on compliance and less on enforcement.

Advocacy also reviews CMS revisions to the payment policies on the physicians' fee schedule on an annual basis. Every year CMS is required to update the prospective payment system. Advocacy has worked with CMS on many occasions in an effort to reduce the burden covered by the PPS system on small health care providers. Advocacy is pleased with its improving relationship it has with CMS and is working to make it stronger. Further improvements in Advocacy's relationship with CMS will ultimately benefit health care providers like those present at the hearing today.

Advocacy pledges to this community that we will encourage CMS to appreciate how their rules and regulations will affect small health care businesses. This will hopefully result in physicians being able to dedicate more time to patient care and less time worrying about government mandates. Thank you.

Chairman MANZULLO. Thank you very much.

Let us see—I guess Dr. Unger can't make it.

Dr. UNGER. I am here. I thought there were going to be two panels.

Chairman MANZULLO. We put everybody together. We will start with you.

Dr. UNGER. Thank you very much.

Chairman MANZULLO. We have a 5-minute rule, and I will wave this.

STATEMENT OF CHRISTOPHER PELHAM UNGER, M.D., PHYSICIAN ADVISOR, TRAVELERS INSURANCE COMPANY

Dr. UNGER. I am going to try to make it briefer than that. I am a family doctor in Bethesda. I am active and participate in the State medical association. I am a member of several committees, and I am also a board member of the Taxpayers' Association. I have been acquainted with Congressman Bartlett for some time. He didn't know that I was one of his unknown fans. And essentially what I would like to do if I could is just talk to you very, very plainly.

We have all heard about what trouble this system is in, and I think if you visited our offices, you would be quite shocked at what you see, and I would like to credit you and everybody here for trying to take this on. What I thought I would do, over the past few years, in the process of my teaching activity in Bethesda, and which I do around the country, I have tried to think of certain solutions. And I would like to ask you all whether you think any of these solutions would possibly have a chance of coming into existence.

My early intention is that I believe that small units in the medical system work better than larger units. I worked in very, very large university hospitals. I have worked in small Hill-Burton clinics, and I have worked in private offices. It is those small offices that really generate efficiency. The reason is continuity. The reason is because those practitioners have known those patients most of their lives.

One of the physicians that I worked with in Pennsylvania, which is a State now that is really in big trouble, could see 20 house calls in the morning and give good diagnoses and compassionate care and move on from that to an operating room, use that operating room all afternoon, and then have night hours in his office where people could just walk in. It was a wonderful thing. And it was a natural part of our culture. The question is, really, how can we preserve and retain that?

Some of the things I think that are stumbling blocks are that we are afraid to say when there is a problem in society that we can't vote to regulate it. I will give you a little example. Here in Maryland, one of my very close colleagues proposed that all of our private gymnasiums would have defibrillators, and it was a good thing to do and wouldn't cost too much, and that would become a mandate. We had many mandates in Maryland, possibly as many or more than any other State. And when I saw what was happening, I was realizing how we could go down this road of having more mandates, which have to be administered, and they have to be enforced, and they raise our taxes. I went to the microphone at that point and said, I don't think it is a good idea, and I think we should vote no on this.

It is very difficult for all of you to say no to these regulations unless we have alternatives. Now, some of these alternatives might work, and some of them may not. One of the basic things is that when you have an argument, we have only so many dollars to put

into this health system. We can't continue to take tax money out and give everybody everything they want. Those tax dollars will either go over to managing the system, as one of our regulators says, overkill regulation, and that is here in Maryland when they come to visit my office. Those dollars will have to go over to management and administration, or those dollars will go over to services.

If they go over to services, we can help our nursing shortage. If they go over to services, we can help our shortages of general surgeons and primary caregivers if we support that. So the first thing is when somebody sees a bill, and the bill has a fiscal note on it, and the fiscal note says $9 million, my thinking is why don't we take the $9 million and spend it on vaccines, or spend it on nurses or spend it on primary caregivers? And that is a very strong argument. I was wondering if someone might be able to offer a comment to me on that argument. Is that a valid argument?

Chairman MANZULLO. Why don't you continue with your testimony and during the question-and-answer period——.

Dr. UNGER. I will postpone that to slightly later.

One of the arguments that comes up, and this is very important, many of our regulations in society which are now sinking the system actually work. A few years ago a family member had to be kept alive with blood transfusions, and I didn't know it at the time, but that blood transfusion system is so beautifully controlled by Federal mandates and Federal regulations that we could have given her blood transfusions for weeks and not have had one worry about AIDS or hepatitis in those vaccines.

Now, the question is why regulations work very well in this system in certain parts of the system and why they work terribly in other parts of the system. And the way I reason this through is when you are regulating a product or commodity, it seems to do very well. If we regulate the way we homogenize milk or they way we put lead or don't put lead in gasoline, it seems to work very nicely, and it protects everybody. But when you regulate relationships—and this system is a relationship-based thing. I have been listening to all these doctors here and their frustrations and how their relationships are intruded upon. If you don't intrude on that relationship, you may have a chance of surviving.

To summarize and conclude, I didn't want to go over my 4 minutes. First, I think the liability reform that you folks and the Congress have passed is absolutely commendable. You got to keep bringing it up. In the 1980s when President Reagan had a vision to win the Cold War, he kept bringing Congress back to it. It was a very, very difficult thing, but he brought them back to it, and essentially it was that repeated pressure that enabled him to get the funds that he needed.

I would like to give you another example. When HIPAA was passed, HIPAA was placed under a concept of covered entities and non-covered entities. What you can do for these doctors here is you can say if you have fewer than 15 employees, and this is a Small Business Committee, you can say, you are not a covered entity, if it is OSHA, CLIA or whatever it is, and that will expand that, and that is rational, and I think it is a passable thing.

Another thing that might be possible is to consolidate all of these agencies that we have. Consolidate them into one agency.

Chairman MANZULLO. It would be a department of aggravation for medical doctors.

Dr. UNGER. Department of aggravation. I think that pretty much summarizes it.

Essentially, I think we should know when we address this to our patients, when we address this to our voters, when we address this to our consumers, that they are in direct competition with this regulatory monster, and it is either going to get bigger or smaller.

[Mr. Unger's statement may be found in the appendix.]

[Additional material submitted by Dr. Unger for the record is retained in the Committee's file.]

Chairman MANZULLO. Doctor, thank you for your testimony, especially the words this is not a regulation of product, but a regulation of relationships. That says it more than anything. It is the first time I had the opportunity to meet you.

Next witness is Bill Sarraille, who is an attorney and represents health care associations, medical associations, and we look forward to your testimony.

STATEMENT OF WILLIAM A. SARRAILLE, ATTORNEY, SIDLEY AUSTIN BROWN & WOOD, LLP

Mr. SARRAILLE. Thank you very much, Mr. Chairman.

You asked for some thoughts on how to try and address some of the concerns that have been raised today, and unfortunately there are no magic answers and no magic bullets here. It is a very difficult problem. But I think there are some suggestions that can be made. Some are incorporated in the H.R. 1, which is a very promising piece of legislation, and hopefully it will emerge well from the conference mechanism.

First I would recommend the development of a special congressional commission to evaluate the extent to which existing regulatory burdens may be modified or eliminated. Although the Bush administration under the direction of both Secretary Thompson and Administrator Scully has made some progress along these lines, clearly there is much more work to be done.

Second, Congress should require that the Centers for Medicaid and Medicare Services adopt an evidence-based approach to new regulatory impositions. Physicians should not be subject to increased regulatory burdens unless a benefit/burden analysis that is based on reasonable data suggests that the burden should, in fact, be imposed. We shouldn't guess at what may be best for our medical system.

Third, given the sharp disagreements that have occurred regarding the accuracy and the credibility of regulatory impact statements, Congress should create a commission to review that process and those determinations. In the case of HIPAA for instance, the Department of Health and Human Services estimated that the average cost for a physician practice to implement the standards in the first year would be $3,703. My experience, having worked with hundreds of practices, is that that estimate is probably off by a factor of somewhere between 5 and 10. The policy probably would have been a lot different if we had known what the real cost would be.

Fourth, in imposing burdens on different classes of providers, both Congress and the regulatory agency should separately consider the effect on and consequences for small physician practices. This should be a required step in the CMS rule-making process. An attempt to differentiate between providers has been made in some cases, and it has been quite successful in some cases. Unfortunately this approach is not uniformly made and followed.

Fifth, in imposing any new regulatory burdens on physicians, any future congressional or agency action should be time-limited, meaning that the new burden should only be effective for a finite period of time and require reauthorization. This would give both Congress and the regulatory agencies an opportunity to reevaluate the policy and life of the actual implementation experience.

Six, both Congress and the regulatory agencies need to think more in terms of carrots than sticks. Physician organizations have designed many mechanisms to improve patient care, such as accreditation and credentialing programs, but those providers that voluntarily adopt those standards receive nothing as a consequence of their commitment to excellence. In this way, the program has actually rewarded mediocrity and competence and stifled innovation in their commitment to excellence.

Seventh, rule-making proposals should be appropriately spaced in time to allow physicians and their representatives to absorb and respond to those proposals. Administrator Scully has recently implemented a process by which there would be monthly releases of new regulatory materials. I think actually a quarterly schedule would be more appropriate for small physician practices.

Eighth, Congress needs to demand increased accountability from CMS itself. Although Secretary Thompson and Administrator Scully have made some progress here, there is unfortunately much more work to be done. For instance, CMS failed for years, despite a clear congressional mandate and statute, to update the list of approved procedures to the Medicare ambulatory surgery center list, which is necessary to permit access to those procedures. Even when belatedly the Agency recently updated the list, it refused to add a number of procedures that it conceded met the statutory requirements because in effect it said it did not have sufficient information on the cost of those procedures. As the Agency admitted however, the reason it did not have this information is that it had failed to meet another congressional mandate to collect that information.

The idea that the failure to meet one statutory mandate was excused by a failure to meet another has proven quite galling to physicians. I recommend the creation of a congressional commission specifically tasked to address accountability issues with an annual reporting obligation to Congress.

Ninth, physicians and providers must be permitted to rely upon the guidance they receive from the agency and from its agents. The General Accounting Office has reported that the information provided by some within the program was inadequate almost 85 percent of the time. Physicians are quite upset and angry that they are threatened with the possibility of criminal prosecution for allegedly failing to meet requirements which the agents of the program themselves cannot articulate correctly.

Couple of other quick observations. Obviously there has been a lot of discussion about the disappointment that physicians have about the Senate's failure to enact medical liability reform. That is a huge and dangerous situation.

With respect to reimbursement rates, we have this ongoing issue of the conversion factor under the Medicare fee schedule. There is some help in H.R. 1. Unfortunately, however, there is still no permanent fix to the problems in the formula itself. This is an unacceptable problem which is crying out for a permanent solution.

Finally, I do have to agree with those that say that there are instances of government prosecution here which is overzealous and in some instances just plain wrong. I was involved in one audit matter where the client was accused of having collected $900,000 in overpayments. Ultimately it was found to have only collected $300 in overpayments. Unfortunately it cost the provider thousands of dollars to prove its point.

Thank you very much for your time today.

Chairman MANZULLO. Thank you.

[Mr. Sarraille's statement may be found in the appendix.]

Chairman MANZULLO. What a wonderful panel of witnesses here. This is—why don't you guys—I know you can't all be in Congress, otherwise Roscoe would have something to do about it, but we need people with common sense and background and just to sit down to try to figure out what is going on. One of the problems that Congress has is that so often many Members just don't see the big picture. They just don't get it, and you folks do.

I have just got a couple of questions here, and one of them that, Dr. Thomas, has bothered me for the longest period of time, and I guess it will continue until something gets done, is the statement—and obviously this is based upon scientific evidence, and it seems to be getting worse because Department of Health and Human Services reports that communities of color experience serious disparities in health access and outcome in six areas: stroke, heart disease, diabetes, infant mortality, cancer, HIV, AIDS. And the gap seems to be getting greater, doesn't it? And I think that is extremely dangerous.

We spend a lot of time in our small business hearings on access, trying to make health insurance premiums more affordable, and I don't see that happening. I see insurance premiums going up, and at the same time this discrepancy—disparity that occurs between people of color and, for example, Caucasians that would suffer from the same maladies. Where are we going to go on that, Dr. Thomas?

Dr. THOMAS. Well, disparities is a complex condition in terms of the health care delivery system and differences in terms of people coming to a state of disease at different stages, but if we look at the 41 million uninsured, half of that population are minorities, and so, therefore, there is a question of access or lack of access. In addition, there are still just remnants of historical racism that exists within the medical system. There are people who are well insured who are not being offered the same treatments for various conditions when they present to the emergency departments or to the physicians' office. So the question of really just accountability to treating people equally is still an issue.

In addition, there are, you know, specific differences in terms of peoples' responses to different medications, and the more that there is more clinical trials involved, minorities, the better we can understand how to treat specific diseases adequately. There are certain treatments that are just totally inadequate for certain diseases within this population. But we have such a large percentage of uninsured within our communities, that those people are just not accessing what health care is available. They are accessing it at a very late stage.

Chairman MANZULLO. Thank you for commenting on that.

Dr. Christensen.

Mrs. CHRISTENSEN. I have a couple of questions. I guess I would start with Dr. Pendleton and Greg Scandlen because both of you talked about putting the patient back in charge. And a few years ago, we attempted to reform managed care and restore the patient and doctor relationship. Wouldn't that accomplish the same thing that you are trying to accomplish through the MSAs?

Dr. PENDLETON. Through managed care?

Mrs. CHRISTENSEN. Reforming managed care so that the patient and the physician really made more of the decisions as to what was really medically necessary, what referrals would take place.

Dr. PENDLETON. I think that having the money in their hands—and I would like to see this in Medicaid, too, because I think for poor people to have money in their hands would get them more respect, more attention. They would be at the center, and they would learn how to handle money and its value.

But anyway, medical savings accounts, I think, bring the patient back. The problem with the third-party payment and particularly the low payment, which is very expensive and wasteful, is that neither the patient nor the physician need to know what it costs. The Forbes Company and quite a few companies, but the Forbes Company sticks in my mind. Steve Forbes said that their company for 7 years, and it may be continuing, had no rise in cost of their medical care, and the patients were delighted. And I just think—I agree with you in the sense that of considering the patient and the decisions that they and their doctor make, my feeling is the focus and the center should be on the patient in consultation with the doctor, whoever else she wants to talk to. Does that make sense?

Mrs. CHRISTENSEN. I think so. I wanted to give—Dr. or Mr. Scandlen? Dr. or Mr.?

Mr. SCANDLEN. Just Mr. I am lucky if I qualify for that.

I take it you are referring to the Patients' Bill of Rights, and without redebating that issue——.

Mrs. CHRISTENSEN. It just seemed to me if you wanted to put the authority to make decisions back in the patients' hands, that maybe that might be another approach.

Mr. SCANDLEN. Unfortunately would not have done that. The review commission actually undercuts the authority of the attending physician to make decisions. It could be a whole discussion.

Mrs. CHRISTENSEN. Let me just follow up on that question. How would you respond on the issue of medical savings accounts to those who say that really it would not really help, but hurt coverage, because it might cause employers to drop coverage from traditional low-deductible insurance coverage and, therefore, then

maybe move more people out of traditional who were well, leaving the sicker in traditional, causing insurance premiums to rise.

Mr. SCANDLEN. I am not sure what traditional means anymore.

Mrs. CHRISTENSEN. Let me say the lower deductibles that may cost more to the employer when you now provide medical savings accounts for a high deductible.

Mr. SCANDLEN. Only 7 percent of the population is currently in traditional fee-for-service indemnity programs of which everyone is in HMOs or PPOs. And generally deductibles are going up anyway. Cost-sharing is going up; co-insurance, co-payments, premiums. What we are seeing in the overall trend of health care is so dramatic that small employers are desperate. Many are dropping coverage entirely.

I think medical savings accounts have the appeal, first of all, allowing patients to self-ration their care instead of a third party rationing for them, and ultimately holding down the rate of increase to a more reasonable level. So I would disagree that it will encourage employers to drop coverage. It will actually give them a way out of the cost limit that they are currently facing and enable them to maintain coverage.

Mrs. CHRISTENSEN. Do I have time for one more question? There have been studies that show malpractice caps for many, many—I mean, there are so many important issues, but this is perhaps the one that is really breaking doctors' backs, the malpractice one. And we passed a bill that would provide the cap at 250,000 for noneconomic damages. Nineteen States have implemented a cap, for example, in the past 12 years; showed that malpractice premiums rose by 48.2 percent. Those without caps, the premiums rose, but not quite as much. So studies are showing that malpractice caps on their own do not really lower insurance premium increases.

Now, we are going to have a debate, I am sure, as to whether that is the approach we should take, or should we take a more comprehensive approach looking at the insurance issues and removing their exemption from antitrust, looking at maybe providing some tax credits to lower the cost of malpractice premiums for providers. Why is that not a better approach than just simply imposing a cap that—where it hasn't been shown to work?

Mr. SARRAILLE. You asked an important question. I think, frankly, the response from most physician groups and the insurance industry, and we can debate about whether or not they have something to bring to bear to the discussion, but I think that the feeling is that what we are really confronting on a national basis at this point is problems in the malpractice systems of actually a fairly finite number of States, but unfortunately the problems are so great there that they have a national effect on the rate system across the United States. And so to talk about what the effect has been in those States that have implemented legislation versus those that have not, the problem is it hasn't been done on a national basis, so you really can't determine what the effect would be if there is a national approach.

You know, I think that certainly the number of organizations that I have represented have in the past been extremely critical of the insurance industry. Physician groups are tending to be less critical of them in the context of this debate, and the reason for

that is that notwithstanding increases in rates that we have seen, there obviously have been huge departures by insurance companies in the medical malpractice field, and one suspects from that that the conclusion is that the insurance companies are not, in fact, reaping tremendous profits from their involvement in the medical liability field. And, in fact, there is a structural problem that needs to be addressed.

Dr. PENDLETON. I would like to add something if I could. The statistic that you quoted, I question about it being low. What I had read, and, of course, that may not be true either, was that the percentage of increase for the States that did not have caps had gone up 162 percent versus I think the 48 you mentioned.

But what I would suggest is going on the Pennsylvania Medical Society's Web site. They did an excellent treatment of something put out by the American Trial Lawyers Association pooh-poohing everything the doctors said. It is pms.org, and I think it is a very well done piece, and you can get a different perspective.

Chairman MANZULLO. Thank you.

Roscoe.

Mr. BARTLETT. Thank you very much.

Do any of you have statistics on the percentage of the amount of money that comes into the doctor's office that actually goes to the doctor today as compared to yesteryear before we had all of this managed care and regulations? Obviously health care costs are rising. Dr. Pendleton had a chart showing them going up ever more as a percentage of the GDP. The testimony we have today is that less and less of that is going to the doctor. Do you have data on what percent of the money that comes into the doctor's office ends up in the doctor's checking account, that ends up somewhere else? It has to be a decreasing percentage; does it not?

Ms. DONALDA TORO. Since our office is very small, we have two physicians, myself, and then a receptionist. So I would say maybe 25 percent, maybe 20 percent.

Mr. BARTLETT. Goes to the doctor.

Ms. DONALDA TORO. Yes.

Mr. BARTLETT. Mrs. Toro has been in my office. I am very impressed that if her husband didn't have her there running the office, he would get even less money. She does a better job than the average office manager does. I am very impressed with her skills and her persistence.

Ms. CHONG. I am the gofer. I don't have the percentage, but I just want to give you a perspective. Twenty years ago, a senior orthopedic doctor took care of a knee replacement at that time versus arthroscopic surgery. Nowadays it is about $700, and in the old days about $2,000. This is 20 some years ago. So you can see in terms of the disparity, I think, in terms of reimbursements. So it is not even giving you the inflationary increase, but it is really decreasing. So it is very hard, very hard to run the offices.

Dr. THOMAS. It is difficult to say nationally and difficult to say across each specialty. There are some areas where people are highly profitable because there are so few, but their profit margins certainly decreased. I have provided with you just an example of my own surgical practice, which is maybe not—it is a small practice,

but it can show you, you know, revenues for 1 month and charges, and it is less than 25 percent.

Mr. BARTLETT. Thank you very much.

As a nonprofessional looking on the outside in, I think that most of the problems that plague your industry and that are increasing costs fall under two categories. The first is third-party payer. Health care is about the only thing that the average American shops for and never asks the costs. That is because somebody else is usually paying the cost. It is a bit like going grocery shopping knowing that someone will be at the checkout counter to pay for their groceries with their credit card. Third-party payer results in uncontrolled costs, and as an attempt to control these costs we now have excessive regulations. And as more than one of you pointed out, these regulations directly or indirectly really result in rationing, because if you had a third-party payer, you got uncontrolled costs. If somebody else is paying the bill, why not go for the max? And then to control the cost, you do that by making it so difficult for the doctor to collect, he finally decides not to collect, and half of the patients decide not to ask for the health care.

And the second thing that is driving our cost is malpractice insurance, or the whole malpractice problem. The insurance premiums are only a part of that. I don't know what your estimate is as to the percentage of the cost of health care that are represented by the insurance premiums and what percent is represented by the defensive medicine that doctors practice. And I know that that is—you can't get inside a doctor's head to know how much of what he prescribes is not to take care of the patients' problems, but to immunize him against malpractice, and you can't get inside the doctor. I have heard estimates like 25 percent of all health care costs are as a result of malpractice insurance.

Aren't there solutions to these problems in a sane society? Why shouldn't we put the patient in charge again? They run the government. They run our whole country. They run our industry. They run our farms. Why can't they make decisions about their health care, if we put them back in charge and they paid for it? Now, the average person thinks he can't do that because maybe it is uncontrollable. But at least to some extent there needs to be meaningful co-pay so that the patient is a shopper. Patients don't shop. They just go and never ask the cost because somebody else is controlling those costs through regulation.

In terms of malpractice, why can't we give patients two routes for their health care? When the patient comes to see you and say, Mary, I would be happy to treat you, there are two routes we can follow. One is if you can agree to a no-fault kind of insurance, I am not going to try to hurt you, but if something happens, doesn't turn out like we both hope it will, you are going to be recompensed for that. No pain and suffering, no punitive damage, but there will be an award for you. If that is the health care route you choose to follow, it will cost you $400 for this procedure. But if you choose to follow the route where you reserve the right to sue me with Joe down the street, now it is going to cost you $1,200 for that health care because I am not going to ask my other patients for your right to sue me. Which of these routes of health care would you choose to follow?

My guess is that 99 plus percent of all of the patients would choose to follow the no-fault insurance kind of a route. I know there are a lot of lawyers out there that would have to seek other kinds of businesses, but I am not sure that that would be bad for our society. Why can't we do—move the policy ownership back to the patient, have meaningful co-pay so they are careful shoppers? Why can't we give patients a choice?

You know, most of the health care costs are driven not by 90-odd percent of the patients, but a tiny percentage of patients who are enticed by lawyers, and I see their advertisements, and I see them in the paper, I watch them on television, and they are enticing the patients to come to them. I will get you rich; me richer, but I will get you rich in the process. Why can't we follow these two routes which seems to be a sane way to avoid most of the problems we have in health care costs?

Mr. SCANDLEN. If I could add an observation, the third-party payment and malpractice compound each other as well. Physicians are able to do more defensive medicine because there is a third-party payer who will pay for it. And patients are suspicious of the motivations of the doctor they are seeing who they probably have never seen before, and they wonder who you are really working for; are you working for the insurance company, or are you working for me? And the system that we have has just absolutely put this barrier up in the patient/physician relationship that medicine has always relied on in the past.

Mr. BARTLETT. You are exactly right. I have often used the illustration you go to the doctor, he writes you 10 prescriptions. And you say, Doctor, do I really need 10 prescriptions? He says, no, Mary, you need four prescriptions, but I need the other six to prevent me from a malpractice suit. And I think that is what you are referring to.

Dr. PENDLETON. Two things. Right now we can't adjust fees. If a person is a member of BlueShield, they can't adjust the fee, and not allowed to pay the patient, and Medicare doesn't allow it, and neither does managed care. But what we need to do is have the patient have the money to pay for those fees, but care enough so they won't have the doctor spending it. I have a friend who has enough money that he self-insures. Not many of us can do that. But he called around several—three MRI radiology departments and said, I am paying cash; what can I get this for? The initial charge was $1,300. He paid 450 for it. Medicare pays even less. If patients began to just call up the doctor, very simple, I have a medical savings account. Now, doctors don't know how to charge cash anymore, they really don't—often, but all the patient has to say is, I have cash, I am paying cash, what are your fees for so and so, and the doctors would very quickly bring the fees down to where they could outdo their competitors, but still manage to pay for the service that they were doing. And the price would seek it so——.

So the thing about medical savings accounts is the patient has first dollar coverage in their bank account, and they can negotiate. It brings cash back into the system, and cash brings on accountability because everybody wants it, and it motivates people, looking at it from the perspective of a cognitive behavior therapist where

we go for rewards and avoid pain. Money is the greatest external reward there is.

So anyway, I totally—there should be this negotiation where the patient can say that is not worth it, or would a CT scan do instead of an MRI, because I am paying for it.

Mr. BARTLETT. You are right. When insurance companies pay for health care, obviously not all the money goes for health care, because you can see the big buildings they build. I note you can tell who is screwing you when you drive into a town, it is the people who have big buildings there, it is the government, the banker and the insurance people.

Dr. THOMAS. We all love cash, but one example from my own experience is I have seen patients who do not have health insurance who are working people, a landscaper who comes in with a large hernia and wants to pay cash for me to repair that hernia and has some of that money to do it, and I am willing to accept that in partial payment and over time, but he has to pay up front the anesthesiologists. He has to pay up front the hospital fee. So we are not in isolation.

So I think what the medical savings accounts can be beneficial to middle-class individuals. Those who have a median income of 23,000, they are not spending anything on health. So, that, I think, is the concern in terms of that being the sole solution to our problems.

Ms. CHONG. I wanted to add to the point in the past 6 years probably about 5 new farmers in our area, and they are just wonderful and hard-working, and they don't have insurance. Even $5, $25 a month, and they will probably take a very long time. But we have a little—it is the respect, not so much about the money, too. Here you have someone who came in here and got the surgery done, and yet they don't pay you. They think you are so rich you don't need the money.

So I am saying is I have found some hard-working folks in our neighborhoods in our county, and we are willing to work with them. They need the surgery, so they continue to work on the farm. I don't have an answer to many of this uninsured situation, yet we work with our patient when they are willing to say, okay, here is $5.

Ms. DONALDA TORO. If I may, I am not proud of this fact, but I spent 10 months working for an insurance company as a consultant manager, so I went through the training. I understand insurance. And I think we have given the insurance companies too much power. They hold the purse strings, and you know it is just to support this giant infrastructure of claims processing.

When I was in your office, you asked me to think about what type of system I thought would work for everyone. I think catastrophic policies. That is what we have in our office. And basically, you can go to any physician. I called the insurance company and I said, I used to sell self-insured plans. So when I was shopping as a practice manager, I said, I want a catastrophic policy. I don't want any of the new-fangled smoking mirror products you have. I want catastrophic care because, you know, that is the only reason I need you, if something serious happens and, say, it costs more than $2,000. And so they said, well, what we can offer you is you

can go to any physician. You can—basically it is a high deductible. We pay $1,500 deductible up front. After that the insurance kicks in, and we pay—they pay 80 percent, we pay 20 percent, and it reduced our insurance premiums by 30 percent.

Mr. BARTLETT. Mr. Chairman, one last observation and question. When I retired, I stayed that way 5 years before I went to Congress, but I wanted to change my insurance to catastrophic insurance. And I tried to buy a policy with a $5,000 deductible. I wouldn't like paying $5,000, but I could pay $5,000. And I wanted them to cover everything after that. Now, for the average American, they don't spend $5,000. The insurance company would have nothing to pay. I couldn't find that insurance. Is it available today, and if it isn't, why not? If you had a $5,000 deductible, you would be a careful shopper. You would want your health care costs to remain as low as possible because you are paying the first 5,000.

Ms. DONALDA TORO. And every American would be self-insuring themselves without paying these huge premiums every month. The problem we have—our patients are hard-working, and they come in and say, I pay a lot of money every month on these premiums, so therefore I am entitled to the best care possible. And I call them and say, well, your insurance company didn't pay, and they say, that is between you and the insurance company. And I say, you understand I have no leverage with your insurance company. You contracted with them to pay your bills. You are going to have to help me out with this, otherwise you have to pay the bill yourself.

Mr. SCANDLEN. I spent a little bit longer in the insurance industry than that. I spent 12 years in the BlueCross/BlueShield system, and I am not unproud of it, but one of the problems is that it is not just Federal. The States get involved also, and $5,000 deductibles are available in most of the country.

Unfortunately in a State like Maryland it is virtually impossible to get a medical savings account for small employers. You can in the individual market, but the Health Care Access Commission has added so many bells and whistles to the medical savings account program that an already too complicated program is indecipherable in Maryland, so small employers simply cannot get it here. And that is a real problem also. This State has got to start moving in this direction, too.

Ms. DONALDA TORO. Speaking for self-insured plans, I understand it isn't available for corporations like that, but I am saying the individual could self-insure themselves. Their employer would just purchase catastrophic health care, basically very high deductibles, and then they could put more money in their employee's pocket. Okay, if you need this $1,500 to pay this high deductible, you are bringing our premiums down by 30 percent.

Mr. BARTLETT. Why should the employer be involved at all? Why don't they put the money and put something in our paycheck and we pay for it and get 100 percent reduction for the premium like they do?

Ms. DONALDA TORO. Yes. Also when a husband and wife both have insurance and have different employers, the important thing is not have the other insurance company as the secondary. Cancel that. Ask your employer to give you $4,000 or $5,000. That is what it is equal to in lieu of having insurance at all.

Mr. BARTLETT. Thank you, Mr. Chairman.

Chairman MANZULLO. Thank you.

We have to wind up. I just wanted to make a comment. You talk about the only major medical, and people were expected to take care of day-to-day visits, et cetera, but do you know who expanded it to make it cover the day-to-day? It is the physicians, because they would go not only to Washington, but mostly State capitals to make sure every primary care physician was there, every OB/GYN, every pediatrician. Everybody said, well, something called preventive medicine, and if insurance covers the cost up front, then it is a lot cheaper at the end of it. And it is because of the State legislators—Illinois for years has had in vitro fertilization covered as a mandate, and one-third of the policies written in the State of Illinois are covered by State law. The rest are under ERISA plans.

But it comes full circle, because I have seen it with the doctors coming to us lobbying that they want this included in Medicare. And you won't believe what happened to the Senate bill. That thing got loaded up; people from your own organizations that want more and more reimbursement, not just moderate reimbursement, but more and more coverage. And you reach a certain point where there are only a certain amount of dollars, and what point do you spread those few dollars that are there to take care of the people in this country?

Dr. PENDLETON. That is what we have now is prepayment. It is not insurance. And high-deductible insurance is a lot cheaper, the idea of putting that same money into an account. Or the person could do it in a savings account, but it is not tax deductible, but we need high-deductible insurance. The Congress, the House lowered the deductible. The savings is in the higher deductible.

And you are right. Every law—every group goes to get their coverage, and all those mandates increase the cost of insurance very seriously.

Chairman MANZULLO. We could sit here for the longest period of time and not resolve the issues, but I find this panel extremely interesting and extremely talented. This gentleman is an attorney down here, and attorneys sitting next to physicians is interesting. There are a couple back home. He is a trial attorney that does plaintiffs' cases for medical malpractice. His wife is an OB/GYN. And we had some very interesting discussions. But what is significant about this couple is they were just getting hammered on their health and accident insurance because they are both sole practitioners, so he set up MSEs because no one else was offering them. That product is still unknown. I don't care. We liberalize the laws on them, and he said, Don, I cannot believe. His premiums got cut in half. He pays 50 percent less in premiums with the MSE. That is just for him and his wife and two children.

And so what he did, he developed a product, and he sells it. It doesn't cost that much to set up, maybe a couple hundred bucks, but here is a product out there that is working. Very few people know about it. There are still a few insurance people that are selling the product out there. So it is something—got to get word out, and the word is we have to get back to Washington.

Thank you so much for your testimony.

Roscoe, I can't tell you how much I appreciated this. The extent of the local talent and knowledge, you are really blessed to be in a wonderful congressional district, and those of you who are represented by Roscoe are lucky to have him.

Did you have a concluding remark?

Mrs. CHRISTENSEN. I also wanted to thank Congressman Bartlett for the hearing, and we still have a lot of work to do, and all of the issues we heard today are extremely important. They are not only important to the providers of health care, but to the patients we serve, and that makes it—them important to the entire country. So I look forward to continuing maybe having some more hearings like this.

Chairman MANZULLO. Let us go down to the Virgin Islands in January.

[Whereupon, at 4 p.m., the committee was adjourned.]

Good Afternoon and welcome to Small Business Committee field hearing in Frederick, Maryland. We will be looking at the issue of Doctors as Small Businesses.

We are in the midst of a healthcare crisis as doctors are fleeing medicine because they spend less and less time with their patients and more time dealing with government regulations, excessive paperwork, inadequate reimbursement rates and escalating malpractice insurance.

It's little wonder that when doctors are forced to deal with all of these complications that they feel they have too little time for their patients and their craft.

Surveys have shown that doctors are doing over an hour of Medicare paperwork for every one to four hours that they spend with their patients.

Insurance companies require more and more paperwork from doctor's offices before reimbursing them.

Add to that, Medicare reimbursement rates frequently do not cover the cost of medical procedures.

Rising malpractice premiums have not only driven up the cost of healthcare, but are driving doctors from their practice.

Doctors across the country have actually gone on strike to protest malpractice premiums that are rising exponentially.

Last year I held a field hearing in my home state of Illinois to hear from doctors about problems were encountering.

An OB-GYN testified to the state of her practice with her three colleagues. She explained that after paying malpractice insurance, she and another physician made $50,000. A third doctor made $60,000 and the last doctor made $70,000. Their office manager made more than all of them: $75,000.

Before becoming a doctor, she was a pharmacist. She was perusing pharmaceutical jobs because she could make over $100,000 being a pharmacist and didn't have to worry about malpractice insurance or being sued.

We are facing a nationwide crisis in medicine because physicians do not believe they are able to provide the level of care their patients deserve.

I look forward to hearing from all of the witnesses before us. I now turn to my colleague and friend, Roscoe Bartlett for his opening statement.

Congressman Roscoe G. Bartlett
Opening Statement
U.S. House of Representatives
Committee on Small Business
Hearing
July 14, 2003
Winchester Hall
Frederick, Maryland
Doctors as Small Business Owners
How Does the Federal Government Help or Hurt?

Frederick is my hometown in addition to being part of the Sixth District of Maryland. I am very pleased to welcome my colleagues to Frederick, Maryland. Congressman Don Manzullo from Illinois is the Chairman of the House Small Business Committee. Congresswoman Donna Christensen is from the Virgin Islands. Small business owners have no more vigorous champion in the Congress than Congressman Manzullo. Congresswoman Christensen is also a physician in addition to her conscientious work as an advocate for small business owners on the House Small Business Committee.

We are here today as representatives of the Congress to examine the role of doctors as small business owners and learn whether the federal government helps or hurts them.

The first panel of witnesses features doctors and private practice managers from the local region who will share their personal experiences as they work to take care of sick people and provide a living for themselves and their families.

No one ever wants to be sick. However, illness and accidents are part of life. As we sit in this room, there is a growing epidemic spreading across America. I am not talking about SARS or any other contagious disease. We all hope that if and when we become sick, there will be a skilled, trained and compassionate person to take care of us. When it is beyond the capability of ourselves or a family member, we turn to doctors. A web of federal regulations, reimbursement cost-shifting, and malpractice lawsuits are combining to make it more difficult for doctors in the United States to do what they want to do and what we expect them to do – to take care of us when we are sick.

There are two big lies that are contributing to a growing national shortage in private practice physicians in the United States.

The first big lie is "the check is in the mail." When was the last time any of us went to a doctor and paid them for their work? Many of us with insurance or an HMO are required to pay between five and thirty dollars that is a co-payment or partial payment. What happens to the rest of the cost? I wonder. Months later, I will receive one of those notices from my insurance carrier marked, "Explanation of Benefits – this is NOT a bill." These complex documents usually list an amount billed by the doctor. Another line will have the "allowable" amount. What is that? It is always significantly lower than the billed amount. Then there might be a line for the copay I remember giving the doctor at the appointment. Sometimes, there's a line labeled "disallowed" on the form with an impenetrable footnote. "Amount of deductible satisfied." Finally, at the bottom, there might be a line: "patient's responsibility." Occasionally, I do receive a bill from a doctor that I promptly pay. None of this paperwork makes any sense to me as a patient or a Member of Congress. What does it mean to the doctors who care for me?

We will learn today that in addition to the receptionist who greets us and the nurse we see in examining rooms, doctors must employ practice managers and accountants and other assistants. We do not see these people and they don't provide any health care to patients. However, private practice doctors would not be in business without them. These employees of solo and small group medical practices spend all of their time fighting with third-party payers to reimburse the doctors. These third party payers are Medicare and Medicaid in the public sector or government. In the private sector, it is insurance companies or HMOs that are the third-party payers. Whether private or public, these gigantic bureaucracies operate to achieve one purpose, to deny or delay paying doctors for the work they do caring for me. None of this makes sense to me. Does it make sense to doctors? We'll listen to their experiences today.

There's a second big lie. That is "I'm from the federal government and I'm here to help you." The federal government is supposed to improve old people's health care through Medicare and provide health care to poor people through Medicaid. There are now thousands of pages of federal

regulations under Medicare and Medicaid. Do these federal government regulations help or hurt the ability of doctors to treat our old and our poor when they are sick?

To quote from a popular book title, American society and culture used to accept the fact that "bad things happen to good people." This acceptance has been replaced with the expectation that if something bad happens, it must because someone made a mistake. Now, there's the unreasonable expectation that a doctor can and must save or improve our lives – and if that doesn't happen, it's because the doctor made a mistake. And if the doctor made a mistake, then they owe us for this failure.

This is how one doctor in Frederick described what he faces every day in an email to me:

"I have grown weary of feeling every patient I see is a potential lawsuit. I work very hard. I try very hard to do my best. I am always concerned for the well being of my patients. I don't know of any other profession that is exposed to the liability physicians have. I feel that I am caught between the proverbial

rock and a hard place- patients whose expectations are absolute answers to their concerns (which are often not possible), but require many tests to evaluate; and economic pressures to control medical costs. Where does it end? As physicians we take the information patients give us and try to make sense of it. But, this does not always work out. It doesn't mean there was a mistake. Sometimes bad things happen, because they happen."

The June 9 issue of Time magazine included a twelve-page feature entitled, "The Doctor Won't See You Now." It noted, "the soaring cost of malpractice insurance…is becoming a worry for everyone, especially patients who see their doctors move away, change specialties or quit medicine altogether." This hearing offers an opportunity to explore the impact of medical malpractice lawsuits and insurance costs on the ability of doctors to care for sick people.

Regulations. Reimbursement. Lawsuits. Up until recently, being a doctor used to be a noble and well-paid profession. Today, the obstacles that a doctor faces should make us all sick. Our second panel of witnesses has the unenviable task of examining the mess that we've got and trying to provide recommendations for improvement.

July 14, 2003

Chairman Manzullo, Congresswoman Christianson, Congressman Bartlett, Members of the Medical Community:

We thank you for your time and interest today in listening to our testimonies. Today the entire medical establishment is in crisis. Working as a physician in private practice is nothing short of abuse. As the wife of a physician and working as a Practice Manager, I speak from both a professional and personal perspective. I am responsible for negotiating insurance contracts, billing, posting payments, collections and accounts receivable and human resources. I manage the business as well as the family.

My husband has built a very successful neurology practice with over 4,000 patients. His schedule as well as his Associate are booked two months in advance. Dr. Toro is well respected throughout the community by his peers and his patients. However, from a financial point of view, our business looks sluggish to grim. Commercial insurance companies and Medicare reimburse 20 – 50% of the billed charges (our charges). The RBRVS system (algorithm used to assess value of work in units of medical care such as procedures and interventions) is ignored; therefore, physicians are only paid a small percentage for the work they do. There is not a billing code for consulting with the family of a patient; patient billing; long distance calls; calling in prescriptions; time spent coordinating patient care with other physicians; telephone consults with patients. On an hourly rate, physicians make about as much as a ditch digger.

Commercial insurance companies refuse to pay more than Medicare rates because insurance companies consider Medicare rates the standard. In fact, Aetna pays less than Medicare. Insurance companies take their time in paying the claims, or they deny receiving the claim, or they refuse to pay the claim. Once a claim is denied for payment, I must pull the records and write an appeal for payment. I spend more time writing appeals than doing billing. Once I submit an appeal, it can take 4-6 weeks before I receive a response. I have appeals that have been overturned to be paid by Blue Shield of Maryland that haven't been paid in two years even though I continue to follow up. If the insurance company over-pays a claim they quickly demand payment in full, or the payment will be deducted from another patient. MAMSI has an "incentive program" for their claim processors called HIPS. The insurance company logs into a claim database to create a possible reason to retract payment by matching names of their recently processed claims against the names in the workman's compensation database. They retract payment from providers even if the case was paid/closed months ago by requesting return payment for the listed claim within 30 days because it could possibly be a workman's compensation claim even though they do not know if this is a legitimate claim. If the payment is not returned, they will take this sum of money from another MAMSI patient in cue to be paid to the provider in question. The burden of proof does not fall on the patient or the insurance company. It falls on the physician's shoulders to demonstrate the validity of the medical claim. This requires the doctor's office contacting the patient; his

employee's human resource department; the workman's compensation insurance carrier to verify that, in fact the patient's medical encounter with the office did not originate from a work related event. The provider sends a report to MAMSI which includes a letter from the patient, the employer and the workman's compensation carrier proving that the case had no merit and was dropped so the claim was the responsibility of MAMSI to pay. These strong-arm tactics can cause a disaster in a small office's overhead costs and cash flow. In my experience, not a single claim brought up under the HIPS program turned out to be a justified workman's compensation, and yet created a delay in payment of several months and an expensive and worthless paper trail. Most offices just give up and return the payment because it sometimes takes months to resolve these matters. Private medical practices have no recourse in stopping such dishonest practices because we quite frankly cannot afford to hire the staff necessary in tracing such matters.

I'll never forget a very troublesome exchange that my husband had with a Utilization Review Nurse from MAMSI who kept leaving sticky notes in his patient's chart indicating that a sick and complicated patient (insurance company money loosing case) had to be discharged from the hospital. He complained to one of the staff nurses about the notes and she pointed to the MAMSI Utilization nurse who was present. He asked, "Under what authority do you leave notes in the chart suggesting the patient be managed differently after the primary care doctor and several specialists including myself recommend otherwise." She replied, "I represent MAMSI as a Utilization Review Nurse and I report to MAMSI's Medical Director." Dr. Toro asked, "The same Medical Director who trained as a Thoracic surgeon " Doctor Toro further suggested that he did not believe a Thoracic surgeon sitting in an office elsewhere was qualified to judge the complexity of this neurological case. Dr Toro went to say that he believed the only motivation for MAMSI's interest in this patient related exclusively to the cost of the hospital stay. Her response was, "MAMSI is a wonderful company. Last year we did great and you should consider buying stock." My husband's reply... "Wrong answer."

It takes a great deal of intelligence to become a physician; however; it takes a very different type of intelligence to successfully manage a business. Physicians are not business people. In fact, the psychological make-up of a physician is contrary to that of a business executive. Physicians are more concerned with saving the patient's life, or improving their quality of life. A business executive is more concerned with the survival of the business and receiving payment in full before services are rendered. If a physician had an earned an MBA after medical school, business school would teach them to practice medicine on a volunteer basis and choose a more lucrative business to make their living and re-pay their school loans.

In order for a small practice to survive today, the commercial insurance products must be limited and under no circumstance can a provider accept an HMO, or worker's compensation. These products are sudden death to a practice. A physician with business savvy would not accept commercial insurance, only fee for service. In other words, payment in full would be expected at the time of service. Medicare rates are a pittance and it would make sense to not participate with Medicare, but the physician could accept

the Medicare rate plus 5% and the office would send the claim directly to Medicare for the patient to be reimbursed. However, if a provider does not participate with Medicare he would not be permitted to be on staff at the hospital. Which is really to their advantage because the hospital is where physicians' incur most of the bad debt. A physician in our community uses the business model I described and seems quite happy practicing medicine.

My husband works constantly, but the insurance companies place every possible obstacle in front of us to deny, or diminish payment. It becomes an endurance race between the medical practice and the insurance company. However, insurance companies have a stronger lobbying group, more staff and more tricks up their sleeve to stall or request a refund of payment long after the books have been closed. According to several claims processors from local insurance companies, they are paid annual bonuses based on the number of claims they deny. Also, if they are not able to process their quota of claims on a daily basis, the supervisor says she will not notice if unprocessed claims land in the trash can.

Insurance companies have been given too much power and a large portion of our health care dollars are going to support a giant infrastructure for claims processing. It would seem reasonable for an individual to purchase catastrophic health care coverage which would allow them to visit the physician of their choice. The insurance company pays 80% of the health claims once a $1,500 deductible is met. If more Americans considered higher deductible coverage which is essentially catastrophic coverage, their premiums would drop by 30% and they would also have a better understanding of their insurance. This would also offer significant savings to employers. Catastrophic coverage was quite popular during the 1970's.

Most of our patients (99.8%) are clueless about their insurance coverage. They only understand that their premiums are incredibly expensive. When their insurance company denies payment some patients will say that is between you and the insurance company. I explain to them that I have no leverage since they contracted with the insurance company to pay their claims. We usually suggest that the patient contact their employer and speak with the Director of Human Resources to act on their behalf. In the past, Congressman Bartlett's office has been incredibly helpful in offering to intervene on behalf of the patient if necessary. As soon as the patient signs the form for the Congressman to intervene and I inform the insurance company, the claim is suddenly paid immediately.

How did physicians get stuck with submitting the billing on behalf of the patient? Physicians are set up to lose from the beginning. Billing is very time consuming and expensive, never mind the time, extra staff, postage and telephone follow-up required. Once you have billed the primary insurer and they produce no payment, then you bill the secondary insurer and they produce no payment, the responsibility then becomes the patients'. However, if there is a deductible, the patient may only be in the position to pay $5 a month on a $250 bill which is very difficult for a small practice (we are not a bank). At the beginning of every year, the physician usually doesn't have a decent cash flow

until the end of March, or April. However, we must take out a small business loan to ensure our employees are paid.

Our office gives every patient several courtesy calls when the balance ages to 90 – 120 days. I contacted a patient and learned from his daughter that he had passed away and left no estate. I asked if she was willing to pay the $72 portion that Medicare had left as the patient responsibility since it was 160 days past due. She shouted, "I'm not paying your bill!" I said, "Will you pay the bill out of respect of the physician who went out in the middle of the night to care for your father at the hospital, as well as the following four days that he took care of him?" She said, absolutely not. I think you can survive without my $72. She continued, I gathered from your receptionist that you are Ms. Toro?" I said, "yes." She said, "I can just picture you wearing your mink coat and driving around in your Cadillac." I said, "Unfortunately this is the stereotype that physicians must fight. I certainly do not live the life of the rich and famous. If that were the case, I certainly wouldn't be making collection calls." Please understand that as a small business, we cannot write off bad debt. The doctor basically takes care of the patient for free because they are liable for any patient who comes to the emergency room when they are on call. They receive no payment from the hospital for being on call." The lady said, "Now that I understand the burden that Dr. Toro carries, I am more than happy to pay the $72." We received a check the following week.

The hospital call schedule is another point of contention since this is where physicians pick up 65% of the total practice bad debt. The hospital by-laws require that all physicians on staff split the call schedule to cover for indigent care. Physicians usually spend about 7 days a month (24 hours a day) to care for all patients who come to the emergency room, or need to speak with a physician for what they feel is an emergency. *Physicians receive no payment from the hospital for being on call. In fact, the hospital charges them $250 annual dues for being of staff.* During this time, I do not see my husband for five day stretches. He treats patients in the office as he rushes back and forth to the hospital for emergencies. He returns home at 12:30 to 1:00 AM. He always gets called throughout the night as well. When patients call the answering service and he returns the call, this is at our expense. During my husband's last stint on call with many sleepless nights, on the last day he was paged to the emergency room to see an alcoholic patient who visits who is a frequent patient with pseudo seizures. My husband called the office to say he would be late, but learns that the waiting room is full and the patient's would be complaining when he arrived. From a liability standpoint, my husband must see an alcoholic patient even though his seizures aren't real according to tests that proved his case. This patient currently owes the practice a large sum of money that will never be collected, but yet my husband is liable for this patient's care. Why doesn't the hospital employ a hospitalist to treat these patients since they certainly are not passing their tax relief on to the physician.

From a personal standpoint, this lifestyle is incredibly abusive for all involved. I really wish my husband had chosen another career. In fact, our electrician earns three times more than my husband and has an excellent quality of life without the liability and overhead. The medical profession no longer receives the respect it once did since the

insurance companies became so involved in practicing medicine. As a pharmaceutical representative I earned much more than my husband earned as a physician. Being married to a physician and managing his practice has been a rude awakening and has totally erased all the warm fuzzy feelings of knowing that your husband is helping others to the best of his ability at the expense of his quality of life and spending time with his family.

I was shocked when our CPA dropped the bomb that we could not write off the bad debt that our practice had incurred during the first year in private practice. She informed us that writing off bad debt had been struck from the tax code many years ago. Our practice is laden with bad debt by in large the indigent patients from the hospital emergency room, denied insurance claims based on technicalities, and "dead beat" patients who fraudulently present medical coverage when they know they have been terminated. Neurological patients are usually quite ill and/or unable to work so bills go unpaid or the patient dies.

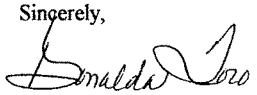
Practicing medicine seems to fit the definition of a ministry rather than a business. I don't know of any other small businesses that can function without payment when the service is rendered. It's hard to picture going to the grocery store with a cart full of groceries and meeting a third party at the check out counter as you observe them negotiating payment of 20 – 50% of what the groceries are worth. Or possibly going to a restaurant and walking out without paying your bill and letting the manager know that you will be happy to send $5 per month until the bill is paid. That being the case, a small business would not survive. Or simply telling the manager, "You have been stiffed again, I have no intention of ever paying "your" bill."

In light of my testimony, Rx coverage for seniors seems like a luxury; especially since the physician writing the prescription isn't earning an honest wage. However, if he writes the wrong prescription and the patient becomes comatose, you can bet that his reputation will be brutally damaged and his livelihood in question and his malpractice insurance will skyrocket to the point that he could never afford to keep the door of his practice open.

Chairman Mazullo, Congresswoman Christianson, and Congressman Bartlett, today I ask you to consider the sacrifices young men and women and their families have made to become physicians to care for the sick and elderly Americans. Our country is known for offering the best medical care in the world. I believe this cause is worth fighting for; otherwise, Americans should not be surprised as they watch the system slowly crumble. Americans have trusted insurance companies to manage their care and pay their bills. We are already seeing a major drop in medical students in the medical schools. The word is out. Just ask any practicing physician if they would choose medicine again? I realize that the system cannot be fixed overnight; however I am asking that small medical practices receive non-profit status as community hospitals receive. After all we are wracked with bad debt and the same indigent patient population. It is time that small medical practices receive some type of retribution for the immense amount of charity work that we are forced to do. *I ask that you will lobby to all people in a position of*

making a difference for small medical practices to operate on a non-profit status. Also, please keep in mind that CareFirst BlueCross and BlueShield of Maryland have a non-profit status. According to an article in the Saturday, May 17, 2003 issue of *The* ***Frederick Post,*** *"The nonprofit health care company reported revenue of $1.8 billion net income in the first quarter of 2003, a 12% increase compared to last year."* At the same time, participants' services and prescription benefits have shrunken while their premiums have risen. The increase in revenue has not resulted in increased physician's reimbursement. I will venture to say that the revenue is going directly in to the pockets of CareFirst BlueCross and BlueShield "high paid" executives and their legions of claim processors. Please help us!

Sincerely,



Donalda Toro
Practice Manager
Spouse of a Physician

July 14, 2003

Chairman Manzullo, Congresswoman Christianson, Congressman Bartlett, Members of the Medical Community:

Thank you for your invitation and for listening to our testimonies.

In preparing this testimony, I initially felt "petty" bringing up my litany of complaints to this distinguished panel. As I reflected further, I realized how universally shared these complaints are with my fellow colleagues. It came to me, that if this feeling of disenchantment with the state of our profession is the rule among practicing physicians, they represent an ominous symptom in the state of our heath care.

I like to use an analogy to encapsulate the concept and responsibilities of being a physician. Akin the Space Program, where the dream, work and lives of thousand of this Nation most talented astronauts, scientist and engineers conceive and deploy their space crafts that take a man to the moon. This nation has created a "giant vessel" representing our health care system. The mission is to care for the heath of its citizens in their journey from conception until death. This vessel is a complex system and requires the expertise of many professions. The main engineers at the controls of this vessel ensuring a safe journey are the physicians. They have trained for years and gone thru rigorous challenges to acquire the skills to carry their mission. They have sworn an oath to execute it with altruism, passion, and dedication. One would expect than in kind, society responds with recognition and respect. In reality, the retribution that society used to confer to their best and brightest for their effort and dedication in terms of quality of life, financial security, societal recognition etc, has been replaced by financial uncertainty, personal and family hardship and constant fear of litigation.

The American Academy of Neurology estimates that mean gross income of a Clinical Neurologist in the year 2000 is $160,000. At first sight it may seem as a healthy "six figure" income. When this number is placed into perspective (increasing work schedules, large patient loads, shrinking reimbursement schedules, after hours work/week end work hours, liability risk, personal/family hardship, bad debt, "charity" work, etc), the reality of today's physicians' financial "package" emerges under a much darker picture. Most physicians work 10-12 hour/days plus frequent weekends and nights. When worked-hours are factored, a Neurologist with 4 years of College, 4 years of Medical School, 4 years of Neurology training and probably 2 years of Fellowship training (12-14 years of training plus years of experience) earns about $50/hour. I was amazed to find out that this about $30 dollars less than my electrician, and $20 dollars less than the Roto Rooter man (Frederick, MD. rates).

The state of our profession can be gauged at the yearly annual meeting of our respective medical societies. These meetings are usually the vehicle of dissemination of updated knowledge in our field and used by hundreds of thousands of physicians to obtain continued medical education. For the last five years, a new breed of "continued medical

education" has surfaced reflecting the nature of our plight. The likely topics include: "Surviving a Medicare Audit", "Coping with Litigation", "10 most frequent HIPPA pitfalls" "Getting paid: Collections and Insurance," "The Secondary Payer," "Negotiating Managed Care Contracts," "Physicians Pricing Guide," "How to Value a Medical Practice," "RBRVS:Resource Based Relative Value Scale."etc. The most likely expenditure of a physician practice in the last five years is the hiring of a billing specialist rather than a contribution to a retirement plan, a pay increase or a needed and most deserved family vacation.

Physicians are hostages to society at large. Society has the perception that health care is an entitlement. The *fee for service* concept has disappeared, in turn; an abstract giant has emerged between patients and physicians whose sole purpose is to turn a handsome profit for themselves and their stock holders. These abstract giants promise consumers the best possible medical care with all sorts of smoke and mirrors when they are not actually delivering care and in return, under the pretense of cost containment, they pay the physician as a factory worker to care for patients and assume all the medical risk.

Reduction on physician's reimbursement is the least likely place to impact on the sky rocketing cost of health care. A demoralized, underpaid, over worked, unmotivated physician fearing litigation is much more likely to practice "defensive medicine" over utilizing expensive unnecessary medical services, as compared to physician assured that his work is remunerated commensurate to his skill and effort. As it should be, the paramount force driving medical decisions should return solely the patient's well being.

Being a physician is in my blood. I am a third generation Medical Doctor. As things are currently, I am saddened to say, that when my three-year-old son plays doctor with a Fisher Price doctor bag or my stethoscope, I feel a knot in my stomach as I shudder at the thought that he will choose medicine as his future career.

Camilo Toro, M.D.

Stanley Chung, M.D., PA 187 Thomas Johnson Dr., Frederick, MD 21702

My name is Elizabeth Chung. I am the Practice Administrator for my husband's orthopedic office. Stanley Chung, M.D., PA.

This is his second career after being a corporate engineer for 8 years. He wanted to be a good country doctor and removed from politics of a corporate world. He is a superb orthopedic doctor, but he was dead wrong about running away from the corporate politics.

First and foremost, we were not well prepared to be a small business owner a year after he started to practice. We were overwhelmed by the complexity of the business. Our typical small practice consists of the doctor, one or two clerical staff and a clinical assistant. Therefore, we found ourselves spending more and more time to fight with the industry that ultimately affect the most important reason for his career change, i.e.: take care of our patients.

I am grateful for this committee to hear our concern and hopefully to provide some relief for us. Here are five major issues that confronted our practice.

ISSUE #1: Call Schedule

Dr. Chung has about ten to eleven call days a month of which 50% or more are for the emergency room (ER) in the Frederick Memorial Hospital (FMH). This means that he treats about 20 % of the orthopedic patients who access the FMH's ER Department each month.

ISSUE #2: Uncompensated Care

There are three major types of uncompensated care patients, many of whom results from the ER calls.

a. The uninsured and indigent patients.

We have seen more and more uninsured or indigent patients who were first seen in the ER. When they called our office, we would give them an appointment within 24 - 48 hours even though we are not required to see them. Dr. Chung often times treated them until they can be released. Not only we see uninsured Frederick County residents through our ER, we have seen patients from West Virginia, Northern Virginia, Pennsylvania, and recently one from Phoenix, Arizona. This last patient is passing through Frederick in June, fractured her ankle. She opted not to have surgery even though it was medically necessary. She went on to Baltimore but was turned down by University of Maryland and the John Hopkins University Hospital. She retuned to Dr. Chung who provided surgery for her three weeks ago. In her case, we probably won't see much of the payment.

b. The automobile accidents and personal liability patients.

Often times, not always, there was third party insurance and the patient might have Personal Injury Protection (PIP) Plan. However, it is the patient's discretion to use PIP for lost wages and opt pay for their medical expenses. It would be fine if patients have health insurance as back up. If not, it is most likely not compensated. But the most ridiculous scenario is when the patients received settlement and took them as personal gain. Then they file for bankruptcy. We have had a few of these patients. Meanwhile, it cost us a great deal for their legal request and claim process.

c. Worker Compensation patients.

Sometimes, the company disputed the cause of injury and refused to pay. There were situations where workers were contracted laborers and the company felt they should not be responsible. And there were undocumented aliens helping companies such as landscaping, construction, and carpeting or mattress manufacturers. They were hurt on the job site. We treated them in the ER and never see them again.

We literally absorbed thousands and tens of thousands dollars of losses. In our current year, as of June 30, 2003, $28,570.17 were account receivable due patients and of which a significant amount is due to uncompensated care.

ISSUE #3: Out of pocket expenses

This is by far the most blood shed in our financial portfolio. And it is unique to orthopedic practices. As I just mentioned earlier when Dr. Chung received not a penny for his time and expertise, we would consider this as community services or simply bad luck. The story did not end here. What happen to those who came back for follow-up care? We must incur expenses such as casting materials, x-rays, sling, walker boots, crutches, knee immobilizes, etc., etc. In addition, we still have to pay for staff, x-ray technician, and utilities... And you can see, it took money out of our pocket to care for those who couldn't even pay a penny for Dr. Chung's professional training and time. Unlike other family physicians or non surgical specialists, we were bled twice.

ISSUE #4: Administrative nightmare with government or non-government system

It would probably take days if not months to illustrate the injustice of our medical reimbursement system. The first thing I learned in our business is to do medical billing. It is also the first thing that I discovered that insurance companies are very reluctant to pay claims, properly and timely. Here are just a few examples of their denial or rejection for our claims:

a. Claims did not have proper referral when in fact they were either mailed or fax.
b. Claims were not filed timely when in fact they were using the second submission instead of the initial submission.
c. Claims were denied because of unqualified staff who could not understand why the doctor did what was considered medically necessary.
d. Claims were kept for endless loop of review upon review, and in the meantime, they could lose a report, change reviewers, or simply forget where or who had the claim last.
e. Claims were bundled or packaged. This means that multiples procedures were packaged together to be paid as one or to be discounted for the 2nd or 3rd procedures. This is an indirect way of reducing payments. If a physician is shrewd, he could have brought the patients back to the operating table two or three more times especially it is not a life-threatening situation. Yet, they penalized doctors who are efficient and conscientious.
f. Coding is the infamous tug of war. Despite of coding guidelines, there is so much games insurance company use in order not to pay for services rendered. We use modifiers to distinctly separate different procedures and expect 100% on both procedures. The result is that the claim came back discounted. Fee schedules connect a given CPT code with a set of dollars amount "in isolation". They give no regard to other CPT codes and data that are in the claim.
g. Claims are rejected because of idiosyncratic rules. Insurance companies may review a claim and insisted that it is work related or pre-existing condition and request a refund. On a personal front, our son broke his leg in 1999. Dr. Chung treated him with cast after taking x-ray in the office. 4 ½ years later, we just received a letter asking for refund. Recently, our son also got hurt in a park on a Saturday; he was operated in our office so that a 1 1/4 inch splinter could be removed. Again, we were asked to refund the insurance because family is excluded. We found this absolutely ridiculous. Would they rather incur higher cost for us to take him to the emergency room? Who would be the best to treat our son in such an emergency situation?

The overarching nightmare for these is the administrative headache and cost to the practices. In order to manage a practice in the 21st Century, it requires careful analysis of good data. That means update software and trained personnel who can use the information. We also have to upgrade our equipment to meet technological advance, often driven by carrier for referrals, treatment plan and operative report. It cost more when we raised our standard to be HIPPA compliance. Coding and billing continues to get more expensive, demanding more personnel, more responses to audits from Medicare and commercial carriers, more dictation and record keeping to justify fills and more payment reduction and denials. The average A/R rate for worker compensation claim is 9 months. We still have to fight for some that are over a year old. Some insurance companies use 800 number and said that "we value your call", but no one ever returns our call. So when we have particular difficulty in dealing with certain unpaid claim over 120 days, we would write them off. This added to our burden of uncompensated care.

ISSUES #5: Contracts, pricing, and rate reduction

Contract negotiation – the 1000-pounds gorillas. Unless we are savvy contract negotiator, or we can afford expensive legal assistance, we are very intimidated by the insurance industry. In the past six years, we have not renewed any of our contracts because it was overwhelming. Recently, I made an inquiry to a carrier who

dominates our local area. The response was that they would reimburse us at 90% Medicare rate for their HMO products for one year and 95% for the subsequent year. This is totally unacceptable because there will be lower and lower reimbursement rate from Medicare as years to come. Furthermore, there is silent "PPO" where third party administrator is involved. Sometimes, rate may be further adjusted according to their formulas. Pricing complexity is very intimidating and we need disclosure to supply complete information on their pricing.

For Medicare, we are very much burdened by its cut this year despite of government's own admission. According to the Centers for Medicare and Medicaid's (CMS) Statistic blue Book 2002, "In real or inflation-adjusted terms, Medicare pay is 6 percent lower in 2001 than it was in 1991."

The elderly population is growing. According to CMS, in 1998, there were 34.9 million Americans aged 65 and older, by 2025, there will be 60.5 million. Life expectancy in 2020 is projected to be 81.6 years for men and 84.8 for women. In many part of the country, primary care physicians are no longer accepting new Medicare patients. Last year, nearly 30 % of family physicians were not taking Medicare patients and physicians with a Medicare provider number declined by 3.5 percent, according to former Rep Greg Ganske (R-Iowa). According to the Washington D.C. based Center for Studying Health System Change (HSC), seniors in practically every state may soon confront serious difficulty in finding physicians.

Medicare population is a significant group of clients in orthopedics. In our practices, they comprised of 18 % of our total patients and they are about 25% of our ER patients. In Frederick area, it is a fact that many of the primary care physicians are no longer taking new patients; this would include new Medicare patients. We can project that we will see more seniors using ER services for acute conditions.

It is a nightmare to run a small medical practice. Not to mention about legal exposure, there are absolute administrative bureaucratic hassles. On the revenue side, there are Medicare reimbursement cuts and commercial reduction linked to this cut. On the cost side, there are malpractice hike to about 26% for 2004. We are seriously looking for more affordable health insurance that would not exclude family members At the end of the day, we ask our self: "if this is worthwhile or not".

It is vital to our mission to be able to take care of as many members of our community as we can. It is not by choice but survival that we may rethink how to meet their needs. We may determine whether to continue participation and accept assignment, which means we will continue to get 5% below the participating physician fee schedule for the service render. Or we may choose not to participate and pick and choose whether or not accept assignment. Finally, we may limit our Medicare patients.

In conclusion, I consider us as a vital force of the US economy. We provided pension, childcare, health insurance, fitness program, education reimbursement, as well as work at home technology for our employees. We are not any less important to the Saving and Loan Bank, Airline companies and alike.

Hospitals usually get tax relief for caring the indigents. Airline companies also got bailed out by the federal government in recent years. It is time for policy makers to rethink the well being of small medical practices. This brings back what I started off; I would like my husband and many good physicians in private practice, to continue their medical practice with compassion and gratification. But I would like to see their effort and personal sacrifices are worthwhile. We felt that we should also help the community or those who are truly in need. My final words are: "Beware; good doctors will not be around to care about the elderly and needy if nothing changes". However, this is your grandmother, grandfather, older aunt and uncle or even yourself. We're talking about Tom Brokaw's greatest generation. We owe them something. As small business entities, we need your help to make it possible.

I have also included two letters from our staff for your consideration.

Thank you.

DOCTORS AS SMALL BUSINESS OWNERS

TESTIMONY BEFORE U.S. HOUSE OF REPRESENTATIVES

SMALL BUSINESS COMMITTEE

TESTIMONY OF

MICHELLE D. THOMAS, M.D.

NATIONAL MEDICAL ASSOCIATION (NMA)

The NMA promotes the collective interests of physicians and patients of African descent. We carry out this mission by serving as the collective voice of physicians of African descent and a leading force for parity in medicine, elimination of health disparities and promotion of optimal health.

Historical Manifesto
"Conceived in no spirit of racial exclusiveness, fostering no ethnic antagonism, but born of the exigencies of the American environment, the National Medical Association has for its object the banding together for mutual cooperation and helpfulness, the men and women of African descent who are legally and honorably engaged in the practice of the cognate professions of medicine, surgery, pharmacy and dentistry." ***– C.V. Roman, M.D. NMA Founding Member and First Editor of the JNMA 1908***

Vision Statement
NMA is poised to enter its second hundred years as an ever present force in medical science, medical education, and medical practice and finance, and as an efficient well-run organization that is strong in numbers, fiscally healthy and stable, and technologically prepared to meet the opportunities and challenges this new century will bring.

Mission Statement
The NMA promotes the collective interests of physicians and patients of African descent. We carry out this mission by serving as the collective voice of physicians of African descent and a leading force for parity in medicine, elimination of health disparities and promotion of optimal health.

Positioning Statement
This national professional and scientific organization of physicians is committed to: 1) preventing the diseases, disabilities, and adverse health conditions that disproportionately or differentially impact persons of African descent and underserved populations; 2) supporting efforts that improve the quality and availability of health care to underserved populations; and 3) increasing the representation, preservation and contribution(s) of persons of African descent in medicine. Towards these ends, the National Medical Association provides education programs and opportunities for scholarly exchange, conducts outreach efforts to promote improved public health, and establishes national health policy agenda in support of physicians of African descent and their patients.

(The Mission, Vision and Positioning Statements were adopted by the Board of Trustees on October 16, 1999.)

I would like to thank Chairman Manzullo for the opportunity to participate in this hearing before the House of Representatives Committee on Small Business. Good morning Congressman Bartlett, Congresswoman Christensen and other distinguished members of the committee and all present who are concerned about the future of healthcare in our country.

I have been asked by Dr. L. Natalie Carroll, President of the National Medical Association (NMA) to represent the concerns of her constituents, some 25,000 African American Physicians and the patients they serve. I am the President of Maryland State NMA affiliate organization. I am a Surgeon and Critical Care Medicine Specialist. I hold Board Certification in these two areas of medicine.

Section I Tort Reform

The National Medical Association is committed to quality health care, the elimination of healthcare disparities, and access for all citizens and immigrant communities to health care. We believe that if an individual patient has been injured or victimized by a negligent physician there should be legal redress and compensation. We do believe that Tort Reform is necessary to preserve the economic viability of physician practice.

I have over the past twelve years worked in hospitals and communities throughout Maryland, including Cumberland, Hagerstown, Carroll County, Baltimore County, Baltimore City, Prince George's County, Montgomery County, Anne Arundel County, as well as the District of Columbia.

I am in contact with physicians in urban, suburban, and rural areas of Maryland and the national crisis in medical liability is taking its toll on health care providers, both professionally and personally. There is no high risk obstetrical care on the Eastern Shore of Maryland due to high cost of malpractice insurance. In 1995 there were fourteen companies underwriting medical malpractice insurance. In Maryland today, there are three companies providing insurance, Medical Mutual Liability Insurance, Society of Maryland (Medical Mutual), covering the majority of physicians. **Attachment**

A is a copy of Maryland's OB/GYN Society Survey on Professional Liability conducted in February 2003 which in brief states if malpractice premiums increase by twenty-five percent (25 percent) – 34 percent of surveyed respondents would stop practicing medicine altogether. The worsening professional liability environment coupled with declining reimbursement for service suggest that the impact on women's and infants health outcomes will be negatively impacted.

Medical Mutual Liability Insurance Society of Maryland on July 2, 2003 has filed with the Maryland Insurance Administration a proposed rate increase of 28 percent. The National Medical Association endorse Tort Reform policy with emphasis on

- Collateral source rule
- Contingency fees for plaintiff's attorney
- Periodic payments
- Non-economic damages
- Statute of limitations
- Qualification of expert witnesses.

Attachment B is a copy of the NMA Health Policy Brief on Medical Liability Reform. We firmly support and believe in all efforts to achieve fewer patient injuries. We recognize that patient safety can be improved and will continue to work toward this goal.

Section II Bureaucracies Impact on Small Medical Practices

"Bureaucracy defined is a system of administrations marked by officialism, red tape and proliferation." (Webster's Dictionary).

Physicians whether they are employed by hospitals, managed care organizations, self-employed in small or large medical practice must traverse non-governmental, federal and state bureaucracies. Medicine is a highly regulated industry, we are licensed, credentialed insured and monitored. The time spent on administrative paperwork is approaching 40 – 50 percent of the work day for small practices.

The Health Insurance Portability and Accountability Act (HIPAA) does feel like an 8,000 lb hippopotamus. There has been a deluge of HIPAA compliance information, services, compliance products which has added another expense item to the cost of medical practice. In the long term the value of HIPAA, I believe is in the standardization of electronic transmission of health information and portability of health insurance when people change jobs. I have already broken two shredders in attempting to maintain patient privacy and integrity of medical records. The specter of penalties of large fines and imprisonment for violation has small practices and minority physicians concerned that they will be unfairly targeted.

The Health and Human Services Order 13166 requiring healthcare providers to offer translating service to non-English speaking patients is unaffordable for small medical practices. The small medical practice have additional frustrations with government, private health care insurers, managed care corporations in obtaining authorization to treat and reimbursement for services.

Example 1. I accept Medicaid patients but if a patient is in a Medicaid HMO I cannot see the patient.

Example 2. I have treated a patient for thyroid cancer by performing surgery, I must obtain preauthorization for treatment and complete a treatment plan which the primary care doctor must sign and date. Payment was denied because the primary care doctor signed but failed to date her approval of my treatment plan.

Section III. Profitability or Solvency of Small Medical Practice

The value of health, i.e. being of sound mind, body and spirit, free of disease is dear to us all. The art and science of medicine once was a noble profession. Today many struggle to sustain their medical practice. Personally, I can say my small surgical private practice is not profitable and barely solvent. Antitrust regulations prohibit me from joining other small practice groups to negotiate fees from third party payors. It is

difficult to obtain fee information, profiles, relative values or conversion facts from most non-governmental health insurance companies or third party payors. Professional medical associations are prevented by Federal Antitrust Legislation from disclosing the results of fee survey. My initial fee schedule for medical services was established in 1993 based upon a geographic adjustment factor (GAF) for Hagerstown, Maryland of 0.910 now that this practice is in Prince George's County, a suburb of Washington, DC my fees were adjusted to a GAF of 1.042.

Today, my reimbursement is 30 percent of my fee schedule set in Hagerstown. I and the majority of the NMA physicians constituency accept Medicare, Medicaid patients in addition to a larger proportion of uninsured patients. The healthcare disparities that exist in this country and the general health of our nation will worsen if small medical practices are not profitable.

Attachment C-1	**Historical Log Report – Charges Only**
Attachment C-2	**Historical Log Report – Payments Only**
Attachment D	**Aging Analysis Report**

Section IV The Impact of the Uninsured on Small Medical Practice

There are forty-one million uninsured individuals in the United States. Not all uninsured are poor, however, the majority of uninsured are of modest to low income especially those from African American, Hispanic and minority communities. According to the latest figures released by the U.S. Census Bureau over half of all uninsured are Asian, African American or Hispanic. More than 6.5 percent of Hispanic and African Americans report having unmet medical needs compared to 5.6 percent of Caucasian Americans.[1] The Department of Health and Human Services report that communities of color experience serious disparities in healthcare access and outcome in six areas: stroke, heart disease, diabetes, infant mortality, cancer and HIV/AIDS. Insurance

[1] Ji Lee Hargrove "Health Services Research" Vol. 38, No. 3, June 2003

coverage, income, and available safety net services are contributors to healthcare disparities.

A small medical practice cost shift when they provide uncompensated care. Charitable care becomes more burdensome for physicians as third party reimbursement rates remain low and practice expenses increase. Prevention services are cost saving for both children and adults. Expanding insurance would do more to improve access for the uninsured across all communities. For the small or large medical practice, hospital or clinic, "something is better than nothing." The fundamental truth about the healthcare industry is that it is difficult to profit on delivery of healthcare to people who are ill.

Attachment E JAMA Sept. 9, 1998 Vol. 280, No. 10 921-927.

Testimony of
James L. Pendleton, M.D.
Emeritus, Psychiatric Staff
Abington Memorial Hospital
And
Member, Board of Directors
The Association of American Physicians and Surgeons

To Hearings
"Doctors as Small Business"

Of the
Committee on Small Business
United States House of Representatives

Frederick, Maryland
July 14, 2003

Committee on Small Business
Testimony; J. L. Pendleton, M.D.
July 11, 2003

Certainly we appreciate the invitation the Association of American Physicians and Surgeons to offer the perspective of our counsel, Andrew Schlafly and myself to this committee. I am a member of the Board of Directors of AAPS. But more than that I appreciate very much the work you are doing to gather information to best serve the patients of the country.

My name is James L. Pendleton. I am a member of the Board of Directors of the Association of American Physicians and Surgeons, founded in 1943 for the purpose of maintaining the practice of private medicine as the best way to serve patients. I am an emeritus member of the psychiatric staff of Abington Memorial Hospital in Pennsylvania, which was selected as one of five hospitals for a site-visit for receiving the American Hospital Association's Quest for Quality Prize honoring leadership and innovation in patient care quality, safety and commitment. Competition for the prize is made known to all 5,000 hospitals in the country. The winner has not yet been announced. I practiced solo in adult, general psychiatry for 31 years and received the hospital's physician of the year award from among an attending staff of 650 physicians. I also majored in political science in college writing a senior paper on the British National Health Service, took courses in philosophy, religion, economics, as well won a prize on graduation from the School of Medicine of the University of Pennsylvania for the best clinical paper in the senior year. I co-authored only one article. I say all this to indicate that my background and interests are in quality and economic efficiency in clinical work. I have worked since leaving government medicine as a flight surgeon in the US Air Force to warn of the exacerbation of the problems you are exploring and retired six years ago to better address them. I am not an academic.

In 1965, the year legislation creating Medicare and Medicaid passed, health care cost 5.9 % of the gross national product. The poor saw physicians slightly less often and were hospitalized slightly more days than the middle class and the wealthy. Blue collar families could pay for appendectomies, hysterectomies, deliveries and most other surgery. The Kerr Mills Act had been passed in 1960 to pay for the elderly poor. Reportedly the average doctor contributed about 20 % of his time to caring for people who could pay nothing or part of the full fee. My fellow medical residents from other countries in training at Pennsylvania Hospital couldn't believe how hard American physicians and house staff worked. The doctor-patient relationship and patient privacy were considered sacred. Was medical care perfect? Of course not. But the care was accepted as the best in the world and the people of the United States were considered well served. However, a means test was said by some to be too humiliating for the poor to be accepted. The meaningless mantra was heard that we should have a government system because the countries of Europe, which relatively unfettered development was likely the reason our system was considered superior. (SLIDE) Section 1801 of Public law 89-97, passed on July 30,1965 to establish

Medicare and Medicaid, stated, and proponents promised, that the government would exercise no "supervision or control over the practice of medicine, compensation of any person, or administration or operation of any institution." (BLANK)Medicare was predicted to cost $9 billion when established and $12 billion by 1990.

In 2003 we are witnessing extensive attacks on the medical field. Doctors have remained relatively passive and accepting of the changes until rising overhead met long-standing price controls and is beginning to close offices. Maybe doctors may have been passive until now because of their training to accept to stress and hard work, or perhaps they are adjusting to life with bureaucratic restrictions. Southeastern Pennsylvania is one of the hardest hit areas in the country for loss of doctors. I experienced that personally over a year ago after a bicycle accident in Bucks County, Pennsylvania, in which I suffered lacerations and fractures of the face and neck I was admitted to a hospital in Trenton, New Jersey, because the St. Mary Hospital's trauma unit was closed because of no neurosurgical coverage for the weekend. If there had been bleeding into the brain, the considerably longer trip might have resulted in death or severe neurological disability.

Very few new doctors are coming into Pennsylvania and many practices are closed to new doctors, both because of the cost of medical liability insurance. Physicians are nationally are retiring early, discontinuing services, even subsidizing their practices for a while. Those of us working on tort reform in Pennsylvania see present political track will delay resolution for years, if then. The counselor AAPS is developing strategies that may give doctors the political answer in a year or so.

Authors report more than 110,000 pages of Medicare regulations and 17,000 IRS regulations. I don't know what is accurate, but I do know that no doctor can know them although he can be prosecuted because he "knew or should have known." Bureaucrats have a saying, "If it isn't documented, it didn't happen." The truth is that "If it's all documented, there wasn't time for much of anything to happen." One author tallied the things government said must be done for patients to receive good care in a day. The time estimated to be required amounted to 7 ½ hours in a day. Conferences on complying with regulations and surviving economically in practice are taking the greater percentage of time that should be going to keeping up professionally.

The number of applicants to medical has been steadily and significantly decreasing for several years. As one college counselor said, "The best students are no longer going into medicine."

Counsel for AAPS, Andrew Schlafly, Esq., has submitted written testimony that I am submitting with mine. I don't have time to cover either fully. Mr. Schlafly's presentation of just a few of the cases of abusive prosecution of physicians makes interesting and important reading. He also gives a legal perspective on malpractice

claims, CPT code revisions and forced electronic billing. He presents how much more difficult it is for the solo or small partnership group to survive the assaults. Interestingly, although economies of scale seems always to mean bigness, a study in the early 1970's by the Department of HEW (now HHS) found that for the same services the solo or two-partner practice cost essentially half what the large group practice or federal clinic cost.

What happened between 1965 and 2003? Planners said repeated and repeated that the doctor, not the patient was the consumer and that the market couldn't work in medical care because of insurance. They said the patient could not make the complex decisions required in medical care or be responsible for balancing quality and cost. Although none of that was true, patient money was almost entirely removed by low dollar and complete coverage of costs by Medicare, Medicaid and a large proportion of private insurance. Doctors' charges and insurance patients were unknown to patients until after the fact. As a result, cost began to escalate markedly, because patients whose money is involved can judge and police much better than government or insurance inspectors.

Prices began to escalate seriously. (SLIDE) This graph, plotted by Dr. Edward Hyman from New Orleans, studied the figure used first to "prove" the failure of the private medical system to prevented wild escalation of costs in medicine. His data from 1946 to 1976 show the annual rise in cost per hospital stay to increase from 7.4 % per year to 12.6 % per year. His research also determined that there were no significant technical advances in medicine to explain the change. Using the same concept (SLIDE) I plotted the next statistic to be bruited about, the Bureau of Labor percentage health care "consumed" of the gross national product. The data for the projection of the green line is taken from 1950 (not shown) to 1966. By 1992 the green projection is at 9 % and the actual percentage is at 13 %. A rough calculation showed that the amount of money between those two plots is in the neighborhood $1 trillion, 225 billion. Incidentally, into the 1970s the cost of prescriptions, the present ogre of the cost "crisis," was increasing less per year than the average of the commodities portion of the CPI. A pharmaceutical executive warned that prices would skyrocket because of the time and cost of proving efficacy to the FDA.

(SLIDE) This slide, created by Senator Specter's office, explains part of the reason for the phenomenon. It represents the new and existing entities and programs required in the Clinton Health Plan. All the people represented in those entities have to be paid and make decisions. Fred Goodwin M.D., former director of the NIMH. estimated as simple a thing as a national committee's promulgating standardized treatment takes about five years and is homogenized, erroneous and obsolete. Another reason for cost escalation in a bureaucratic set up is that innovation and effective industry are almost impossible.

The HMO Act of 1973 forced managed care on Americans by requiring any employer providing medical insurance to its employees PSROs, Certificate of Need, mandatory second opinions, nor any other mechanism that I know of have saved money, and they have cost a great deal in time and money. Price controls were instituted in the early

1970s and have essentially been in place again since 1984. They have not worked throughout history and usually result in disappearance of the goods or services, as is happening in medicine.

The RICO regulations have been used on physicians who have no relation to organized crime or drug dealing.

Despite its name, HIPAA does not make insurance portable. It contains such Draconian punishments as up to a year in prison, $10,000 fine or both for a physician convicted of less than $100. Its privacy regulations require the health sector to jump through ridiculous hoops while opening patients' record to federal state and local law enforcement and agencies without a warrant.

Both Democratic and Republican leadership praised MSAs in the early and mid-nineties. Now they have become a partisan football. MSAs demonstrate the reality that government decisions are very often made for political or bureaucratic reasons.

The private-government partnership, or third way, has resulted in government's extending more and more control over medicine to gain its objectives. That is not surprising because that was the economic principle of Fascism that was very highly praised by many prominent intellectuals and politicians in the 1930s.

What should be done? The most important thing that Congress could do is to remove the crippling restrictions from tax-deferred medical savings accounts and make them permanent. We thank the House for doing so this year. Health Reimbursement Arrangements lack the very important condition of patient ownership of the money. Patient money will bring back accountability and balancing of value and cost. Patient choice of doctor will help healing and allow patients to go elsewhere if care is not satisfactory. Government or insurance inspectors and regulations will not accomplish what's needed.

Much government regulation should be removed, but that cannot be done until market factors are controlling the health sector with the patient and his money at the center. The incredible increase in paperwork required by government and managed care for some physicians will only block the conscientious, while the unethical doctors will fake their reports.

Health insurance should be selected and owned by patients and non-cancelable except for failure to pay the premium.

Tort reform with caps is a necessity. It is a state responsibility, but it appears that states like Pennsylvania will not resolve the issue.

Abuse of physicians by prosecutors should be reigned in by Congress.

Committee on Small Business
Testimony; J. L. Pendleton, M.D.
July 11, 2003

The dissatisfaction with managed care and its failure to continue to control costs, American medicine is at a crossroad. We will either take the road that leads to a completely government system or that terminating in a competitive market system. To maintain value for patients and economy the choice must be toward the market.

a. RICO used on physicians (30+% used on non-drug dealers
b. The so-called third way or private public partnership are another name for the economic principle of Mussolini's fascism.
    i. At one point Churchill
    ii. The market is the only truly democratic mechanism we have where people vote on every transaction with their money.
    iii. The crooks get around the regulations and the conscientious jone get choked by them.
    iv. Bureaucracy say "If it isn't documented it didn't happen". If you document everything the doctor doesn't have time to do much of anything.
        1. Someone studied the govt. recommendations for what questions ask and provide good care it would require 7 ½ hours each day.
c. Administrative law takes away important rights of physicians.
d. HIPAA states a physician cannot be put in jail for more than a year or fined, I think now, $10,000 or both if he or she is convicted of Embezzling less than $100.

Individual freedom or civil rights is the greatest social and economic good.
The wealth of country correlates proportionate to the freedom of its citizens.

Retired surgeon, "Incredible increases in paperwork from government and managed care."

OBGYN "85% of insurance claims are for less than $100 and cost an average of 55% to process."

MSAs became a partisan issue, letter, Clinton

Private contract, but 2 yrs. Opt out

Committee on Small Business
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WSJ said New York's Floating Hospital System got 6 times amt for a nurse practitioner.
And a big hosp clinic $160 per visit

$1,225,000,000,000

Certificate of need.

What should be done?

1. Remove the crippling restrictions from medical savings accounts to get patients to discipline
2. MSAs for Medicare and Medicaid
    a. Put patients at center.
        i. Value
        ii. Accountability
3. Allow patients to have their own insurance
4. Give everyone the same tax break.
5. Doctors have been cowed or gone frome cats, to sheep and some are turning to lemmings.
6. Have the FDA judge only safety; doctors will find the efficacy for free.
7.

Statement of

Greg Scandlen
Director
Center for Consumer Driven Health Care
Galen Institute

before the
Committee on Small Business
of the
United States House of Representatives

Field Hearing
On
Independent Physicians as Business Owners

July 14, 2003
Frederick, Maryland

Mr. Chairman and Members of the Committee,

Welcome to Frederick. I'm sure Dr. Bartlett has given you a full briefing on the wonders of our community, but nothing will do it justice until you walk around and visit our antique stores, restaurants, and historical sites. I hope you have brought your credit cards with you.

I am Greg Scandlen, the director of the Center for Consumer Driven Health Care at the Galen Institute. I am here to share my own views on the problems physicians are facing as small business owners and independent practitioners. My views are informed in part by the many hundreds of such physicians I work with every day in trying to create a more sensible health care system in America – one that puts the needs and demands of the patient at the forefront.

Health care is, ultimately, about the patient. Insurance companies, employers, government agencies, drug companies, hospitals, nurses, even physicians, have a role to play only to the extent they adequately serve the patient. How well they do their jobs can be measured only by the patients themselves. Not by their peers, not by bureaucrats, not by academics.

But patients will be able to express their views meaningfully only when they are able to control their own resources, and reward those who serve them well, and punish those who do not. That is the core concept of everything my organization tries to do. That is the fundamental basis for a consumer driven health care system.

I asked a number of independent physicians to name the things that most interfere with their ability to succeed in their business. Virtually all came up with the same four items:

- Inadequate reimbursement,
- Excessive regulations,
- Burdensome administrative requirements, and
- A tort system that is out of control

These factors add to substantially to the cost of providing care, frustrate physicians, and interfere with their relationships with patients.

There are at least two ways to address these issues. I suggest one will have far better and longer lasting effects than the other.

On one hand, Congress could increase physician payment, especially in Medicare and Medicaid, roll back many of the more onerous regulations, and enact a package of tort reforms that will remove the extremes and still protect victimized patients. These would all be worthwhile measures and a job well-done.

But it wouldn't be long before the same old impulses come back to move the pendulum back the other way. The next Congress could begin to cut payments again, re-enact the regulations, and dismantle the tort reforms you worked so hard to enact.

It is a never-ending battle between the regulators and the de-regulators, between generous appropriators and thrifty appropriators, between the plaintiff's bar and the defendants, between insurance companies and drug makers, between nurses and hospitals, between employers and

doctors. Everyone is fighting for a bigger piece of the pie, for more political influence, for less regulation for themselves and more for their competitors.

But where is the patient in this struggle for influence?

Let me suggest an alternative approach -- one that will serve independent physicians by empowering their customers. And one that will create a permanent change in our health care system that will reduce the need for regulation, improve the efficiency of paying for health services, lessen the need to sue for redress, and pay physicians and other health care workers according to their skill and their service to the customer.

This is putting resources in the hands of the consumer, so they can make their own choices, based on their own values and the needs of their own families.

You took a baby step in this direction with the enactment of Medical Savings Accounts in 1996. A much larger step was taken last year when the IRS issued its guidance on Health Reimbursement Arrangements. Allowing the self-employed to deduct 100% of their insurance premiums was another good move. There is a proposal in the current House Medicare bill for Health Savings Accounts that would be another bold step forward. The President's proposal for refundable tax credits would also help.

The private sector is also moving rapidly in this direction. Employers and health plans are putting more control in the hands of individual consumers. This includes control over the type of insurance coverage they choose, control over the way their money is spent, and the information resources needed to make wise decisions. We are entering a period of great innovation and experimentation, all in the name of "consumer driven health care."

Let me put these initiatives in context. Over the years America has come to rely almost entirely on third-party payment for health care services. Today only 15% of total costs are paid directly by consumers, and it keeps dropping every year. This means a third-party -- insurer, employer or government -- is deciding who gets paid, how much, and for what. Third-party payers are making the decisions, but all the money comes from consumers, either through premiums, taxes, or earned compensation on the job. It is all our money, but we control only how fifteen cents on a dollar is spent.

Third parties are not about to write a blank check and pay for every whim a patient or a physician might have. To control their costs, they impose rationing. The rationing may take the form of outright denial of care. But it might also involve excessive administrative burdens, essentially rationing through hassle – "you may perform this service, but only if you jump through all these administrative obstacles and barriers we have created,"

Consumers know they are being deprived of the services they believe they need. Because they don't control the money, they have to find other ways of expressing their wishes. They end up in court or before legislative bodies or regulators to complain about inadequate service, poor payment, lousy care, and excessive paperwork.

In a consumer driven system, consumers would control the funds, and could express their wishes directly, by refusing to pay for inadequate services and paying more for superior care. Using direct payment would be a far more efficient way of paying for services than processing every encounter through an insurance mechanism. Let's look at how would this effect the four areas of concern the physicians have expressed:

Inadequate Reimbursement.
Third-party payers pay all "providers" the same, regardless of their skills, efficiency, or bedside manner. Arrogant, indifferent, distracted physicians are paid at the same rate as caring, involved and focused physicians. The kid just out of medical school gets paid the same as the town's best doctor. Having Congress increase reimbursement rates, means you have to increase everybody's payment, regardless of how good they are. If patients controlled their own funds, they might very well be willing to pay more to get better quality care. The best physicians would prosper, while the mediocre ones would struggle. There would be an incentive to improve, to serve patients better, to listen more carefully.

Excessive Regulations.
Many of the regulations are aimed at correcting problems created by third-party payments. Mandated benefits are one such example. A legislature decides employers or insurers aren't responding to the needs of workers, so it passes a law requiring them to cover some service. If consumers controlled their funds, they wouldn't need to get a law passed. They would simply buy the service they wanted to have. The same is true of physician regulations, which are too numerous to name. If patients control their own funds, they could make their own decisions on whether a physician-owned lab is providing good value. So-called "private contracting" under Medicare would be the norm, not the exception. Patients would decide for themselves whether a particular doctor is worth the extra cost.

Administrative Burden.
Our system of third-party payment adds substantial cost and irritation to the provision of health care services, none of which contributes to the quality or value of the service provided. Most of the available information reports that every working physician requires about five full time staff, at a salary cost of $150,000 or more, primarily to manage the paperwork burden from payers. One insurance regulator informs me that in his experience 45% of claims denials that are appealed are overturned after review. This, too, adds costly burdens and delays in treatment to a physician's office. A system in which patients controlled their own resources would slash these costs. People would pay at the time of service. Billing could be based on the physician's time, not the procedures used. Denials and appeals would be a thing of the past.

Medical Malpractice
The entire tort system needs reforming, of course. But a consumer-driven payment system would reduce the animosity between patient and physician. They would build mutual trust, and patients would be less worried about being given short shrift because the doctor is more concerned about the requirements of the insurer than about the needs of the patient. As quality is rewarded, there would be fewer incidents of negligent behavior by doctors.

This is a system that would be eternally self-correcting. As new technologies and new services come along, patients would be willing to pay for them – or not – depending on their perception of value. It would inspire a greater pursuit of clinical skills by physicians because they would be rewarded financially for their better service. It would spawn a new era of lower costs facilities and therapies. If patients are paying directly, they will be more inclined to look for generic or over-the-counter substitutes, more likely to go to a neighborhood clinic than the ER department of the giant Medical Center, more accepting of seeing a nurse practitioner for common ailments.

But they wouldn't be forced into doing any of that. They would make their own judgments based on their own needs and values.

Physicians would be happier in their practices. They would be more independent, they would have the opportunity to improve their incomes, and they would have far less overhead expenses as the administrative burden lessened and malpractice premiums were reduced.

Already we are seeing a substantial movement in this direction from America's physicians. More are refusing to participate in Medicare and managed care, preferring to see only cash-paying patients who appreciate their services. We see this in organized efforts such a SimpleCare, but also in completely individualized decisions. Other physicians are starting "boutique" practices which promise enhanced, personalized services for a retainer.

Unfortunately, too many of our best physicians are retiring early or changing careers because they resent the frustration of our current system. We will never know how many promising careers never got started because young people decide to go into other professions.

We are at a critical crossroad in American health care. We can continue on the path we've been on, of ever-increasing regulation, cost, and frustration. Or we can change directions and move to a system that empowers patients and values physicians.

I hope you will take the latter course.

Testimony of Christopher Pelham Unger

Congressional Field Hearing
Frederick, Maryland
Monday, July 14, 2003

Over the weekend I had the experience of seeing a sixteen year old boy who's life threatening medical condition was misdiagnosed initially by the British Medical Service and subsequently mismanaged by a centrally bureaucratized US Medical Service. I would like to give you a few more details. And explain how this can be avoided.

The problem of shortages is growing with ever greater concern in the medical care system. We have shortages of nursing skills, shortages of vaccines and shortages of primary care givers. We have an impending shortage of general surgeons, pediatricians, and hospital services. I bring to this critically important public debate front line experiences from daily clinical application for nearly thirty years. Background...

To friends and family in all fifty states, the crisis in medical services shortage has begun with a legislative direction beginning with Medicare rationing in the 1980's euphemized under the title "utilization review" and continued with an unending stream of federal controls which essentially regiment the way we receive medical care and relate to those who are specially trained to safeguard our health. The latest series of mandated controls emanating from Washington past congress as the Health Insurance Portability and Accountability Act. The regulatory imperative is consuming our energy, talent and resources and will continue to impair, limit, slow down and ultimately freeze clinical practice and hospital services.

From time to time, health administrators, planners or legislators will stop by my office to witness first hand the fragmentary medical care that managed competition has brought to US physician's offices, clinics and hospitals. What they see is quite perplexing and I would venture to say that had the Wright Brothers been over managed and regimented in this manner, they would have never gotten off the ground.

Injuries in the U.S. Workplace increased after OSHA.

When it comes to Medicare, Clia: "me first!" OSHA: "me second!" HIPPA: "me third!" ...a trickle.

Let me explain how this works. When a new law is passed by congress the promulgation or carrying-out of those regulations places a substantial burden on the federal budget, which is ultimately borne by tax-payers. At the receiving end of these lock step, regimented rules and regulations is an impairment of the physicians' ability to function, focus and individualize medical services. The time consumed by your physician to provide a standard office service for a relatively uncomplicated ailment is doubled or tripled when it is necessary to comply with managed care. The volume of

services and overall productivity are severely reduced and cost per service will therefore go upward or that clinical practitioner will vacate medical practice. Adding to the shortage of experienced primary care givers.

Regulated product v. regulated relationships. Legislators, inspectors: you don't belong in my office.

I'd like to explain this a different way; of all premium and insurance dollars that are paid into the system, thirty-nine percent are spent on administrative, regulation and management as more federal mandates come into existence. e.g. legislation to insure patient rights, legislation to avert medical errors, that thirty-nine percent will go up. The thirty-nine percent will go to fifty percent or more of all our health dollars. **The more we legislate healthcare, the more shortages come about and tighter rationing and restricting of services.** We should reverse the trend of mandated, regimented medical care and put in place polices that control cost through increasing productivity.

I would like to conclude by sharing with you a few concepts on what you can do to prevent further shortages and rationing. A medical colleague recently advocated that we mandate the presence of the paddles in all gymnasiums. I ran to the microphone where this was being debated and told my fellow physicians not to vote for it. Fortunately for those who pay for mandates (which is all of us) the measure did not pass. There was some resentment to own up to after this vote and some of my physician friends ran me through the paddles. The object lesson however, was clear; when there is an impulse to legislate or regulate, vote no. Avoiding any more mandates will may have short term pain and long term gain.

What you can do:

-Vote no when regulation issues come up
-Use non-legislated means toward the high efficiency generalist and low tech management.
-Write to government – no state run single payor or "universal" / yes on MSA & HRA
-Energize and contribute to congressional candidates with good voting records
-Determine that there shall be an independent health system - low cost and unencumbered by mandates.

A real life experience… From the Bureau of Medicine and Surgery

Testimony of William A. Sarraille at the Hearing before the Committee on Small Business of the U.S. House of Representatives
July 14, 2003

Good afternoon Chairman Manzullo, Vice-Chairman Bartlett, and the other committee members. Thank you for inviting me to today's hearing. I am pleased to be here and to testify about the impact of federal government regulation on physicians as small business owners.

I am an attorney in private practice in Washington, D.C. at the national law firm of Sidley Austin Brown & Wood, LLP. My practice focuses on advising health care professionals, including physician practices, on the myriad of regulatory obligations imposed on them. I also represent a number of professional medical associations, health care trade associations, and similar organizations. I am testifying today, however, in my individual capacity, rather than on behalf of any client.

My work for both individual physicians and professional associations has included advice on issues ranging from development of the Medicare physician fee schedule and other reimbursement issues, counsel on Stark Self-Referral Law, anti-kickback, and HIPAA Privacy Standards matters, the creation and implementation of compliance programs, the defense of audits and False Claims Act investigations, appropriate structuring of business relationships in accordance with federal health care regulations, assistance with clinical trials research, advice on billing issues, payer contracting, managed care, and many other matters. This list illustrates the highly regulated (and difficult) environment in which solo and small physician practices must function.

Compliance efforts with these and other regulatory and contractual obligations are incredibly expensive--both in terms of the financial and personnel investments necessary. In an environment where, in my view, the federal government has all too often resorted to the rhetoric of the criminal law as part of its effort to ensure compliance with regulatory matters, physicians are acutely aware that even honest errors (or an inability to penetrate the disturbingly ambiguous and confusing nature of so much federal regulation) runs the risk of subjecting them to criminal prosecution.

I have seen first-hand the impact that changes in payment structures and government regulation have imposed upon physicians. These pressures have made it increasingly difficult to practice medicine and have subjected physicians to significant administrative and psychological stresses as well. It is becoming increasingly common for clients to discuss plans for early retirements, leaving the practice of medicine for other work, dropping coverage for Medicare beneficiaries or at least closing practices to new Medicare enrollees, and attempting to deal with an ever-worsening environment in which to recruit and retain specialists in such areas as radiology, anesthesiology, and emergency medicine.

The decline in physician confidence in the health of the health care system is, in turn, a significant factor in the decline of interest among bright college students to enter medicine. Nor is this problem limited to physicians. Although there are well-publicized shortages in nursing,

there are even more dramatic shortages in other areas of health care, such as vascular technology and sonography, the persons who use ultrasound to provide widely-used and critically important ultrasound services to millions of Americans each year. This situation does not bode well for the ability of our health care system to meet the basic access needs for Medicare beneficiaries as the number of those beneficiaries increase each year.

The sad but undeniable fact is that the financial threats, regulatory burdens, and other challenges that are so overwhelming to physicians and other clinicians are increasingly overshadowing the intangible reward they have experienced from furnishing quality patient care. This situation constitutes a major public policy challenge. Your Committee, with its unique ability to bring focused attention on the impact of federal regulation on physicians as small business persons, will be critically important in the effort to meet that challenge, if, indeed, we can be successful. It is for this reason that I join so many others in applauding you for holding this Hearing.

I was asked to try and focus at least some of my remarks on possible solutions to the problem presented by regulatory burdens on physicians as small business persons. I believe that the following nine point plan would constitute a step forward in reducing the risk that regulatory burdens and other pressures will destroy the health care system as we currently know it.

First, I recommend the development of a special Congressional Commission to evaluate the extent to which existing regulatory burdens may be modified or eliminated. Although the Bush Administration, under the leadership of Secretary Thompson and Administrator Scully, is to be congratulated for various efforts to reduce the burdens placed on physicians and other providers, the work that has been done to date is clearly insufficient and the review of regulatory requirements by those, often, who were involved in the development of those regulations creates, unintentionally, a situation in which the status quo is just as likely to be defended, as it is to be questioned.

Second, Congress should require that the Centers for Medicare and Medicaid Services adopt an "evidence-based" approach to new regulatory burdens. Physicians do not believe that they should be the subject of increased regulatory burdens, unless a benefit/burden analysis that is based on reasonable data suggests that the burden should be imposed.

Third, given the sharp disagreements that have occurred regarding the accuracy and the credibility of regulatory impact statements, Congress should create a Commission to review that process and those determinations. Physicians' organizations believe that incorrectly designed impact statement analyses have led Congress and the agencies to impose burdens on small health care providers that were overly burdensome.

HIPAA seems to be a clear example. Although physicians feel strongly about maintaining the confidence of their patients, they have been overwhelmed by the more than 600 pages of Federal Register text on this subject. It is our experience that the financial costs of compliance efforts imposed on each physician office or clinic is significantly greater than the $3,703 that the Department of Health and Human Services estimated for the first year of compliance, perhaps by a factor of five to ten.

For example, most practices have dedicated resources to educating at least one staff person as a HIPAA expert. This process required multiple exposures to the regulations and diverted attention from patient care and business operations. As staff in small offices function in multiple roles, each individual in the office would typically be trained in many different components of the regulation's nuances, which are far from clear. The fact that so much of the rule changed over its four iterations drove compliance costs up significantly.

Written policies and procedures had to be developed for every practice, no matter how large or small. Even tailoring form policies and procedures has been timely and expensive for physicians.

Additional funds and personnel resources also have been spent in obtaining appropriate written agreements with almost every business entity that furnishes services on behalf of the practice. Since almost each of these organizations has a slightly different version of these "Business Associate Agreements," and since small practices have little leverage in imposing the use of their own form agreements, lawyers often were hired to review the contracts, or again, significant staff time was devoted to the task.

We also believe significant funds and/or staff time have been spent by every provider to develop and print a "Notice of Privacy Practices," a document that most individuals do not read or consider to offer any value. The mere act of providing that NPP to each patient of the practice and answering questions where they are posed is a huge cost.

With that said, many physicians greatly appreciate the efforts of the Bush Administration and others to make the Privacy Standards less onerous. Physicians have noted and welcomed the change in the tone that the Office of Civil Rights has adopted, where an emphasis on punishment has given way to talk of education. We also have heard positive comments about the volume of information that is being offered on government web sites and in response to provider inquiries. Our clients urge Congress to ensure that these efforts remain adequately funded.

Interestingly, even compliance with the HIPAA Transaction and Code Sets Standards has been a subject of concern to our clients. These regulations were promoted with the hope of achieving cost savings by ensuring that electronic communications in health care are made uniform and efficient.

Unfortunately, many information system vendors are unable to or refusing to support all of the new transaction standards. As many practices, even small ones, rely upon electronic claims submission, this situation is very disturbing. Affected physicians are being forced to use health care clearinghouses to submit their claims, with these clearinghouses charging a per claim fee for a service that the practice historically had performed on its own at lower cost.

The failure of many vendors to support the status inquiry transaction standard also is particularly disturbing. Implementing this standard would have permitted physician practices to electronically determine the progress of a filed claim without having to work through multiple telephone menus or busy telephone lines. These obstacles substantially drive up the cost of back office help for practices.

While Congress cannot mandate that vendors support providers in HIPAA implementation efforts, we urge Congress to seriously consider the practicality of meeting the upcoming transaction and code set compliance deadline of October 16. With the ability of vendors to furnish the software necessary to permit compliance in doubt, some physicians are considering whether to take out lines of credit to prevent cash flow problems in the event that they are not able to submit electronic claims as of the compliance deadline.

As a fourth item in my plan, when in imposing burdens on different classes of providers, both Congress and the regulatory agencies should separately consider the effect and consequences on small physician practices. This should be a required step in Centers for Medicare and Medicaid Services rulemaking. The relative effect and the desirability of a regulatory burden will routinely be fundamentally different depending on whether large institutional providers or small physician groups and other clinicians are the focus of the regulation.

An attempt to differentiate between provider classes has been made in some cases. For instance, the HIPAA Privacy Standards contemplate a flexible approach based on the circumstances and the resources of the Covered Entity. Further, in mandating the electronic submission of claims to the Medicare program under a recent provision of law, Congress provided an exemption for small physician's offices and other small providers. This type of approach has not, however, been taken consistently, and it very much needs to be.

Fifth, in imposing any new regulatory burdens on physicians, any future Congressional or agency action should be "time-limited," meaning that the new burden only should be effective for a finite period of time. This will allow the burden to then be reevaluated after its introduction, in light of the implementation experience. Unless either Congress or the appropriate agency makes the determination at that time that the requirement has, on balance, proven to be more of a benefit than a burden, when solo and small physicians are considered, then the burden should automatically be retired or sunset. Such a "built in" reevaluation would allow for timely elimination or modification of burdens.

Sixth, both Congress and the regulatory agencies need to think more in terms of "carrots" than "sticks." Physician organizations have designed many mechanisms to improve patient care, ensure that medically necessary services are provided, and to save on the costs for health care. Two such mechanisms are diagnostic laboratory accreditation (a system to ensure competency in the delivery of diagnostic services such as ultrasound, MRI, CT, and other services) and technician and technologist credentialing (a system to ensure minimum levels of competency among the non-physician personnel performing diagnostic tests). Although accreditation or credentialing is required by most Medicare carriers for the provision of vascular ultrasound services and in some other areas, the Medicare program generally has not supported expanded efforts by providing incentives to adopt them. Providers that have adopted higher standards have not been rewarded with additional reimbursements that even cover their higher costs. In this way, the program has actually rewarded mediocrity and incompetence and stifled innovation and a commitment to excellence.

Seventh, rulemaking proposals should be appropriately "spaced" in time to allow physicians and their representatives to absorb and respond to those proposals. Although under the current Administration's direction, regulatory proposals are now to be released on a monthly schedule, absent unusual circumstances, most physicians find the prospect or possibility of even monthly regulatory proposals overwhelming. We believe that Congress should require agencies, particularly the Centers for Medicare and Medicaid Services, to release rules affecting physicians no more frequently than quarterly. Even a "schedule" such as this would prove daunting to physicians.

Eighth, Congress needs to demand increased accountability by the Centers for Medicare and Medicaid Services. Although both Secretary Thompson and Administrator Scully have made this important topic a high priority, there is much yet to be accomplished.

For instance, the Centers for Medicare and Medicaid Services failed for years, despite a clear Congressional mandate, to update the list of approved procedures to the Medicare ambulatory surgical center list, which was necessary to permit access to those procedures for Medicare beneficiaries. Even when, belatedly, the agency recently updated the list, it refused to add a number of procedures to the list that it conceded met the statutory requirements because, in effect, it said that it did not have sufficient information on the cost of these procedures. As the agency admitted, however, the reason that it did not have this information is that it had failed to meet another Congressional mandate to collect that information. The idea that the failure to meet one statutory mandate was "excused" by a failure to meet another has proven galling to many physicians who practice at ambulatory surgery centers and believe them to be the best place to provide their services in an efficient and safe manner.

Another example would be the refusal of the Centers for Medicare and Medicaid Services to implement the expedited appeals provisions of the Beneficiary Improvement and Protection Act of 2000. The agency's proposal to implement the appeal provisions, which were themselves a reaction to the abysmal record to provide timely appeals to physicians and others seeking redress, have left many physician groups something more than disenchanted. The proposal is clearly inconsistent with the Congressional mandate. A number of physician groups oppose the proposal to move the administrative law judges who are responsible for appeals from the Social Security Administration to the Centers for Medicare and Medicaid Services. This change will, I fear, only further insulate the Centers for Medicare and Medicaid Services from appropriate accountability.

I recommend the creation of a Congressional Committee specially tasked to address accountability issues, with an annual reporting obligation to Congress.

The ninth and final item in my plan is that physicians and other providers must be permitted to rely upon the guidance they receive from the agency and from its agents, the carriers and the intermediaries. The General Accounting Office has reported that the information provided by some within the program was inadequate almost 85% of the time. Physicians are angry that they are threatened with criminal prosecution for allegedly failing to meet requirements which agents of the program cannot themselves articulate correctly.

Though Administrator Scully has stated that a Congressional mandate requiring timely information to be provided to program participants is unnecessary, because the agency has mandated such responses within 45 days for some years, the Administrator is, unfortunately, misinformed on this point. Medicare carriers and intermediaries continue to fail to respond (timely or otherwise) to many requests, fail to have their employees fully (or sometimes even partially) identify themselves, fail to provide written confirmation of the advice given, and fail to allow providers to rely upon the advice they receive, when it proves to be incorrect. Although the agency has begun to focus on contractor accountability, its efforts have not focused on these issues of provider guidance sufficiently. Congress should mandate that the agency do this. Carriers and intermediaries should not keep contracts to act on behalf of the Medicare program where they cannot provide accurate guidance in a timely way to program participants.

In some sense, the emphasis that the Centers for Medicare and Medicaid Services do plan to place on provider education is itself an indication of an even more fundamental problem. Although physicians welcome the emphasis on education, the reality is that the Medicare program should not be so complicated and confusing that such an emphasis is needed.

At this juncture, I would like to make some additional observations. The failure of Congress or the regulatory agencies to act in situations where action is required to address the legitimate needs of solo and small physician practices is just as great an issue as the imposition of overburdensome regulation. Nowhere is that more apparent than in the case of the Senate's very disappointing failure to take up the increasingly urgent problem of sky rocketing malpractice insurance premiums.

Out of control malpractice insurance premiums are one of the most serious concerns for many small (and even very large) physician groups today. The rapid and inexorable increases in many jurisdictions has made it financially impossible for many small practices to function. Physicians across the country have expressed outrage and frustration at the annual premiums they must pay, with premiums in certain areas having been increased over 900% in the past four years (in some cases premiums have gone from $6,500 to $80,000).

Although some argue that this untenable situation is to be blamed on the insurance companies, the fact that so many of those companies have left the medical malpractice marketplace, even with the rate increases that have occurred, would seem to belie that argument. In any event, while the argument continues as to why the problem has come to be, more and more physicians are forced to consider abandoning their practices. The point seems obvious that the malpractice crisis imposes an even greater burden on small physician practices that do not have the flexibility to reduce costs, like larger organizations might. Action by the Senate similar to that taken by the House this year is critically important and any further delay is nothing short of dangerous.

Reimbursement rates under the Medicare fee schedule also are an annual source of (quite unnecessary) worry for small physician practices. Today's small practices support significant overhead. The need for a reliable and reasonable revenue stream is a critical component of the ability of physician practices to continue to provide services to Medicare beneficiaries. The most recent debate about reforming how the Medicare physician fee schedule conversion factor is calculated has highlighted the volatility of the current reimbursements. It is unacceptable that

the current methodology is such that reimbursement may unpredictably change from a reduction of 5.4 percent to an increase of 1.6 percent back to a reduction of 4.2 percent.

Not only does this system place an unacceptable strain on practices, but it causes delays in upgrades of equipment used for patient diagnosis and treatment, instability in staffing, and a reluctance to expand services that could improve patient access. Unfortunately, even this year's Medicare bill only seeks to temporarily address the problems created by the conversion factor formula, without changing the formula itself. We need more comprehensive and longer term action from Congress, and we need it now.

Another topic that is frequently discussed concerns government enforcement activities. Almost all health care providers are interested in "doing the right thing" when it comes to adherence with government regulations and Medicare or Medicaid program instructions. They make good faith efforts to remain current and follow the myriad of regulatory requirements found in continually refined policy guidance, new Medicare manual instructions, new or updated local and national coverage decisions, and new regulations. Unfortunately, some physicians make mistakes or are perceived (incorrectly) to have made mistakes by government enforcement agencies, angry competitors, and disgruntled current and former employees. Depending upon the allegation and surrounding circumstances, government efforts to investigate may wrongfully subject a physician practice to burdensome post-payment or pre-payment audits, extensive government investigations, overpayment demands, civil money penalties, False Claims Act penalties, and criminal prosecution.

Based upon our experience, we do not believe that the current Senate proposal to significantly increase the civil monetary penalties that may be imposed under the Social Security Act and the penalties for violations of the Federal False Claims Act will improve physician compliance with federal law. This proposal will, however, reinforce physician fears that their efforts to comply with overwhelming and confusing regulatory burdens are, in fact, not appreciated by Congress and their view that they are seen as criminals for trying to care for sick patients. Without question, government enforcement should be supported where it is designed to prevent those very few unscrupulous providers from abusing the federally funded health care programs. Nevertheless, the tools government enforcement agencies may already bring to bear upon a health care provider are more than sufficient. For example, a health care provider currently may be subject to a fine of up to $11,000 per claim for false claims. A fine this size could be imposed even when the underlying claim was a laboratory test worth as little as $6. Does the government really need more tools in its fraud and abuse arsenal?

The psychological and financial impact that a government audit or investigation may currently have on the operations, morale and finances of a practice are enormous. When confronted with these circumstances, many providers feel powerless in the face of the seemingly infinite resources of the government such that they feel that they are incapable of defending themselves. The costs of a potential loss, even for a few claims, are simply too great. Small practices often cannot afford the additional costs associated with hiring any necessary auditors, consultants, and lawyers.

The government, unfortunately, can be overzealous and just plain wrong. For example, I was involved in one matter, where the client was accused of having collected approximately $900,000 that it should not have. Ultimately, it was found only to have collected $300 or so in overpayments. Unfortunately, it cost the provider thousands of dollars to prove to the government's carrier that it was horribly mistaken in its accusations.

Again, I appreciate the opportunity to participate in this hearing. I look forward to addressing any of your questions.

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Doctors Shrug

by Edward L. Hudgins

In her 1957 novel *Atlas Shrugged*, Ayn Rand imagined a monstrous world in which the laws and the political regime, rather than protecting productive individuals, actually make it easy and legal for the rapacious and the envious to steal from them. Not surprisingly, many producers drop out of this society. In response, politicians warn the remaining producers not to leave their jobs, claiming that it is their duty to serve society.

This nightmare scenario is now breaking out across the United States. The victims are physicians.

Faced with the high costs of malpractice insurance and bogus lawsuits, plus onerous government regulations and mountains of bureaucratic paperwork, many physicians are simply quitting their profession or giving up parts of their practices. Last year in Las Vegas, for instance, dozens of trauma surgeons resigned from hospitals over insurance costs. Other physicians are moving to states and counties that have more reasonable tort and regulatory regimes. According to the American Health Association, 27 percent of hospitals report doctors leaving or retiring, 25 percent report that it is difficult to find doctors, and 20 percent have cut back services. (The Politically Active Physicians Association in Pennsylvania maintains a Web site that lists all doctors who retire or leave the state, as well as hospital service cutbacks and closings: http://www.fightingdocs.com/main.htm.)

In an even more dramatic move, physicians are going on strike. In West Virginia, dozens of top-flight surgeons at four hospitals began a thirty-day work stoppage on January 1 because of soaring insurance costs. One of the doctors has seen his annual insurance premiums triple in seven years, although not a single suit has been filed against him. In Pennsylvania, a wider strike was threatened for the same day, but the work stoppage was averted just hours before it was scheduled to begin when Governor Ed Rendell promised to fight in the legislature for a relief package. Late in January, the Medical Society of New Jersey

backed a doctors' work stoppage that could bring routine checkups and non-emergency services to a halt. And on February 3, an estimated 70 percent of that state's 22,000 physicians participated in a work stoppage that cancelled nearly all but emergency services.

A System Gone Wrong

The immediate cause of physician strikes has been the skyrocketing cost of malpractice insurance. For example, a Philadelphia-area orthopedic surgeon found his annual rates jumping from $65,000 to $130,000 in two years. A Neptune, New Jersey, obstetrician-gynecologist (OBGYN) faced rates that would triple in 2003, to $170,000 annually. According to the Medical Liability Monitor, average annual rates for OBGYNs in 2002 rose 19.6 percent; those for internists increased 24.6 percent; and those for general surgeons rose 25 percent. In Detroit, in 2002, general surgeons paid on average $107,000 for insurance, while in Miami the rate was $174,000. Cleveland OBGYNs paid $156,000, while their colleagues in Miami paid $210,000. One New Jersey obstetrician faced a rate of $563,000.

Those high costs are not due to an increase in physician errors or to degeneration in surgeons' skills, contrary to the claims of lawyers, Naderites, and the Leftist media. Nor is the problem due to insurance companies' raising rates on doctors to make up for money lost in the stock market, as also claimed by these critics. Malpractice insurance rates differ greatly from state to state, yet lower stock prices affect all states and all insurance companies. Rather, the cause is a legal system that facilitates theft, government regulations, and the rise of a new predator class in the legal profession.

In a free society, the legitimate function of tort law is to allow someone to recover damages if he is harmed by the accidental or negligent behavior of another. Insurance is the principal way that responsible individuals undertake to cover the costs of their rare, harmful actions. Certainly, there are real cases of malpractice in the medical profession that should be covered by insurance of some sort.

The problem is that tort law makes it easy for professionals such as doctors to be sued. In the United States, in contrast to many other countries, losing plaintiffs do not have to cover the legal bills of defendants whom they sue unsuccessfully. There is thus little downside—and a significant upside—to filing a weak suit. Consequently, insurance companies often settle with plaintiffs even though their clients are innocent, as long as the settlement is

substantially less than the projected cost of mounting a defense. According to a 1990 study published in the *New England Journal of Medicine* that examined the treatment of more than 30,000 New York patients, in almost 20 percent of the lawsuits filed against physicians the patient's treatment had not led to any adverse consequence. Nevertheless, these baseless suits were settled for an average payment of just under $29,000, and, naturally, those costs are passed along to all of the insurance company's physician-clients, even to those who have never been sued.

Beyond the system's structural flaws lie moral flaws. In recent decades, Americans have become much less willing to bear responsibility for themselves and to accept the misfortunes of life. Even when the injuries that befall them are no one's fault, many seek someone to blame and sue. Doctors are frequently targeted in such suits because their reputation prompts juries to demand from them god-like perfection. According to the study of New York patients, in lawsuits involving a patient who *had* suffered an adverse consequence, that consequence was the result of substandard treatment less than 20 percent of the time. Yet, fully half of these "adverse result" cases were bought off, for an average payment of $98,000. Obviously, suing those who do their best to cure us is the ultimate act of moral ingratitude.

The combination of defective laws and immoral individuals has given rise to a new predator class: plaintiffs' lawyers. (For an in-depth treatment of this problem, see Walter K. Olson, *The Rule of Lawyers*, St. Martin's Press, 2003.) Rather than merely helping individuals collect just compensation for injuries, these attorneys are systematically targeting the most productive and wealthiest members of society for the same reason that bank robbers rob banks: that's where the money is. And because no objective limits exist for "pain and suffering" damages or punitive damages, a plaintiff lawyer's cut of his client's award can be huge indeed. In the years 1994 to 1996, 34 percent of malpractice awards exceeded $1 million; by 1999 to 2000, 52 percent reached that level.

The harm wrought by these predators is not confined to looting doctors. For example, in the 1990s plaintiff lawyers launched a campaign against silicone breast implants, claiming the product was defective. In the end, they extorted a $4.3 billion settlement out of manufacturer Dow Corning, with $1 billion of that sum going to the lawyers. But as Marcia Angell of the *New England Journal of Medicine* showed in her book *Science on Trial*, medical evidence did not

establish a connection between the implants and the illnesses that the lawyers claimed they caused. Still, Dow Corning went bankrupt, and women who wanted reconstructive surgery after mastectomies were denied the silicone option.

Or consider this case: until the mid-1970s, the Dalkon Shield was a popular and effective form of birth control. But following a study that alleged the device increased the risk of uterine infection and other health problems, an assault led by plaintiff lawyers netted them about $1 billion in fees and drove manufacturer A.H. Robins out of business. Later studies showed the damning study failed to meet scientific standards.

Perhaps the most repulsive element of the assault on doctors is that the predatory lawyers try to give their efforts the sheen of moral superiority by claiming to help "little guys" who suffer injuries at the hands of the greedy rich. Naturally, the plaintiff bar is a major donor to the Democratic Party, which specializes in loot-the-rich rhetoric and supports laws that make possible such predation.

Government Burdens

Governments contribute to the assault on physicians in ways other than the judicial system. For example, most doctors need to maintain some relationship with a hospital to practice their trade, and many are required to provide their services at certain times to patients who come in through the emergency room rather then through their own private practices. In 1986, Congress passed the Emergency Medical Treatment and Labor Act (EMTALA), which requires all general hospitals to have emergency rooms that provide emergency services in every specialty that practices at that hospital. These emergency rooms are required to treat all patients who come in, whether they can pay their bills or not. And it makes no provision for compensating hospitals or physicians for patients who cannot pay. As a result, border-state hospitals are being flooded with immigrants, legal and illegal, who receive expensive services and do not pay their bills. In poor neighborhoods, hospitals and doctors face similar problems. In other words, the federal government virtually forces doctors to provide services, and if the patient cannot pay—too bad! That is a backhanded form of conscription and slavery.

The federal government also hinders physicians through the sheer volume of its Medicare and Medicaid regulations. Doctors spend a great deal of time filling out paperwork, and not a few find themselves

facing huge fines and even prison as the result of innocent mistakes made in trying to understand federal rate-tables and regulations. As attorney Jonathan Emord showed in his article "Murder by Medicare" (*Regulation*, vol. 21, no. 3; Summer 1998), many solo or smaller medical practices have folded under this regulatory burden.

In addition, the 1986 changes to the Civil False Claims Act had a particularly pernicious effect on physicians. That act allows private parties to file actions against anyone who innocently runs afoul of even the most innocuous bit of federal red tape—and to collect part of the fine. Madeleine Cosman has pointed out that physicians have been hit especially hard by bounty hunters looking to enrich themselves by stealing from the productive members of society.

The Ultimate Insult

In response to government oppression, Atlas is shrugging—and the reaction from politicians has been as appalling as anything Ayn Rand predicted.

On December 20, Pennsylvania's secretary of the commonwealth, C. Michael Weaver, sent a letter to the state's physicians threatening that a work stoppage would be detrimental to "your practice...as well as your license should your conduct be found to constitute abandonment." Remember that doctors are barred from practicing without malpractice insurance, and that Pennsylvania's dysfunctional laws make it costly and difficult for physicians to acquire such insurance. Now one of that state's top politicians is maintaining that physicians are in effect feudal serfs chained to the jobs the state makes it impossible for them to perform.

Other politicians no doubt will be tempted to resort to similar strong-arm tactics. A spokesman for New Jersey governor James McGreevey, for example, called a proposed strike by doctors in his state "irresponsible." Few would deny to auto mechanics, steelworkers, or other citizens the right to strike. But doctors, precisely because their services are so valuable, are to be denied this right.

The current assault on doctors is a moral outrage. Phoenix-area general surgeon Jeff Singer observes that he and many of his colleagues became physicians because of a fascination with medicine and biology, the pleasure of dealing with people, the challenge and fulfillment of healing the sick, and the chance to open their own practice and to be their own boss. Now many doctors find themselves

spending much of their time trying to get paid; keeping up with the regulations of Medicare, Medicaid, OSHA, and the Health Insurance Portability and Accountability Act; and trying to keep out of jail when they run afoul of such regulations. They no longer enjoy their work, and many are trying to make enough money to be able to quit their practice and retire early. In other words, the best men and women in our society are being driven out of it.

Striking Back

President Bush has proposed a cap on payments for pain and suffering in malpractice suits as a means to hold down the insurance costs of physicians. Such caps make sense. According to the *Medical Liability Monitor*, the nineteen states with caps on non-economic damages have insurance rates that are, on average, lower than those in states without such caps. A cap on pain and suffering payments would still allow injured patients to be fully compensated for all actual harm, but awards that gratuitously drive up insurance costs would be limited.

Unquestionably, such arbitrary caps could create injustices. For example, a woman recently opted for a double mastectomy after a lab mixed up her results with another patient's. With a cap on awards for pain and suffering, this victim might not receive the large award she should undoubtedly be paid. But, if so, she would not be a victim of the arbitrary cap itself, but of the rampant subjectivism in tort law that has made such arbitrary caps necessary.

The Bush proposals also raise some serious questions about federalism. After all, the Constitution does not grant the federal government jurisdiction over tort law and insurance. These matters are traditionally reserved for state and local governments, and if states and counties lose their doctors and hospitals because of bad local laws, it is up to local voters to throw out the politicians who maintain the dysfunctional system. But President Bush is right to call attention to the serious problem of law gone bad.

It is also time for physicians to call attention to the problem and to take the moral high ground when they do so. They toil for years to acquire the skills necessary to save lives, cure diseases, and alleviate pain and suffering. Their challenging work demands the best within them—high levels of intelligence, dedication, and endurance—and it makes them prosperous, as well it should.

Physicians should reject the notion that their importance, status, or wealth binds them to serve under a legal and political regime that punishes them for their virtues. They should resolve to offer their services only in a system that grants them the freedom owed to all productive persons, that compensates patients only for acts of genuine negligence, and that protects physicians from the pseudo-judicial predation of the envious.

Edward L. Hudgins is the Washington director of The Objectivist Center.

New Jersey Doctors in Work Action

On February 3, approximately 70 percent of New Jersey's 22,000 doctors took part in a work stoppage to protest the skyrocketing costs of malpractice insurance, according to Robert S. Rigolosi, the president of the Medical Society of New Jersey. The doctors either did not hold office hours or canceled appointments for non-emergency treatments or check-ups. But many of the physicians' protests were not wholly passive. Some 700 chanted "Tort reform now" outside of a Neptune, New Jersey, hospital. In Paramus, some 100 physicians gave blood to show that they want to continue to treat patients, if only the politicians will address their concerns. At other hospitals and medical facilities, doctors carried placards demanding that something be done about their insurance rates, which in certain cases have doubled or tripled in a period of a year or two, reaching into the hundreds of thousands of dollars.

Because most doctors refused to work under an intolerable tort law system that allows them to be victimized by predatory trial lawyers, many patients who might otherwise have been handled by the striking physicians had to turn to hospital emergency rooms for treatment. For example, the Hunterdon Medical Center in Flemington, New Jersey, reported treating fifty-two patients in a twelve-hour period when normally they treat sixty patients every twenty-four hours.

New Jersey governor James McGreevey's office received nearly a thousand calls from patients on February 3, after many of their doctors gave out his phone number on their

office answering machines.

Indicative of the attitudes that drove Garden State physicians to strike—and one that they should not tolerate—was an opinion in the *Hutchinson News*, a Kansas newspaper, which complained about doctors who "put their financial interests ahead of medical ethics." The assumption is that doctors are mere servants whose duty it is to serve others, no matter how difficult the politicians and the public make it for them to practice their profession. The strike serves as a reminder that the best and the brightest in our society will tolerate this inverted and monstrous morality only for so long before leaving their tormentors to fend for themselves.

Newspaper reports say that the New Jersey action may well be only the first of many physicians' strikes in this country. Similar actions have been planned in New York and Connecticut. —Edward L. Hudgins

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The government's envy engine

Released On: September 4, 2002

By Madeleine Cosman

Many Americans understandably are concerned about the Bush administration's proposed Terrorist Information Prevention System, a program to encourage citizens to report suspicious activities to government officials.

While common sense diligence must always be encouraged, this program raises serious civil liberties concerns. Do we really want a government program to encourage us to spy and snoop on each other like in some communist country, tempting neighbors to report the neighbors they dislike as suspicious characters?

A preview of what TIPS will offer exists. It's a legal monstrosity that encourages citizens to rat out individuals who accept federal money and who allegedly violate federal regulations.

An old Civil War-era statute, revived in the 1986 Federal Civil False Claims Act, allows private parties to file "Qui Tam" actions in the name of the feds, with government informants getting one-third of the loot that the feds take in fines or reimbursements from often-innocent victims.

Cases under this provision have risen from 32 in 1987 to over 1,500 in 2001, with nearly $1 billion in collections.

Qui Tam might seem to be a good way to encourage people to report misuse of taxpayers' funds. In fact, Qui Tam encourages disgruntled or fired employees to seek revenge on their bosses, divorcees to inflict maximum pain and suffering on their ex-spouses, ingrate customers to grab quick big bucks from those who do them a service, and trial lawyers to plunder the productive elements of society.

Consider how this envy engine actually works.

Many Qui Tam cases involve Medicare and government payments to physicians.

Physicians must attest to their familiarity with the laws governing those funds. Medicare has over 110,000 pages of regulations. No doctor, patient, bureaucrat, or legislator actually can read and understand those complex, contradictory regulations. Further, not just intent, but an honest mistake -- an inevitable outcome when more than 100,000 pages of regulations are involved -- can convict you.

Worse still, there is a $10,000 fine for each alleged infraction plus triple damages assessed for the allegedly amount misbilled plus other penalties.

Consider the case of Irwin Halper, whose lab performed 65 medical tests for which he billed $12 each for a total of $780. According to the feds, Halper should have charged only $3 per procedure and collected only $195. For this $585 error he was fined $130,000 -- with a snitch getting part of the take -- and spent two years in jail.

Consider the case of J.J. Rutgard, who earned $65,140 for removing cataracts from 15 patients among the nearly 20,000 that he treated over a five-year period.

The skillfully done operations were necessary to improve the patients' vision, and the patients were thrilled with their improved eyesight. But the eyesight of those 15 patients was not considered poor enough for the procedure to be "medically necessary" as defined by the Medicare regulations for that year.

Several employees, seeing an opportunity to destroy their boss and to feed off his shattered life, ratted him out.

Rutgard's fine was $16.2 million, of which his ex-employees took their cut, and he was sentenced to 11 years in a federal penitentiary. After appeal, he served five years in the clink.

Consider the current case of an orthopedic surgeon who did successful procedures on the elbows of 300 patients, at $250 a piece, or $75,000 total over a three-year period. His fired office manager, who was having an affair with the surgeon's wife, argued that the good doctor had billed improperly, using the wrong reimbursement code.

The anticipated fine: $3.25 million. The adulterous office manager expects to run off with the doctor's wife and a cool $1 million. We can expect more such cases in the future.

Activists hold seminars for the elderly, giving them 1-800 numbers so they can supplement their Social Security by stealing from their doctors.

Non-medical Qui Tam abuse abounds as well.

Gilbert Realty allegedly overcharged the government $1,630 over a number of months for providing housing for the poor. The fine: $290,000. The tenant Mr. Smith who already had his rent subsidized by the taxpayers was able to commit a Qui Tam theft against the landlord.

Mr. Bajakajian had contracted a legal debt of $357,144, and had the legal right to take the money out of the country in order to pay the debt. When he failed to fill out the proper form, he was reported in a Qui Tam action. The fine: the total $357,144. The snitch expected over $100,000.

The Qui Tam record augers the effects of the TIPS program on our personal liberty and our civil culture. TIPS will unleash people's lower urges, and give them a dangerous weapon with which to indulge petty jealousies, irrational impulses, and mean little hatreds.

A free society is built on laws that foster mutual respect, not malicious envy. A free society stimulates trust, not suspicion between citizens. The TIPS program, like its Qui Tam predecessor, will undermine rather than protect our freedoms.

Madeleine Cosman, Ph.D, Esq. is president of Medical Equity Inc. and a research associate with the Objectivist Center.

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Marcia Sheppard
4 Rocky Fountain Court
Myersville, MD 21773

07/09/03:

To Whom it May Concern:

It has recently come to my attention that there was to be a hearing to consider the plight of the physician in private practice, and I wanted to share my feelings.

For almost 3 years I have worked for Dr. Stanley Chung, an orthopedic surgeon in Frederick, Maryland as a billing manager. Due to the low compensation rates with private insurance companies as well as the self-pay patients that we are forced to see as a result of being on call with the ER, the amount of work for Dr. Chung as well as the rest of his staff has increased, and the compensation rate has significantly decreased.

Due to the fact that I deal so closely with insurance companies, myself, and several of my colleagues have noticed that we have to do double the amount of work for decreasing payment. This is because of mistakes made by the insurance companies that require lengthy phone calls to rectify, and sometimes multiple calls are necessary. In addition, the time that it takes for payments to come in is completely unacceptable, especially for worker's compensation and liability claims. It is also not uncommon for a patient to need multiple surgical procedures, and most insurance companies do what is called "bundling", meaning that they pay only the main procedure and denying the second. This is a significant loss for the physician, who is then never compensated for his time and service.

It seems that the physician is the only professional that is expected to offer and provide services for no cost, can you imagine walking into a construction company and requesting that a house be built, although you could not pay? On a consistent basis the physician is expected to provide services to indigent and self-pay patients for absolutely no compensation, and for some reason it is considered somehow uncompassionate or unethical for the physician or his staff to request payment or inquire how the patient plans on taking care of the bill.

I trust that you will take all the facts into consideration and take action accordingly.

Sincerely,
Marcia Sheppard
Marcia Sheppard
Billing Administrator

Kristin Detrow
15709 National Pike
Hagerstown, MD 21740
(301) 582-0227

07/09/03

To whom it May Concern:

I have been employed by Dr. Stanley Chung for approximately 2 ½ years, and can say without hesitation that he is a physician with ethics, integrity, and compassion. Each day he puts his patient's health and overall quality of life first and foremost in his practice, regardless of their insurance situation.

Due to the fact that Dr. Chung takes a great deal of Emergency Room call as a service to the community; we treat a great deal self-pay, indigent, and medical assistance patients. Without exception, Dr. Chung deals with these patients as he would for all patients with private health insurance, despite the fact that his time, supplies, and services will likely remain uncompensated. For this fact both Dr. Chung's patients and his staff have a great deal of respect for him as a physician; however, in the past several years we have noticed an alarming trend.

Not only has the number of patients that we treat and are never compensated for increases, so has the cost of maintaining a practice and medical malpractice insurance. Recently it has come to our attention that private insurance companies are reimbursing us as low as 65% of Medicare. With the rising cost to maintain a HIPPA complaint office, malpractice insurance, taxes, etc, how can the physician in private practice continue with this low reimbursement rate?

In the past, we attempted to cover the losses we suffer when providing services for the indigent and medical assistance patients with the other's reimbursement. This is no longer possible, and we are fighting to maintain our practice with drastically reduced reimbursement. For an example, many times with medical assistance and indigent patients, they require expensive Durable Medical Equipment (DME), because of Dr. Chung's philosophy of treatment, he gives patients all supplies that he feels they need in order to achieve the maximum results, even though his cost is never reimbursed. In addition, the reimbursement with private insurances regarding DME, x-rays, etc, is so low that sometimes they do not cover the cost to Dr. Chung's practice. For example, due to the fact that our practice is orthopedic in nature, a great deal of x-rays are necessary to diagnose and treat our patients. The reimbursement rates for x-rays do not come close to covering the cost of our x-ray machine, x-ray tech's, film, etc, resulting in a significant loss for our practice. If Dr. Chung would decide not to take the x-rays in-house, some of the patients would need to come to the office twice, resulting in more expense to the insurance company, as well as significant inconvenience to the patient, who may be in considerable pain at the time of the visit.

I ask you to carefully consider the above and take action to rectify this situation as soon as possible to allow the good, ethical, hard-working physicians to continue practicing and employing responsible and educated staff. Many times I have seen Dr. Chung see patients in the office all day, and rush off to perform surgery without eating or resting. He puts his patients needs above his own and is dedicated to their care, it is only fair and prudent that he be compensated appropriately. Consider yourself and your family, if you were in need of a surgeon anytime, day or night, the chances are that a doctor such as Dr. Chung will be there to provide quality care for you, do they not deserve your attention to this matter?

Sincerely,

Kristin Detrow
Medical Assistant