

Community health centers are unique public/private partnerships which were created to provide increased access to health care services for the Nation's poor and underserved. Located in isolated rural and inner city areas, with few or no physicians, that suffer with high levels of poverty, infant mortality, elderly and poor health, they hold the distinction of being locally-owned and operated by the very communities that they serve.

Our health care system relies heavily on charitable care to meet the growing health needs of the Nation's 37 million uninsured—as well as the million individuals with insufficient coverage. Community health centers provide invaluable health care services to more than 10 million of the Nation's most vulnerable and underserved individuals. These patients include minorities, women of childbearing age, infants, persons infected with HIV, substance abusers and/or the homeless and their families. In fact, according to the Bureau of Primary Health Care, of the 33 million patient encounters at community health centers in 1996, 65 percent of the persons served were African-American and other minorities, 85 percent were poor, and 41 percent were uninsured.

Community health centers are the true safety-net providers of this Nation. As such, they obligated to provide health care services to all patients without regard to their ability to pay. Patients are billed for health services on a sliding fee scale in order to ensure that neither income nor lack of insurance serves as a barrier to care. And, Federal grants received by the centers are used to subsidize the cost of health care that is provided to uninsured patients as well as those services which are not covered by Medicare, Medicaid, or private insurance.

Community health care centers also provide high quality cost-effective care. In fact, studies show that the average total health care costs to patients are 40 percent lower than for other providers that serve the same population. Significant savings are also achieved by reducing the need for hospital admissions and emergency care.

Mr. Speaker, as a member of the House Appropriations Subcommittee on Labor, Health and Human Services, and Education, as a health advocate, and as chairman of the Congressional Black Caucus Health Braintrust, I am concerned about the toll that the changing health care market is taking on many families across this Nation. Congress must recognize that community health centers play a critical role in filling health care service gaps. Therefore, I join my colleague, Congressman DAVIS, in urging our colleagues to ensure that this unique provider of health care services is preserved and strengthened to accommodate the growing health needs of the most vulnerable among us, the poor and the underserved.

CBO ANALYSIS OF KYL-ARCHER AMENDMENT: BAD NEWS FOR SENIORS AND DISABLED

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 4, 1997

Mr. STARK. Mr. Speaker, last week, the Congressional Budget Office made public its

analysis of the budget impact of the Kyl-Archer amendment which will make it much easier for doctors to charge Medicare beneficiaries anything they want, anytime they want.

The Kyl-Archer amendment effectively ends Medicare insurance. There is no insurance if you never know whether the doctor is going to reject your Medicare card and ask you to pay the whole bill out of your pocket.

CBO describes a scary Halloween trick for the Nation's seniors and disabled. Doctors will be able to hold sick patients hostage for higher payments, fraud will increase, total national health care spending—already by far the highest in the world—will increase. It will be a treat for doctors, but the end of insurance peace of mind for seniors.

The full CBO letter analysis follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 30, 1997.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: At your request, the Congressional Budget Office (CBO) has reviewed H.R. 2497, the Medicare Beneficiary Freedom to Contract Act of 1997, as introduced on September 18, 1997. (S. 1194, an identical bill, was introduced in the Senate on the same day.)

Direct contracting allows beneficiaries to make financial arrangements with health providers outside of the established Medicare payment rules. The direct contracting provision in current Medicare law, enacted in the Balanced Budget Act of 1997 (P.L. 105-33), requires providers contracting directly with patients to forgo any Medicare reimbursement for two years. Under that condition, CBO expects that direct contracting will almost never be used.

H.R. 2497 would eliminate the two-year exclusion period, allowing health providers to contract directly with their Medicare patients on a claim-by-claim basis. For example, a physician could bill Medicare for an office visit while directly contracting with the patient for an associated test or procedure.

Enactment of H.R. 2497 would affect Medicare outlays. Because of uncertainties about the number of claims that would be separately contracted and about the effectiveness of the regulatory oversight of those contracts by the Health Care Financing Administration (HCFA), however, CBO cannot estimate either the magnitude or the direction of the change in Medicare outlays that would ensue.

With Medicare's restrictions on balance billing—which limit the amount beneficiaries must pay for services covered by Medicare—providers may in some cases receive lower payments than what their patients would have been willing to pay out of pocket. The bill would allow physicians and other health care providers to increase their incomes by negotiating direct contracts that included prices in excess of Medicare's fees, effectively bypassing the limits on balance billing. For some services, CBO believes that such contracting would not be very widespread because few beneficiaries would be willing to pay the entire fee (not just the difference between the provider's charge and what Medicare would have paid). For other services—such as those where the need for timely medical treatment might increase patients' willingness to pay—direct contracting could become much more common.

If direct contracting continued to be rarely used, there would be no changes in benefit

payments, no additional difficulties in combating fraud and abuse, and no major new administrative burdens placed on HCFA.

If direct contracting were extensively used, however, Medicare claims could be significantly reduced. At the same time, HCFA's efforts to screen inappropriate or fraudulent claims could be significantly compromised because it would be difficult to evaluate episodes of care with gaps where services were directly contracted. Furthermore, HCFA would be unlikely to devote significant administrative resources to the regulation of direct contracting. HCFA's efforts to administer other areas of Medicare law, including many of the new payment systems envisioned in the Balanced Budget Act, will continue to strain the agency's resources. Without adequate regulatory oversight, unethical providers could bill Medicare while also collecting from directly-contracted patients.

Although the impact of H.R. 2497 on the federal budget is uncertain, the bill would almost certainly raise national health spending. Even if direct contracts were rarely used, payments made under those contracts would probably be higher than what Medicare would have paid, and Medicare's efforts to combat fraud and abuse would probably be hampered to some extent.

If you have any questions about this analysis, we will be pleased to answer them. The CBO staff contact is Jeff Lemieux.

Sincerely,

JUNE E. O'NEILL,
Director.

CAMPAIGN FINANCE REFORM

HON. RON KIND

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 4, 1997

Mr. KIND. Mr. Speaker, we are starting another week of legislative session, possibly the last week this year, and still no campaign finance reform. The news over the weekend was encouraging for supporters of reform. Speaker GINGRICH announced that the House will schedule debate on campaign finance reform no later than March 6 next year.

This is another positive step on the road to reform, but it is not the answer. As I and many of my colleagues have warned, a vote next year, during an election year, is not satisfactory. By March of next year we will all be involved in our reelection campaigns, and any change will be too late to take effect in the 1998 elections. Mr. Speaker, rather than wait until March of next year to consider this issue, the House should take up campaign finance reform this week. There are a wide variety of bills currently introduced that could be considered. The House Committee on Government Reform and Oversight has been holding hearings on these bills. We have the time to consider campaign reform legislation this week and have a bill passed before we adjourn for the year.

The voters of this Nation want us to clean up our house. The leadership in the Senate and the House have agreed to allow a vote on this issue. The time to act is now. I refuse to take "no" for an answer.