EIR Investigation

How the Gingrich plan will dismantle, not save Medicare

by Linda Everett

On Oct. 20, after months of brazen lies, and suppression of congressional debate and public review of their legislation, the Republican majority of the U.S. House of Representatives passed its "Medicare Preservation Act," in a vote of 230-201. The bill would destroy the Medicare program and strip it of every protection that Congress has mandated over the last 30 years. The Republican Congress would deregulate health care costs under Medicare, by allowing health care providers to charge beneficiaries whatever costs the "reformed" Medicare program wouldn't cover because of successive, increasing, and massive cuts to all health care providers of Medicare services.

House Ways and Means Committee Chairman Bill Archer (R-Tex.) hailed the passing of the bill as "historic." Rep. Sam Gibbons (D-Fla.) agreed, calling it: "A truly . . . a truly historic day. Unfortunately, it's another day of infamy for 40 million Americans who depend upon Medicare for their health care."

President Clinton told Republicans: "I will not let you destroy Medicare. I will veto this bill." He said their bill amounted to a "$270 billion cut in Medicare that will eviscerate the health system for our older Americans."

The reality is even worse. The Contract with America's Medicare and Medicaid reforms have to be reviewed together, because the two programs are integral to the nation's hospital and health care delivery system. The impact of the GOP bills is so broad that we're told that health care providers are "struck dumb" when the bills' provisions are described to them.

How can such damaging changes to a 30-year program advance so quickly, so stealth-like?

Simple. The "Imperial Congress," as Rep. Henry Waxman (D-Calif.) calls the majority, squelched all requests for hearings from Democratic members, advocacy groups, providers, and senior groups. They "jack-booted" their bills through without debate, arrested a group of senior citizens in wheelchairs who asked to speak at the one hearing that was allowed, and are in the process of repealing the non-profit status of one seniors' group that is critical of the bills.

Therefore, as part of an ongoing review of the Senate and House GOP bills, we excerpt testimony presented to the Senate and House Democratic Caucus hearings, along with analyses and releases from those medical professionals, patients, their families, and advocates who have sounded the alarm against what they call the GOP's blueprint to dismantle the country's only public health care programs for 80 million elderly, poor, and disabled Americans.

The reader should not be swayed by media reports that the Republicans have amended their bills to cover "this group" or "that service." Such amendments are made within the context of legislation that is meant to abrogate government responsibility to its citizens—no matter how disabled, indigent, or vulnerable they may be. The testimony presented here addresses the GOP's original bills, not their sales-pitch to the elderly.

Whatever the insufficiencies of the admittedly flawed Medicare and Medicaid programs, they are based upon a 60-year national mandate to provide for Americans who are unable to provide for themselves—a principle the Conservative Revolution says has no place in their free market perspective. Within a historical context, the Republicans have abdicated the conceptual basis for the nation-state within western civilization—that is, that each individual is created in the image of God. They have, as St. Augustine wrote, turned away from the face of God—and intend to drag the nation with them.

Where will the emergency care facilities be when we need them? House Majority Leader Dick Armey (R-Tex.), who authored the Contract with America, predicts that 25% of all U.S. hospitals will close—and with them, critical care services, such as burn units and trauma centers.

The GOP plan to 'save the Medicare trust fund'

Donna Shalala, *secretary of health and human services, testimony before the House Democratic Caucus on Sept. 29:*

Congressional Republicans have called for $270 billion in cuts over the next seven years, claiming that Medicare is facing a sudden and unprecedented financial crisis and that such draconian cuts are required to avert that crisis.

The Republican claim is simply untrue. On behalf of myself, Treasury Secretary Robert Rubin, Labor Secretary Robert Reich, and Social Security Administrator Shirley Chater—the Trustees of the Part A Trust Fund—let me say for the record that we are deeply disturbed by the way the facts in our annual report have been distorted. . . .

Each year, the Medicare Trustees examine the financial health of the Part A Trust Fund [which covers hospitalization and some long-term care]. Our most recent report notes that the trust fund will be depleted by 2002. While everyone agrees that we must take action to make sure that the fund has adequate resources, the claim that it is in a sudden crisis is unfounded. Nine times the Medicare trustees have warned that the trust fund would be insolvent within seven years. On each of those occasions, the President and members of Congress from both political parties took appropriate action to strengthen the fund.

Martha McSteen, *president, National Committee to Preserve Social Security and Medicare (6 million members); former commissioner, Social Security, testimony on Oct. 5.*

. . . The Medicare program cannot sustain the level of cuts under consideration without significant hardship to seniors, the disabled, and their families.

The most recent report of the Medicare trustees projects that the Medicare Part A trust fund will be depleted in 2002. Such reports are not new. In fact, trustees predicted bankruptcy was only four years away as far back as 1970, and Medicare is still here today. The reason for this are the determination of the Congress over the intervening years to maintain the program and the full support of the public for doing so.

The report of the trustees has been misused by members of Congress to convince the public that these drastic proposals are necessary.

Shirley Chater, *Social Security commissioner; board of trustees, Medicare trust fund, testimony before Senate Democrats on Oct. 5:*

"In my role as trustee, I was a signatory to the 1995 annual report. That document was issued in April 1995 and I come here today to clarify the misrepresentations and distortions of the facts . . . [that] are being consistently and conveniently used by some as justification for proposing massive cuts in Medicare. . . .

"We reported our concerns about the solvency of the Part

A trust fund. The 1995 trustees report suggested in no way that we needed to do this draconian cut that we see before us. Not only is such a claim unwarranted, it's simply untrue, if you read the fine print of the report.

"The trustees have reported that it would take $89 billion . . . not $270 billion, to keep Part A solvent through the year 2006. So, there's no reason, no logical reason to take such extreme action. . . . It needs to be made clear that a substantial portion of the proposed cuts would drastically hurt our seniors citizens without contributing one penny to the trust fund Part A. . . .

"As has been pointed out . . . none of these savings [taken out of Medicare Part B, which covers doctors visits and other outpatient services] would go to the Part A trust fund. . . ."

Medicare Part B premiums are drawn directly from the Medicare beneficiaries' monthly Social Security check. Seniors have asked her, Chater said, how can they pay double premiums, higher deductibles, and larger co-payments as the Republicans propose, with a only a $600 monthly Social Security check that currently leaves them with only $15 a week to purchase food and medication? Chater said that senior citizens saw the increased Medicare premiums "as reducing the amount of money they have left over for food. They see it as a cut in Social Security" which they cannot afford.

"For millions of elderly men and women, their Social Security check serves as the sole barrier that stands between them and poverty. For approximately two of every three seniors, Social Security represents more than 50% of their income. For 25% of older Americans, Social Security is 90% of what they have to live on. And for 14%, that is, one in every seven seniors, Social Security is all they have."

Higher costs and a delay in eligibility

Robert Reich, *secretary of labor. On Oct. 6, he presented the results of a recent survey on elderly income before Senate Democrats, regarding the GOP's plan to move Medicare eligibility up to age 67:*

The vast majority of Medicare beneficiaries—75 to 85%—have incomes under $25,000 a year. We hear mythical reports about very wealthy retirees. More than half of our seniors have no pension income other than Social Security. And half of them get less than $7,000 a year; 40% of those who receive Social Security and a pension, have a median amount of $14,400 a year.

The survey also revealed that employer-provided health care is declining dramatically. In 1988, 40% of retirees in the country had some form of employer-sponsored health care retirement help from their companies. Now, we're down to 33%. The trend is for companies to be providing less and less health care to retirees.

Twenty-seven percent of retirees have dropped employer health coverage because it had become too expensive; [this group] has increased from 21% in 1988, to 27% today.

Now, the Republicans are proposing that we raise the coverage from [age] 65 to 67. This . . . means that 4 million older Americans will lose their eligibility for Medicare. If the GOP plan is passed, about 800,000 Americans in this age range, will have two choices. If these men and women are lucky enough to be able to buy private health insurance . . . this is not an easy task for seniors—they will have to pay up to $5,000 a year and up. If they cannot get coverage or cannot afford it, they will sink into the rank of the uninsured.

Four-hundred thousand men and women between the ages of 65 and 67 live in poverty. Three-quarters of these people rely solely on Medicare and Medicaid for health insurance.

So, you see that upping the Medicare eligibility age will force these Americans to rely on Medicaid, which is also being cut—or private health insurance, which they cannot afford. They lose health insurance at a time when they vitally need it. [The states use Medicaid funds to pay all Medicare costs, including deductibles, co-payment, and purchase of premiums for the poor elderly.]

Jay Rockefeller, *(D-W.V.), chairman, Senate Democrats Medicare hearings on Oct. 6:*

I have a letter here from a group called the Corporate Health Care Coalition. The companies in it are Allied Signal, Ameritech, Amoco Corp., Atlantic Richfield, Bell Atlantic, Boeing Co., Dow Chemical, DuPont, Eastman Kodak, General Electric, etc. . . . They're big companies, and they strongly oppose raising Medicare eligibility from 65 to 67 years of age. They claim that raising the age to 67 will have a serious and immediate impact financially on those companies that have retiree health plans, and as a result could force them to limit or to eliminate what they do have.

Eugene Glover, *president, National Council of Senior Citizens, testimony on Oct. 5. NCSC, which represents 5 million older and retired Americans, was founded in 1961 to lead the fight for Medicare.*

The Republicans are trying to offer us a Trojan Horse. They want us to believe their promises to "strengthen, preserve, and protect" Medicare. . . . How do they plan to do this? Raising the age of eligibility to 67. Interestingly enough, we find more and more people are being forced to retire earlier . . . due to company "downsizing" (layoffs) or plants closing to move overseas. These people are left without any health benefits at all. Rather than lowering the age of eligibility to alleviate some of the suffering, they propose to prolong it.

The arbitrary cap on Medicare and the 'BELT'

Gail Warden, *chairman, American Hospital Association; president, Henry Ford Health System, Detroit, Michigan. Testimony on Sept. 22 to the House Ways and Means Committee. The AHA represents 5,000 member hospitals and health systems.*

The proposed reductions have been referred to as a slowdown in the rate of growth of Medicare spending—from 10% annually to 6.4% annually. . . . The deep reductions in payments for Medicare hospital services . . . lead to such small rates of increase for hospitals that they do not even cover general inflation. . . .

Donna Shalala, *secretary of health and human services, testimony before the Senate Democratic Policy Committee hearing on Oct. 5:*

The Republican plan [would] cap Medicare spending at a level that will be impossible to reach without ruining the program and causing great harm to seniors. They are saying, that in the year 2002, no matter what the health needs of our seniors are . . . no matter how much it actually costs to provide health services to seniors . . . we will have only a fixed amount of money—and that amount is far too low.

These caps . . . have nothing to do with the future costs of health care. . . .

Second, there's their radical new mechanism for implementing these cuts, which . . . they call the "BELT."

Here's how it works: If we don't hit the very low Medicare cap, the BELT requires huge reduction in payments (about $37 billion more in cuts) to doctors and hospitals in the current fee-for-service plan.

That means that all the doctors, hospitals, and other caregivers who serve patients in Medicare fee-for-service will have their fees cut arbitrarily.

Seniors and disabled citizens may find it increasingly difficult to find a doctor who accepts fee-for-service patients under Medicare.

Balance billing controls eliminated

One immediate impact of the BELT may be that hospitals and providers will shift their unreimbursed Medicare costs to the general population in order to survive. The resulting increase in health insurance premiums will force an estimated half-million Americans a year to lose their employer-covered insurance or to drop coverage themselves due to increased costs.

Another provision of the House and Senate bills would eliminate the prohibition against Medicare balance billing, which is the amount a doctor, hospital, or clinic charges to a patient above and beyond the amount covered by Medicare. Currently, in Medicare fee-for-service, doctors are allowed to "balance bill"—or charge—patients no more than 15% above Medicare's payment level. Republicans *eliminated* any amendments that would continue to limit balance billing and to protect seniors against excessive charges. It now appears that doctors, hospitals, and others can demand that the elderly pay unlimited amounts in additional charges, making office visits or hospital care financially impossible for many. Data show that the GOP's Medicare cuts will trigger such considerable cost-shifting for the general patient.

Higher fees to beneficiaries

Republicans have made lots of noise about their "choice" plans, where beneficiaries can choose health maintenance organizations (HMOs) and managed care alternatives to fee-for-service plans. Both the House and Senate Medicare bills had provisions that let insurers and HMOs charge Medicare beneficiaries premiums based on experience rating. The insurer can charge the Medicare beneficiary who has a history of heart disease or who has a disabling condition, much more than the fee that the Medicare program pays the beneficiary, because of the expected higher costs involved in treating a person with complicated medical needs. Reportedly, the House bill removed this provision.

Martha McSteen, *president, National Committee to Preserve Social Security, on Oct. 5.*

"Medicare is a remarkable success story. Seniors are universally insured. They cannot be denied coverage for preexisting conditions, lose protection if they become ill, or have a payment denied for medically needed services. Seniors have complete freedom to select the provider or managed care plan of their choice. Because payments to providers are at deep discounts from what private insurers pay, Medicare is, in effect, a nationwide preferred provider organization. Over the last decade, outlays per enrollee have grown more slowly than private outlays. All of this has been accomplished with administrative costs averaging only 2% of program outlays when you compare similar health care services. The private insurance large group market, in contrast, has administrative costs of 5.5% and the small group market 25%. . . . The private market holds no magic bullets for Medicare—its record on coverage of individuals . . . is inferior to Medicare. . . ."

McSteen correctly scores the Republican leadership's claim that quality managed care can be provided by lower fee-for-service plans as "unsubstantiated," as well as the claim that "quality care can be maintained with a cap on payments set below private-sector inflation. . . . Let's not forget that the same private sector that currently leaves one-third of the non-elderly uninsured and contains costs in significant part by restricting benefits and choices, [does so by] increasing out of pocket costs and dropping the very sick."

Use 'Hill-Burton' approach to restore health care

"Hill-Burton" is the common name for a federal law that went into effect in August 1946, which launched a major drive to expand the number of hospital beds. Only nine pages long, the bill had enormous impact in creating the health care system that is now being dismantled. Officially called the "Hospital Survey and Construction Act," the bill was a bipartisan effort, co-sponsored by Sens. Harold Burton (R-Ohio) and Lister Hill (D-Ala.)

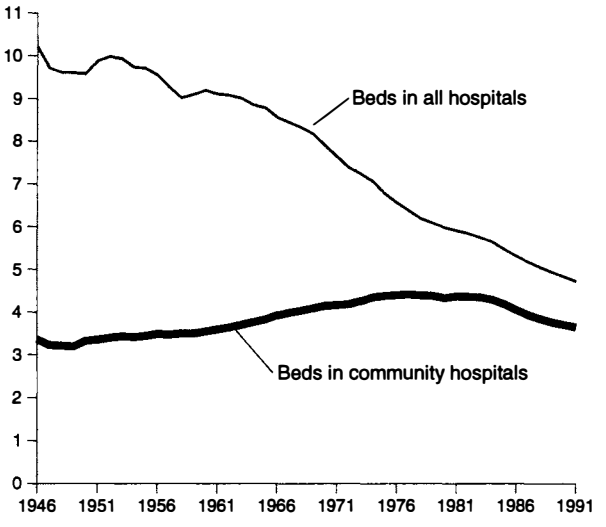
Hill-Burton called for universal care for Americans, stating that state hospital construction plans "shall provide for adequate facilities for the people residing in a state, without discrimination on account of race, creed, or color, and shall provide for adequate hospital facilities for persons unable to pay therefor."

The Hill-Burton approach was based on the physical-economic premise that even if every person had the money to pay for health care, it would be worthless unless the needed ratios of infrastructure were present to provide that care per 1,000 people—enough community hospital beds, physicians and nurses, diagnostic and treatment equipment, and so forth. The exact ratios were dependent on the medical care standards prevailing at that time, and on the disease profile of the period. For example, in the 1940s there were needs for additional hospital beds for tuberculosis patients, and special facilities, such as iron lungs, for polio cases.

The Hill-Burton Act specified that for general care, there should be made available an average of 4.5 beds per 1,000 people in all states, with local distribution made according to density of settlement. In 1946, the national average of beds for community hospitals was 3.5 per 1,000 people, and many hundreds of counties had no hospital at all.

Under Hill-Burton auspices, that average rose to the mandated 4.5 per 1,000 by the mid-1970s. Community hospitals were built all over the country. Within the first five years of the Hill-Burton Act, mortality rates fell by half for appendicitis, childbirth, and other common conditions requiring facilities for prompt attention.

FIGURE 1
Hospital bed availability, 1946-91
(beds per 1,000 people in the United States)



Sources: *U.S. Statistical Abstracts; Historical Statistics of the United States.*

Since the late 1970s, however, the needed health care infrastructure ratios have all gone into decline, and not because technological improvements have made them obsolete. Today, there are again counties with no hospitals, and hospitals without adequate ratios of nurses to patients or diagnostic and treatment equipment per population served. In such metropolitan areas as Minneapolis-St. Paul, Seattle, and San Diego, there are fewer than 3.5 beds per 1,000 people. The crisis in the rural areas is epitomized by North and South Dakota (reviewed in the accompanying testimony).

A Hill-Burton approach to restoring medical infrastructure, along with other economic and financial emergency measures, would both restore the U.S. health care system and create an economic boom. The full text of the Hill-Burton Act (Public Law 725), in effect as of Aug. 13, 1946, can be found in the public laws volume for the 79th Congress, 2nd session, Chapter 958. See also *EIR*, July 29, 1994, "Why U.S. Health Care Must Return to the Hill-Burton Standard."—*Marcia Merry Baker*

Consortium for Citizens with Disabilities Health Task Force on Medicare Reform, *comprised of over 65 national disability-related organizations, statement on Oct. 13.*

. . . While Medicare serves the health care needs of nearly 40 million seniors, it also covers 4.2 million people with disabilities below 65 years of age. Coupled with the dramatic dismantling of federal protections in the current Medicaid program, these reforms constitute a serious threat

to the health, independence, and dignity of all Americans with disabilities.

If Medicare and Medicaid are growing at unsustainable rates of increase, it is largely because the private sector has failed to adequately provide for the health care needs of the populations covered by these programs. In this respect, the Medicare and Medicaid programs represent enormous high-risk pools that skew rates of medical inflation for public versus private health programs.

Comparing the growth in Medicare spending to the recent decline in private insurance spending fails to recognize that the number of Medicare beneficiaries is growing and these persons tend to use more health care services, while employer-sponsored health care is declining and those who are covered tend to be less frequent users of health services. In fact, over 1 million people under the age of 65 become uninsured each year.

Dr. Thomas Peters, *director, health and human services for Marin County, California; chairman, Association of Bay Area Health Officials; executive committee, County Health Executives Association of California, testimony to the House Democratic Caucus on Sept. 27.*

I have given 22 years of services to the public sector. . . . I must tell you, from what I understand of the "reform" proposals now being outlined in Congress, the American health care system and the health of all Americans is being threatened. . . . I am frankly astounded, flabbergasted and chagrined. Astounded—because the hearings of such a complex and critical matter for the country must be held outside the chamber of Congress. Flabbergasted—because . . . in California, for even a fraction of the changes being proposed, we would have to hold, under mandate of law, specific, detailed hearings on the cuts and their likely impact. . . .

If the health care field had the equivalent of a District Attorney, this plan would be subject to three violations, each filed as a felony: *Fraud,* because there's no verifiable data that the magnitude of Medicare's problem requires $270 billion in cuts. *Extortion,* because by simply declaring the problem is so severe as to warrant a half-trillion dollars in Medicare/Medicaid cuts, means that billions will be extracted from the country's medical providers. . . . This would undeniably undermine the basic financial structure of U.S. hospitals, clinics, nursing homes, and medical offices. *Assault:* Count 1 will be assault against seniors, for they are the ones most immediately pounded by these proposals. The sicker they are, the more outcast they will become; Count 2 will be assault against working Americans. Not only will they invariably be paying much more for their health care (through cost-shifting), but they will also find the health care network on which they depend will be weakened and more inaccessible.

GOP will close 25% of nation's hospitals

Republican Medicare reforms not only severely reduce hospital reimbursement dollars for treating Medicare patients, but they would impose massive cuts in or the elimination of Medicare funds to hospitals for a host of programs—each directly linked to providing the nation as a whole with critical services, such as burn units and trauma centers. When details of these cuts got out, Gingrich attempted to mollify provider groups. For example, the House bill would have eliminated all funds for foreign medical graduates—upon whom the majority of our inner-city public hospitals depend to treat their overwhelming share of poor patients. Without these residents, public hospitals couldn't function. Instead, Gingrich made a "deal"—to cut the program by 75%.

The more a facility depends on federal funds, the larger its crisis. About 40% of the average U.S. hospital's gross patient revenues is attributed to Medicare. According to the American Hospital Association, Medicare and Medicaid patients combined generate over half of the gross patient revenues for 83% of all community hospitals (nearly 4,400 hospitals). Some 1,300 hospitals (one-quarter) have particularly large Medicare patient loads—60% or more of their patient days are Medicare patient days; 2,300 hospitals (44%) have particularly large Medicaid patient loads.

House Majority Leader Dick Armey (R-Tex.), who authored the Contract with America, had predicted that as many as 25% of all U.S. hospitals will close. That is, as a study by the American Hospital Association found, that the proposed reductions in Medicare hospital payments do not "slow the growth" or "reduce the growth" in Medicare. The cuts "do not allow hospitals to keep pace with overall inflation, projected to increase at an average of 3.3% per year through 2002." The Medicare reductions "could result in real cuts in Medicare spending per person for hospital services, *below* the overall growth in inflation."

Lynne Fagnani, *vice president, National Association of Public Hospitals, press conference on Oct. 16. NAPH's members include over 100 metropolitan area safety net hospitals. With combined revenues of over $17 billion, these hospitals provide more than 90% of their services to Medicare, Medicaid, and low-income uninsured and underinsured patients. They provide many preventive, primary, and tertiary services to entire communities, not just the poor and elderly. These services include maintaining a wide variety of round-the-clock standby care, such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, crisis response units for both natural and man-made disasters:*

Reducing spending in the Medicare and Medicaid programs by almost half a trillion dollars over seven years . . . will destroy both programs and disenfranchise tens of millions of elderly and low-income Americans. Essential providers such as NAPH member hospitals have traditionally been the sole source of critical health care for these individuals. . . . Fifty-five percent of NAPH members' gross revenues come from Medicare and Medicaid, a full 33% fall into the "self pay/other" category. On the outpatient side, "self-pay/other" makes up 47% of our gross revenues. Unlike most other hospitals, "self-pay/other" patients for safety-net institutions are essentially "no pay" patients—they simply do not have the means to cover their bills, and our hospitals do not recover the bulk of this revenue. The impact of reduced support for such patients due to budget reductions and health system reform is already graphically evident in metropolitan areas as diverse as Los Angeles, Memphis, Washington, D.C., New York, New Orleans, Milwaukee, and Boston, where safety-net hospitals are proposing to close, eliminate many services, or to merge with or be purchased by private organization or entities.

Reductions of the magnitude contemplated in the House and Senate Medicare/Medicaid bills will simply accelerate the spread of this trend into most American cities, and many underserved rural areas as well. We estimate that the impact of the proposed Medicare legislation would be over $300 million in reductions in the year 2002, or 12% of our members' Medicare revenues—primarily due to cuts in disproportionate share hospital payments and graduate medical education funding. . . . Medicaid reductions will cause NAPH hospitals to lose $4.6 billion in Medicaid revenues in 2002, or 31% of their Medicaid revenues. The Urban Institute has estimated that almost 9 million Americans will lose health insurance as a result of eliminating individual entitlement to Medicaid coverage combined with $182 billion in Medicaid reductions. The loss of these revenues, coupled with the increases in the number of the uninsured, will devastate safety-net hospitals—seriously compromising their ability to care for low-income communities as well as to continue to provide specialized services to the community-at-large.

Timothy McMurdo, *CEO, San Mateo County General Hospital; CEO, Division of Hospitals and Clinics, San Mateo County, California, testimony on Oct. 5:*

The proposed cuts will have a catastrophic effect on hospitals and clinics that have heretofore relied on the stability of federal and state payments to help cover the costs of care. This reliance has grown increasingly important since private insurance carriers continue to cut payments to hospitals and physicians and as the number of uninsured people continues to grow. . . .

[The loss of Medicare and Medicaid dollars] will put hospitals that are currently in financial jeopardy . . . at a much higher level of risk of closure or significant curtailment of programs or personnel. . . . Heavily utilized public hospitals will be required to take an even greater burden of uncompensated care as resources at private hospitals to provide charity care dwindle and as those once eligible to receive Medicare and Medicaid now find themselves in the ranks of the uninsured. . . . Ultimately, counties will bear the brunt of the financial responsibility for caring for this increased number of patients dispossessed by Medicare and Medicaid. If county revenues are not available . . . access to important medical services will be reduced or eliminated.

[Under the proposed GOP cuts, San Mateo General will have to cut over 80 doctors, nurses, and other staff; curtail 500 acute care inpatients and 7,000 outpatients per year; and cut services for mentally ill, disabled, and elderly patients, and public health nursing.]

Hospitals on the San Francisco Bay Area Peninsula are also major employers that spend in the aggregate approximately $200 million per year for over 5,000 employees. . . . Cuts will affect local economies as well . . . if major job losses result.

Teaching centers threatened

The following demonstrates how integrated Medicare and Medicaid are with public and teaching hospitals, and burn and trauma care centers. Cripple one, and the other centers, patients, and the region suffer.

David Jaffe, *executive director-CEO, Harborview Medical Center, Seattle, Washington, testimony on July 25.*

Harborview is a King County-owned facility, managed by the University of Washington's School of Medicine. Harborview is the only Level 1 trauma center in the State of Washington, and along with its Regional Burn Center, serves patients from Washington, Alaska, Montana, and Idaho. This region represents approximately one-quarter of the land mass of the United States. These critical emergency care programs serve as models across the country, as does the Medic One Emergency Response Program for which Harborview was the first home.

Harborview has 48% of its patients reimbursed through Medicaid (one of the highest percentages in the country), 19% through Medicare, 25% through private insurance, with 9% no-pay. Note that Harborview receives no operating support from King County.

Harborview is central to the unique role of the University of Washington's School of Medicine—the only medical school in the Washington, Alaska, Montana, and Idaho region . . . which trains, places, and supports retention of providers in the four states. Harborview is one of the pivotal patient care, teaching, and research institutions in this . . . regional partnership. The salaries of full-time staff are supported through the services provided by them at Harborview . . . 123 residents in general and speciality fields . . . [are] an

Medicare cuts mean higher local taxes

This interview with Donald Hume, a Democratic state representative from southern Indiana, was conducted by Marianna Wertz on Oct. 19.

EIR: The Republican version of the Medicare cuts will probably pass shortly in Congress. President Clinton has threatened to veto it. You are involved in a fight to prevent the shutdown of at least two rural hospitals in your district. What do you have to say about this issue?
Hume: The only thing I can say on this is that I hope that our congressman in the 8th District [John N. Hostettler, R] definitely does vote against it. I hope that he sees fit to vote against it, because it will be quite a blow to the rural hospitals, even though they have made some adjustments. So many of them are running right on the line or in the red, and they're doing a lot of charity work right now.

EIR: Is there a threat of shutting down two of the rural hospitals there?
Hume: There's always that threat, even in good times, and if you take away what they have now, it's going to make it worse than ever.

EIR: And that's what would happen under the Republican plan?
Hume: I think it would.

EIR: Have you talked to the congressman about it?
Hume: I've called down to his office but I haven't gotten any response.

EIR: Have you heard from your constituents and how they feel about what's going on there?
Hume: Yes. They're not at all happy about the whole Republican plan. A lot of people realize that if we don't take care of the indigent as a nation, then it falls back onto the locals in the form of poor relief, and then that goes directly onto the property tax rolls. And property taxes are not popular as it is, they're much too high.

EIR: So, it's just passing the buck.
Hume: Yes. Lindell [Sen. Lindell Hume, his brother] and I have been trying to get less property taxes, and instead of that, it seems like on a state level we have a Republican-led House and Senate both, and they seem to be pushing welfare-type cuts down to where it will be forced onto the property taxes.

I think that people are tired of too much government, but when they look at some of the things that the Republicans are doing, shifting the load from the rich more to the poor, I think they realize that it's not altogether just too much government, but it's what kind of government.

integral part of the University of Washington's educational, training, and research programs. The School of Medicine, with Harborview being one of its primary focuses, maintains one of the largest National Institutes of Health-supported research programs.

The impact of the proposed . . . cuts [$185 million over seven years] on Harborview will be devastating. . . . It is not by chance that we must depend on Medicaid and Medicare to provide many of the services needed by our patients. Trauma and burns for instance, are not limited to people with insurance, and they are not personal choice. They are the result of accidents—a car running a stop light, a boiler in a ship exploding. The proposed cuts will severely limit our ability to provide these services.

The impact of these reductions is exacerbated by the disproportionate cuts being proposed for medical education. The primary purpose of our residency programs are education and training. Nonetheless, Harborview's ability to provide Level 1 trauma services depends on having advanced house staff available 24 hours a day in the hospital. A substantial part of the cost of those staff is paid by Medicare. Also, the indirect part of medical education payments reimburses us for our disproportionate percentage of services provided to sicker and poorer patients.

Harborview's problems, and those of many providers of basic services, cannot be solved by caring only for those with insurance. . . . Our hospital is full, so we cannot just increase our volume. . . .

Our community . . . [and] Washington State [have] been supportive of Harborview, recognizing the critical regional role we play. Washington State, however, cannot pick up the slack . . . from cuts in federal funding.

Gerald E. Thomson, *MD, president of the American College of Physicians, the nation's largest medical specialty society, testimony before the Senate Democratic leadership, Oct. 5.*

"Neither Medicare patients nor the health delivery system can absorb the magnitude of the budget cuts proposed. We do not believe that the health care system can absorb the loss of half a trillion dollars in public spending in the next seven years," Thomson said. He was critical of cuts to teaching centers that "play a unique and precious role in developing and delivering high-technology medicine," and pointed out

that the House GOP eliminated funds for hospitals to train residents in subspecialties such as cardiology, gastroenterology, and neurology.

The attack on rural America

Historically, the health needs of farming and rural towns have been underserved, mainly because Medicare reimbursed rural hospitals and doctors at a much lower rate (as little as 52% in 1987) than it paid urban providers for treating Medicare patients. The rationale is that it is less costly to deliver health care in rural areas. In reality, rural facilities have to offer doctors and others higher wages to relocate and work in isolated, rural areas. According to the National Rural Health Association, in 1994 the average payment for a Medicare beneficiary served in an urban setting was $850 more than that paid for a beneficiary served in a rural area.

Leon Panetta, *White House chief of staff released a report on the impact of the GOP budget on rural health care and states on Oct. 11:*

. . . Health care generally in rural America is very tough—tough on families that live in those areas because of the distances and lack of care. There are few and far between hospitals in that part of the country, and the ones that are there depend for almost 50 to 80% of their revenues on Medicare and Medicaid.

In the 1980s, when there was a Medicare cut, 367 rural hospitals were closed. The average reduction in hospitals in this country, closures of hospitals, was about 8.8%. In rural America, it was 17%.

The budget that the Republicans propose would cut $58 billion from Medicare in rural America and about $45 billion from Medicaid. That's over $100 billion in cuts in health care coming out of rural America. About 9.6 million seniors and disabled who depend on Medicare would have their premiums increased and their benefits severely cut; 2.2 million would be denied coverage.

Rural families would suffer almost a $9 billion cut in their income because of the severe cuts in farm programs (almost $13 billion), and a 40% cut would take place on grants and loans that . . . help rural families clean their water—almost 900,000 families would not have access to safer drinking water.

Kent Conrad, *senator, (D-S.D.), Oct. 11:*

I've likened the Republican budget plan to the neutron bomb. . . . You drop the bomb. The buildings remain, but the people are gone. The combined effect of the Republican plan . . . would mean the loss of about a third of the farms in North Dakota. . . . About 8,000 or 9,000 farmers would be forced off the land in the State of North Dakota, out of 30,000. . . .

On rural hospitals, cuts of the magnitude that are going through Congress now would mean 26 hospitals out of 30 rural hospitals in North Dakota would go to negative returns. Medicare patients make up 70% of their hospital populations.

We just had a meeting of all the hospital administrators and nursing home administrators in North Dakota. One after another stood up and said, "If these proposals go forward, we're going to close. Whether we close quickly or it takes a couple of years, we cannot survive with cuts of this magnitude.". . .

Tom Daschle, *(D-S.D.), Senate Minority Leader, Oct. 11:*

The Republican budget . . . cuts Medicare for rural Americans by 20%—in the year 2002. It also cuts Medicaid. It eliminates coverage for 1 million children; 230,000 older Americans, 350,000 people with disabilities; 77,000 rural older and disabled Americans would be denied nursing home coverage; and, 55,000 rural and disabled Americans would be denied home care benefits. . . .

The South Dakota Hospital Association will tell you that the Republican plan to raid Medicare and Medicaid could force at least 10 and perhaps as many as 15 of our 51 rural hospitals in my state to close their doors. Half of all South Dakotans live in rural America. Imagine if your child wakes up in the middle of the night with a burst appendix, or your father suffers a heart attack, and the closest hospital is a hundred miles away.

Paul Wellstone, *senator, (D-Minn.), Oct. 9:*

In 1993, ninety-eight of our state's 140 community-based hospitals received at least half of their revenue from Medicare and Medicaid. . . . Many hospitals in small agricultural communities count on Medicare for 60 to 70% of their annual revenue. In the last nine years, 22 community-based hospitals have closed across the state. Medicare is also the largest explicit payer of graduate medical education.

Currently, 43% of Minnesota hospitals lose money on Medicare. If the $270 billion in GOP cuts are approved, 67% of the hospitals will lose money on Medicare. Those losses will have to be made up for by another source. . . . $100 billion of the cuts in federal spending will be shifted to private insurers. Families already struggling to pay for the high costs of medical insurance, will be forced to pay even more. . . .

Most Medicaid spending in Minnesota—about 60%—is for long-term care. Over two-thirds of nursing home residents in Minnesota rely on Medicaid to pay the staggering costs of nursing home care. Regional treatment centers, group homes, respite care, residential- and home-based services are all paid by Medicaid. As for the TEFRA program, which allows over 3,000 Minnesotan children with severe disabilities to be eligible for Medicaid based on their income and thus receive in-home family supports and health care . . . what's going to happen to kids? Nobody has any idea right now how all these programs would be affected by the proposed cuts. Clearly cuts will be made and protection eliminated. [TEFRA, the Tax Equity and Fiscal Responsibility

Act of 1982, allows disabled children under the age of 18, who required the level of care provided by a hospital or nursing home, to receive that care, if it is appropriate, within the community. TEFRA is a Title XIX provision of Medicaid. The GOP bill eliminates Medicaid and Title XIX.]

From a teleconference with President Clinton and rural hospitals on Oct. 12.

Don Sipes, *CEO, St. Luke's Northland Hospital, Smithville, Missouri:*

. . . If these Medicare cuts are approved, rural hospitals, and the communities they serve, stand to endure the greatest losses. . . . There are 132 hospitals in Missouri, 64 of which are in rural areas. Right now, 24 of them are operating out of reserves or on borrowed funds. With the proposed caps, Missouri hospitals will lose $315 million. . . . That means no money for equipment, facility updates, new service, or, for attracting new doctors and nurses.

H.D. Cunnington, *administrator, Jay Hospital, Jay, Florida:*

These tremendous cuts . . . would probably force Jay Hospital to close, [and] disrupt the health care system in this rural area that has been developed by the Baptist Health Care Affiliates in Pensacola. . . . And I also think it would be devastating to the community of Jay through the economic impact that would be felt by the loss of jobs totaling in our areas about $3.4 million [in salaries and benefits]. . . .

We're providing not only hospital inpatient care, skilled nursing, emergency care, [but] we also have rural health clinics, home care in rural areas; we provide diagnostics. . . . If the hospital closes, these other components of the health care system close as well.

John Kelly, *administrator, Soldiers and Sailors Memorial Hospital, Penn Yan, New York:*

We're one of the poorest counties [Yates County, upstate] in New York State. We're the largest employer in the county [providing medical-surgical, psychiatric, long-term care, outpatient mental health services, and local emergency medical services coordination]. The GOP proposals are real threats to the physical, the mental, and the economic health of this community.

Margo Arnold, *CEO, Westfield Hospital, Taft, California:*

. . . I can guarantee you that our hospital will not be able to sustain [the cuts]. We have no reserves. . . .

The rural hospitals save lives on a daily basis.. They're delivering those babies if they can't make it to Bakersville. If there's an industrial accident out there in the oil fields, we're there to save those people's lives; to stabilize them before they're transported to a larger facility if it's a life-threatening situation.

What's going to happen when we're not there anymore? Where are these people going to go? What's going to happen to our doctors and their families?

Todd Lyndon, *CEO, Grinnell Regional Medical Center, Grinnell, Iowa, Oct. 12:*

Iowa has the highest percentage of citizens over age 85 in the nation; and the third highest for 65 and older, yet, Iowa hospitals are paid almost 20% less per case than the national average Medicare beneficiary recipients. . . . [The GOP's Medicare vouchers for HMOs and other plans are worth half of those received by their counterparts on the West Coast or New York. How can Grinnell provide all the services of a New York HMO when] we receive less than half the premium from Medicare than a New York plan. . . . There's simply no way that much money can be taken out of the system by the year 2002, without real reduction in patient care. . . .

[Instead], more support for continued research into telemedicine [which can improve access and quality, reduce isolation, and travel costs] is an example of the kind of things, along with dealing with these devastating cuts that's extraordinarily important for us to be able to have the tools to really take care of our patients.

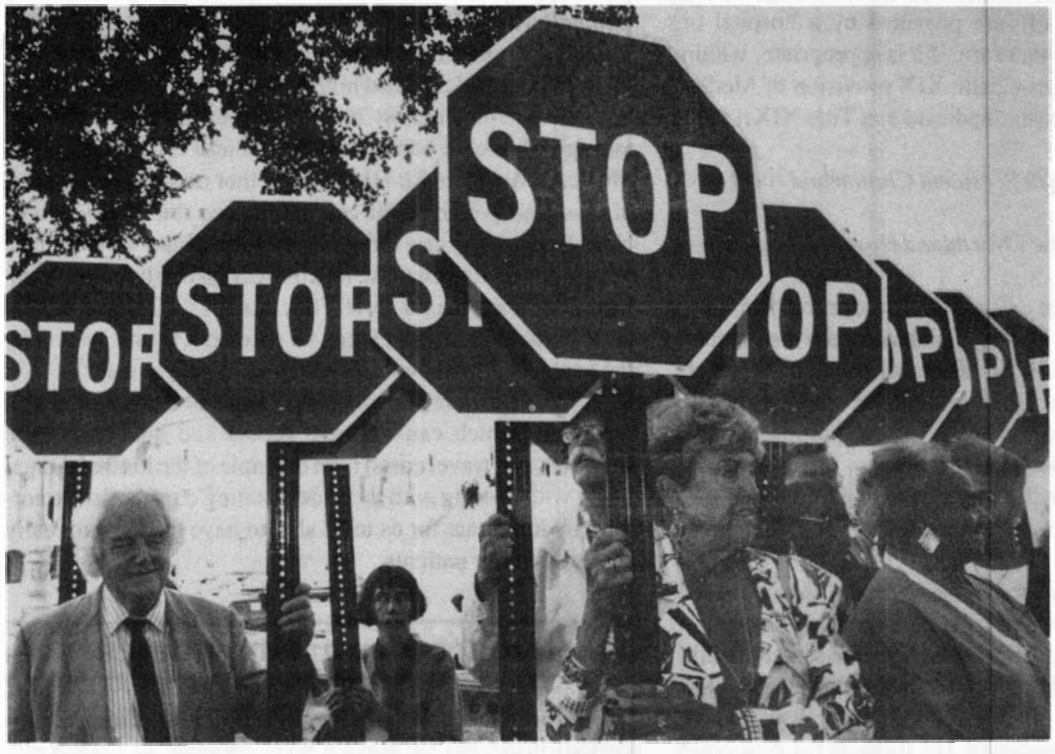
The impact on nursing homes

The Republican Congress has decided to eliminate protections mandated for nursing home patients, as a result of a nationwide Institute of Medicine study ordered by Congress in 1986.

Through their Medicaid block grants to the states, the GOP has eliminated any right to Medicaid- and Medicare-provided nursing home care for 10 million elderly and disabled individuals. About one in four are likely to lose all aid. About 70% of all Medicaid funds go toward long-term nursing home care for this group.

Morris J. Kaplan, *attorney; owner, administrator of Gwynedd Square Nursing Center, Lansdale, Pennsylvania, testimony on Oct. 6 before Senate Democratic Caucus hearings:*

The block grant legislation sacrifices the needs of senior citizens to balance the budget . . . in three ways: 1) It eliminates a fundamental entitlement that seniors now have—the right to Medicaid coverage for nursing home care when your own funds have been used up. Seniors have the assurance that if they suffer catastrophic, long-term illness and they deplete all their funds, or if they are simply too poor . . . the Medicaid program will pay for their nursing home care. The block grant legislation eliminates this safety net for the elderly. 2) It specifically repeals one of the only pieces of federal law that protects residents of nursing homes from abuse, neglect, or bad care—the Nursing Home Reform Act. 3) Most significantly, the block grant legislation will likely mean that funding for nursing home care will be drastically cut. The federal government is giving up full responsibility for nursing home care and is transferring it to the states . . . [and is] cutting out the money needed to pay for the program.



The Save Our Society (SOS) Coalition to Protect Social Security holds a press conference to protest cuts in Medicaid and Medicare, in Washington on Sept. 29. Contrary to claims that wealthy retirees are ripping off the Social Security system, more than half of America's senior citizens have no pension income other than Social Security, and 75-85% of Medicare beneficiaries have incomes under $25,000 a year.

The block grant legislation will over seven years cut $67.8 billion from beneficiaries who depend on it for nursing home care. This is an extraordinary amount! This is a major dismantling of the safety net for seniors. The states will be free to make new rules as to who can qualify for nursing home services and they can simply deny these services if their budgets don't allow it.

The Nursing Home Reform Act provides minimal federal standards for good quality care. The act's requirements are not a burden or an inconvenience. They are common sense requirements for providing competent staffing, training, care planning, and respect for residents' rights. They are not over-regulation. They are only over-regulation and a burden when the government slashes the funding as proposed and makes it impossible to provide good care. The legislation also seeks to repeal the Boren Amendment. The Boren Amendment is another common sense law that requires that "economically and efficiently" operated providers receive "reasonable and adequate" reimbursement in order to meet state and federal standards of care. The block grant legislation simply says we're not going to pay a reasonable and adequate amount anymore, [and], consistent with this legislation, lower the standards of quality, because it takes money to have good quality.

My facility has been nationally recognized by consumer groups and organizations around the country for providing outstanding quality care. We have been recognized as a model for good care consistent with the requirements of the Nursing Home Reform Act. Let me tell you first hand, good care costs money. The House Medicaid funding for nursing home care in Pennsylvania will be cut $1.9 billion over the coming years. That is staggering! Where do you cut? It is simply not possible to drastically cut nursing staff that frail residents need and depend upon. It is not possible to deny supplies and treatment for the sick and infirm elderly. Seniors must stand up and say, "No! Don't balance the budget on the backs of the sick and dying."

Joshua M. Wiener, *Ph.D., senior fellow, the Brookings Institution, Oct. 6, testimony before Senate Democratic Policy Committee. Dr. Wiener provides ample footnotes of innumerable studies for most of his assertions which we are unable to include:*

The Congress is considering proposals that would drastically change Medicaid—the federal, state health insurance program for the poor—from an open-ended entitlement program with a number of federal requirements, to a block grant to the states with few strings. Under the plan, federal expenditures would increase at far below historical experience or the rate needed to preserve the existing program. The congressional budget resolution calls for $182 billion in Medicaid cuts by the year 2002, leaving expenditures about 30% below what they would be under current law. Over the long-run, the rate of increase in Medicaid expenditures will be held to about 4% a year, well below the rate of increase for private health insurance.

These changes will have a major impact on the elderly and disabled, who account for two-thirds of Medicaid expenditures. Spending for long-term—nursing homes, home and

community-based services, and institutions for the mentally ill and mentally retarded—account for about 35% of Medicaid expenditures. Over three-fifths of all nursing home and almost all intermediate care facilities for mentally retarded (ICF/MR) residents are dependent on Medicaid to help pay for their care. No other part of the health care system is as dependent on Medicaid as is long-term care. This heavy reliance reflects a lack of either public or private insurance coverage.

Advocates of block grants argue that large program savings can be achieved by allowing states 1) to be tougher on nursing home patients who transfer assets to appear artificially poor, and by allowing states 2) to require adult children to help pay for Medicaid nursing home care. They . . . argue that 3) detailed federal requirements that protect community-based spouses of nursing home patients are unnecessary. But there is little data to support the claim of large potential savings and [there are] strong policy reasons to retain federal protection.

Although many people identify long-term care with nursing homes, the predominant provider of care for persons with disabilities is the family. Only about 21% of the disabled elderly are in nursing homes. The rest are in the community, mostly in their own homes. Those with severe disabilities are more likely to be in institutions, but even among the severely disabled, considerably less than half are in nursing homes.

Nursing home residents are primarily very elderly, severely disabled, white widows. Among the elderly population, almost half of nursing home residents are age 85 and older. Over three-quarters of nursing home patients are women and 87% are not currently married. Over 70% have problems performing three or more activities of daily living (eating, bathing, dressing, toileting, getting in or out of bed, and getting around indoors). Although only about 5% of the elderly are in nursing homes on the average day, persons who live to age 65 face over a 40% chance of spending some time in a nursing home before they die, and about a 20% chance that they will spend more than a year in an institution.

The strong role of the family in long-term care runs counter to the myth that American families, who supposedly took care of their aging relatives at home "in the good old days," are now "dumping" them in nursing homes. In fact, in the past, few families cared for elderly parents because relatively few people lived long enough to experience a prolonged period of disability. Because of increased longevity, the odds of being called upon to provide parent care are much higher now than in the past.

- *Transfer of assets:* In the last few years, policymakers and the media have focused attention on the growing number of middle- and upper-income elderly who transfer, shelter, and under-report assets in order to appear poor and thereby gain Medicaid eligibility for nursing home care. Federal law and regulation as amended . . . (1993) prohibits transfer of assets. . . . Observers claim that as much as $5 billion—20% of nursing home expenditures—could be saved by ending so-called Medicaid estate planning. Recently, in justifying the Medicaid block grant, Speaker Newt Gingrich stated that transfer of assets to gain Medicaid eligibility by millionaires was "a very common problem.". . . The available evidence suggests that the numbers are small. . . .

The disabled elderly population is disproportionately poor and has little . . . of financial assets to transfer. . . . Two-thirds of the disabled elderly admitted to nursing homes had incomes below 150% of the federal poverty level; only 7% had incomes of 300% of the poverty level or higher. . . . Logically, an individual cannot transfer large amounts of assets unless they have large amounts of assets.

- *Family supplementation:* Federal Medicaid law (1965) has prohibited states from holding adult children financially responsible for their parents. In addition, nursing homes must accept Medicaid reimbursement as payment in full. Under the proposed block grant, these requirements would be repealed and states would be allowed to require adult children to contribute to the costs of nursing home care for relatives who are nursing home eligible. States could also . . . require relatives to supplement Medicaid reimbursement to nursing homes. . . . A policy of family supplementation would . . . save little money.

[That] policy might discourage people who need institutional care from seeking it, because they do not want to burden their kin.

Family supplementaion policy could be inequitable. While the state could enforce family contribution requirements on in-state relatives through garnishing or attaching wages and placing liens on property holdings . . . identifying out-of-state relatives and forcing them to pay . . . could not be accomplished in most cases. In Idaho's family responsible initiative, about half of all identified relatives lived out of state. Is it fair that in-state relatives have to pay and out-of-state relatives do not?

The estimated net savings for a national family responsibility initiative in 1983 [was] only $25 million. . . . The Idaho family responsibility program had a projected goal of $1.5 million annual collection from relatives but succeeded in collecting less than $32,000 in its six months of operation.

- *Spousal impoverishment:* Under spousal impoverishment provisions of the Medicare Catastrophic Coverage Act (MCCA) (1988), states are to permit the non-institutionalized spouse to retain a minimum level of the couple's income and assets. . . . The goal was to allow community-based spouses to continue a decent standard of living and not to be unduly "punished" bcause the other spouse requires nursing home care.

Prior to the MCCA . . . the nursing home resident had to use them to help pay for their care. . . . This left the community spouse with only $2,000 in assets. If the husband was institutionalized, he had to contribute all of his income toward the cost of nursing home care . . . [and] was allowed to send only a minimal allotment to the community-based wife for her support. In most states, the maximum income allowed was two-thirds of the federal poverty level. As a

result, a spouse (usually the wife) of a Medicaid nursing home patient who had little or no income of her own was forced into poverty. The spousal impoverishment requirement . . . prevents the spouse of a nursing home patient from becoming destitute.

[Dr. Wiener concludes that block grant advocates intend to repeal all these protections—without so much as a general blueprint on how states could slow the rate of increase in Medicaid expenditures simply by making the program more efficient. They will repeal these protections when all the data suggest there would be little savings. If there are problems in these protections, then changes can be made without eliminating individual entitlement and shifting to block grants.]

- *Interaction of Medicare and Medicaid:* The effort to "reform" Medicare and Medicaid as separate programs fails to recognize the vital interaction of these programs on beneficiaries who are dually eligible. The House and Senate leadership's Medicare plan allows managed care plans to charge beneficiaries for deductible and co-payments as high as traditional indemnity plans. An open question remains whether low-income Medicare beneficiaries will be able to receive the covered services they need when they cannot afford these deductibles or co-payments. This problem is crucial because the Republican leadership intends to eliminate the Medicaid entitlement, thereby eliminating the guarantee of subsidies for low-income elderly persons who cannot afford Part B premiums.

Guaranteed treatment and home care eliminated

The GOP has dropped all guarantees for severely disabled individuals of all ages to receive Medicaid. To secure the vote of Sen. John Chafee (R-R.I.) for the Senate Medicaid bill, Republicans, in a Senate Finance Committee mark-up, voted overwhelmingly for Chafee's amendment that would guarantee Medicaid coverage "for pregnant women, children age 12 and under, living in families below 100% of the federal poverty level, and to individuals with disabilities." Days later, behind closed doors, several GOP committee members, in an unprecedented action, dropped the official recorded amendment and eliminated Medicaid eligibility for 4.9 million physically and mentally disabled Americans.

A provision to allow states to use a portion of their block grant on these groups is in both bills, but it is up to the states to decide what they will spend, and on whom. There is no definition of what constitutes a disability.

The TEFRA provision

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 is a Title XIX provision of Medicaid. The Republican Congress would completely eliminate Medicaid, and all of the Title XIX provisions. TEFRA allows children with severe disabilities who are under the age of 18 and are eligible for Medicaid based on their income, and who require the level of care provided by a hospital or nursing home, to receive that care, if it is appropriate, within the community, and to receive in-home family support and health care.

Advocates have told *EIR* that the end of TEFRA would cause severely disabled children to be institutionalized; the Medicaid block grants will also eliminate federal guidelines and Medicaid funding for virtually all intermediate care facilities for mentally retarded (ICF/MR) residents who are dependent on Medicaid to help pay for their care. Instead of training and therapy, these residents would be "warehoused." But, because the Republican Congress would eliminate any legal right to Medicaid eligibility, it is not clear that any of these vulnerable populations would even get that.

Further, for two decades, the courts on all levels have allowed the outright murder by starvation of institutionalized disabled individuals of all ages, because some proponents, ethicists, and doctors allege that these individuals have a "poor quality of life." Their "medical treatment," i.e., their daily tube feedings, was deemed "medically futile" because it didn't cure the patient or return him to health. This rationale was deemed, by Virginia and Massachusetts courts, as cause to starve patients.

Amid the focus on cost-efficient care, an ominous movement was forged among medical professionals, self-appointed medical ethicists, economists, euthanasia advocates, and utilitarians who all determined that providing life-saving medical treatment for severely handicapped newborns, or terminally ill patients, was "medically futile" and that society (and the Medicaid program) could make better use of that money. The argument proposed by one such group, which includes the notorious former governor of Colorado, Richard Lamm, is that the monies and resources spent on saving the life of one such infant, could be used to immunize hundreds of children.

The Third Reich used similar rationales to kill the mentally retarded and handicapped—they wanted those monies, hospital beds, and staff for their soldiers.

Today, the rationale for the Conservative Revolution's denial of the poor's right to life-saving treatment, i.e., Medicaid (the only insurance program available to them), is that this denial is needed to balance the budget.

The impact on hospital nursing staff

Mary Foley, *MSN, RN, second vice-president, American Nurses Association, to the House Democratic Caucus hearings on Sept. 28:*

. . . We know that pressure to contain costs already means that fewer people are admitted to hospitals. And those who are admitted are sicker, stay fewer days, and have fewer

registered nurses providing their care. RNs often care for twice as many patients as they did a few years ago, and proposed cuts in Medicare are likely to exacerbate this already precarious and alarming current situation. In the face of such cuts, hospitals are likely to reduce staff further, despite research indicating that with more RNs, there are better patient outcomes.

Decisions based upon a requirement to find massive savings in a very short time to meet arbitrary budget cuts will inevitably lead to poorer care for all patients and intolerable working conditions for nurses.

These costs-savings will be illusory. Providing a lower level of care, a less safe level of care, will result in more patient complications, in longer patient hospitalizations, and will cost the Medicare system and the entire health care system in terms of financial and human costs. . . .

There have been highly publicized examples of tragic, and sometimes even fatal, mistakes occurring at hospitals. The kinds of reduction proposed for these entitlements could result in an increase in similar kinds of errors as hospitals continue to lay off staff to cope with these latest constraints. . . .

Joan Swirsky, *RN, MS, CS; editor-in-chief,* Revolution, the Journal of Nurse Empowerment*; organizer of the March 1995 nurses march on Washington:*

. . . The bill is predicated on a drive for managed care—which, as everyone knows, means "managed" by insurance companies and *not* by health care providers. In addition, it is designed to fill the coffers of insurers and managed care companies and to cut back on fee-for-service health care delivery. . . .

Hidden in all of this is the fact that the care elderly people will receive as a result of this cut will not only be minimal, but largely unprofessional. Why? Because the preamble to this bill has already been taking place in hospitals across the nation that have slashed their registered nurse staffs and replaced them with unlicensed aides and technicians who have had only 3 to 12 weeks of training.

As people age and their health declines, many have multiple illnesses which require expert clinical care. Today—and certainly in the future—patients who need IVs calibrated, several medications administered, wounds dressed, tracheotomies suctioned, the list goes on, are being attended by uneducated, minimally trained personnel with little of no clinical experience.

Gwendolyn E. Johnson, *MA, RN; American Nurses Association, which represents 2.2 million registered nurses; staff nurse, D.C. Metropolitan Hospital, Oct. 17:*

. . . We call for strengthening and enforcing patient safety regulations to prevent hospitals from staffing at unsafe levels, and we call for requiring disclosure of staffing levels and mix by all hospitals that receive Medicare funding.

. . . Nurses are already alarmed about the safety and quality of care in hospitals today, and these reductions in Medicare will further wound the already-limited access to care, the deteriorating quality of such care, as well as the uncertain status of employment in many communities.

. . . According to the Congressional Budget Office, Medicare spending over the next seven years is expected to rise by 4.9% annually compared to 7.1% for private health benefit expenditures. When you consider the health needs of the elderly and disabled compared to those covered under private plans, it is simply not possible to curtail the growth in Medicare outlays to this level [$270 billion].

Patient care is already suffering as hospitals have reduced their RN [registered nurse] staffing and transferred a number of complex patient care functions, such as giving medications and inserting catheters, to nurses' aides and their unlicensed personnel who have only a few weeks of training. For instance, in Indiana, the Attorney General is investigating charges that janitors and other non-nursing personnel have been providing care that only licensed professionals are legally allowed to provide. . . .

This Congress is headed in a direction that will negate any stride that has been made to protect vulnerable consumers.

GOP eschews medical advances

For all his twaddle about saving Medicare for the next generation, Gingrich seems to work harder on making sure there isn't a next generation or the advanced medical sciences needed to support it. For example, the House Ways and Means Committee specifically passed an amendment to provide funding for the use of oral anti-nausea drugs that are known to have save tens of thousands of lives in the fight against cancer since their development for NASA astronauts in the 1970s. This generation of anti-nausea drugs allowed many more patients to tolerate their chemotherapy and cancer-fighting treatments long enough to defeat the disease. Previously, patients were often so debilitated from nausea and vomiting, that they gave up treatment and died as a result. The GOP decided to eliminate this life-saver altogether from their bill.

Martha McSteen, *National Committee to Preserve Social Security and Medicare, Oct. 5:*

[The GOP "quick fix" approach to budget deficits is] self-defeating over the longer term. For example, by constraining funding for research into the diseases of aging, this nation may be turning its back on the most promising long-term hope for slowing the growth in Medicare costs. A report submitted to the recent White House Conference on Aging documents that the entire savings which the Republicans hope to achieve in seven years would be achieved each and every year if the most common conditions of aging could be postponed by just five years.