HEALTH CARE OPPORTUNITIES FOR MINORITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON MINORITY ENTERPRISE, FINANCE, AND URBAN DEVELOPMENT

OF THE

COMMITTEE ON SMALL BUSINESS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

WASHINGTON, DC, NOVEMBER 9, 1993

Printed for the use of the Committee on Small Business

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HEALTH CARE OPPORTUNITIES FOR MINORITIES

TUESDAY, NOVEMBER 9, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON MINORITY ENTERPRISE,
FINANCE, AND URBAN DEVELOPMENT,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 11:20 a.m., in room 2359–A, Rayburn House Office Building, Hon. Kweisi Mfume (chairman of the subcommittee) presiding.

Chairman MFUME. Ladies and gentlemen, the subcommittee hearing will come to order.

I am going to say good morning and thanks to those of you who have waited because of the delay cause by the vote. I would like to welcome those members of the subcommittee who will be coming back from that vote, as well as our distinguished witnesses and those of you in the audience.

Today, the subcommittee will take up an issue that has been the topic of much debate and controversy since President Clinton's national address on September 22. That issue is national health care reform.

Not since the New Deal has a President proposed such a grand plan that appears to offer so much to so many. The debate over this plan, however, has generated, as most of you know, acclamation as it has criticism partly because of the details of the legislative proposal, details that have not yet been totally released or worked out.

Meanwhile, the Congress has been engaged in the consideration of a broad range of proposals to control the growth in health care spending, which is at the center of the debate. Another fundamental element in this debate is the issue of how to expand health care access for an estimated 36 million uninsured Americans and a large number of underinsured, without, at the same time, fueling inflation in health care costs and without imposing significant cost on the Federal or State governments.

It should be noted that the Federal Government now spends 42 cents out of every health care dollar. There are a lot of different estimations as to what that is being spent on.

But it is fair so say that all sectors of the health care industry hope to influence the shape and the scope of the President's plan to address their individual concerns and are currently staking out positions for the struggle that lies ahead in the months to come. The distinct and, oftentimes, divergent interests surrounding these debates is not surprising when one takes time to consider that the

President's plan could lead to a massive redistribution of income among American workers and businesses within the estimated $800 billion health care industry.

Many of my colleagues and myself believe that the hallmark of any health care package should be quality coverage for every citizen that is accessible and affordable.

To paraphrase one writer, the quality of our lives is best measured by how the poor and disenfranchised among us are treated. Accordingly, many of us have challenged any proposal that makes low- and fixed-income elderly citizens to be forced into a position where they have to choose between copayments for health care and meals and other sustenances necessary for their basic survival.

As I mentioned earlier, the debates surrounding health care have been focused on the need to contain medical-related costs and how to expand health care access.

When we examined the current variety of health care reform proposals, I, like perhaps some of you, see little evidence that that consideration is being given, particularly to minority communities beyond health care status and beyond its role as an ultimate consumer of health care services, which many in the minority community are.

We have not seen yet any manifest regard for Hispanic American, African-American, or Native American primary care physicians and those practitioners, insurers, managed care organizations, generic drug makers and distributors and others, frankly, that are involved in this massive undertaking where the Federal Government plays such a large and such an overwhelmingly critical role.

In addition to concerns about the potential costs that will be imposed on minority-owned small businesses, this subcommittee is also concerned about the potential for managed competition proposals and others to limit, by exclusion, opportunities for minority providers or suppliers of health care services to be able to participate in a meaningful fashion in the day-to-day operations of a national health care system.

While many questions and many details concerning the implementation of a national care system still remain unresolved, many of us believe that we should at least recognize the courage exhibited by this President and the First Lady to bring this issue to the forefront of our current political debate.

Far too often I think it is fair to say that, as a Nation, we tend to permit major problems to grow unrestrained while we remain paralyzed by their complexity. Someone once called it "analysis that causes paralysis." Since all of the elements of this multibillion dollar health care industry are delicately intertwined and require proper balance, it is imperative that we build into any comprehensive reform measure an obligatory and effective mechanism for inclusion of minorities and every facet to be able to expand health care coverage in such a way that we really make it available to all of our citizens.

So that, ladies and gentlemen, really is the focus of our hearing today and what we hope to do. The testimony that we receive today we expect will help to undergird our intent to ensure that future

debates on national health care reform address the entire range of economic interests of the minority community.

The subcommittee is quite honored, I should say, to welcome two of our distinguished colleagues who are here today and present to outline, in their own way, their respective proposals for national health care reform that contemplates a broad range of health care needs of the minority community.

We are also pleased to have the Deputy Secretary of the U.S. Department of Health and Human Services who has been invited, like others, to share with us in this instance the commitment of that specific agency to the participation of minority businesses in the framework of health care reform and more generally within the overall mission of the Department.

Finally we will hear from the President of the oldest African-American physicians group in the United States and representatives of a medical testing and medical supply company.

Before I take a moment to introduce our two distinguished witnesses, I would advise Members that we will proceed today under the 5-minute rule.

Witnesses are further advised that your full statement shall be printed in its entirety in the official hearing record and that record will be kept open for 5 legislative days to permit testimony from individuals not yet present and to allow Members also to revise and extend their remarks.

At this time, I would yield to the Ranking Minority Member of the subcommittee, the Honorable Ron Machtley, for opening remarks.

[Chairman Mfume's statement may be found in the appendix.]

Mr. MACHTLEY. Thank you Mr. Chairman. I am pleased to be here and very appreciative of this hearing and our colleagues and others who will testify.

As we as a Nation begin to debate and look at the issues related to health care, it is particularly important that we understand how these changes affect the small businesses, minorities, and other segments of our Nation. Mandated costs and higher taxes may not be the answer to our health care dilemma if, in fact, it means that fewer people are able to participate in full employment in this Nation.

Since two-thirds of our businesses in the United States are small firms, it seems to me that we cannot force unreasonable costs and regulations on these job generators without having a reciprocal loss of jobs. While these issues are being debated, there is another important issue that has been often overlooked, the effects of health care reform as it relates to minority enterprises within the health care industry and as health care relates to minorities in general.

This is an issue that will not often attract public attention, but it is an important one that we ought to address. I commend the Chairman for holding this hearing this early in the debate on health care. This morning our focus is to center on the problem of minority business participation within the health care industry; but, nevertheless, we should also focus on what will be the impact, particularly from urban areas of some of these changes. As an example, within the United States, there are only approximately

seven minority-owned HMO's. Less than 3 percent of the physicians in this Nation are minorities.

An industry that generates $800 billion a year, the lack of minority participation should be considered not only from a health care standpoint but from a jobs standpoint. During my preparation for this hearing, it became clear to me and to those who were working with me that there is, frankly, very little information available on the participation of minority-owned enterprises within the health care industry.

I am concerned that such limited information will, in fact, not permit us to begin a debate on how to encourage minorities to participate in the health care industry.

This hearing today, I hope, will provide us more information and will also open up the spectrum so that others will gather information that will be increasingly important to us. Increasing the number of minority-owned enterprises within the health care industry is extremely important.

Two thoughts come to mind. If we take into account that most minority small businesses are located in urban areas where Medicaid recipients are highest, then the creation of minority-owned small health care enterprises will certainly benefit those who are able to participate in the ownership but also those who are able to participate as receivers of the health care services.

Job creation is second. It is an important benefit. In my home State of Rhode Island, the health industry is the fastest growing segment of our economy. I think we should make sure that all of our people in this country are able to access that growth and that jobs are, in fact, available to minorities in the growth that we anticipate.

I am anxious and look forward to the testimony today, and I hope that it will shed more light on how we can ensure a full service health care delivery system that takes care of all Americans as well as how we can have more minority-owned enterprises in the delivery of that service.

Thank you, Mr. Chairman.

Chairman MFUME. Thank you.

We have been joined by Mr. Conyers of Michigan. The Chair would ask if Mr. Conyers has any opening statements before I introduce the first panel.

Mr. CONYERS. Thank you very much, Mr. Chairman. I am delighted that we are here. This part of health care reform is one that has been neglected, except for in the Congressional Black Caucus, Louis Stokes has been manning the health care area for many, many years. We are delighted that, across the years, he has marshalled together the medical authorities, the paraprofessionals, and those that support equity in our health care system for many, many years. We are delighted that he is joined by our distinguished friend from Illinois, who has also worked in his area with great diligence.

It talking about the minorities and health care, we now join in the national debate on an area that has been very, very long ignored.

It is a pleasure to know that the present president of the National Medical Association, Dr. Lawrence, is with us today to join

in with that discussion as the major sponsor of the most popular bill in the House. We should come very directly to the point that battle being developed here has several sectors. One of them is, will the powerful institutions in health care delivery, which are larger than the Pentagon, than the military lobbies, one out of seven people are connected with health care. It is a trillion dollar annual business. More than 40 million people have not got a nickel's worth of insurance.

The tragedies inside our city can be measured almost by the degree of the dislocation of health services that are available. People getting their health care out of engineer rooms. We all know the stories, and we will hear more about them.

But this is a wonderful opportunity for us to begin this examination of not only how America fits in but how we get up to par. So it goes beyond as important delivery health care to every American is, it goes to the question of who is going to deliver health care and who is going to be trained and what are the circumstances; and where can the public health model be reclaimed; and how can we deliver services to beleaguered communities.

I congratulate you on putting together a more representative panel to begin in discussion.

Chairman MFUME. Thank you very much, Mr. Conyers.

As the Chair noted earlier, we are particularly happy to have with us this morning Lou Stokes of Ohio and Luis Gutierrez of Illinois.

Mr. Stokes is a senior Member of the House of Representatives, one of our more distinguished Members. He serves, as many of you know, on the Appropriations Committee where he Chairs a subcommittee of that full committee.

Mr. Stokes has served as Chairman of the House Ethics Committee. He has been called upon by previous Speakers of the House to serve on the Intelligence Committee.

In crucial times facing this country and facing this Nation, oftentimes it was Lou Stokes who was singled out among so many of us to take up very difficult and responsive tasks.

He was a founding member of the Congressional Black Caucus. Called upon to help this Nation wrestle with the assassination of President Kennedy and to do the proper research and background work affiliated with looking at that tragic issue and reporting back to our country.

The same holds true with his service as a member of the Iran Contra team and a number of other delicate and sensitive matters upon which he has been called upon to provide his leadership.

Mr. Conyers is absolutely correct when he talks about the number of years that Mr. Stokes has dedicated to the issue of health care, long before it ever got on anybody's radar screen. So we are extremely happy to have Lou Stokes here on this first panel to offer his testimony this morning. We welcome it. We look forward to it.

We are particularly happy to have with us Luis Gutierrez of Illinois, a member of the House Banking Committee, a member of the Hispanic Caucus, one of the brightest stars in the freshman class and one who has begun to distinguish himself in the House of Representatives.

Leadership that he has given so long to the city council in Chicago is now leadership that our Nation benefits from.

Thank you for—because of your difficult schedules, for being with us. Mr. Stokes, proceed in any manner that you see fit.

STATEMENT OF HON. LOUIS STOKES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. STOKES. Thank you, Mr. Chairman.

Mr. Chairman, Mr. Machtley, and Chairman Conyers, it is, indeed, an honor and a great privilege for me to appear before you this morning. Mr. Chairman, I appreciate that opportunity, because of your great Chairmanship of the subcommittee. I also appreciate the great leadership that you give as Chairman of the Congressional Black Caucus, here in the Congress, an organization that I am proud to be a member of under your leadership.

Also, I am very pleased to be here with Mr. Gutierrez as co-panelist.

Mr. Chairman, I will summarize my statement, and ask that my formal statement be entered into the record in its entirety.

I appear before the subcommittee this morning to discuss a very pressing national issue: Health care reform and, more specifically, minority participation in the resulting health care industry enterprise.

As Chairman of the Congressional Black Caucus Health Brain Trust and as a member of the Appropriations Subcommittee on Labor, Health, and Human Services and Education, I would also like to take this opportunity to thank you for the cooperation and assistance you have afforded my advocacy to help bring health care to the forefront and to help ensure minorities' fullest participation in the Nation's health care enterprise at all levels.

The reform of our Nation's health care system affects each and every one of us individually, collectively, personally, and professionally. As our Nation stands poised to effect major changes in the health care delivery system, whether the legislation which gets enacted, mirrors single-payer, or managed computation or some mixture thereof, to be effective in addressing the health care needs of African-Americans, it is vital that the legislation includes provisions for the expansion, strengthening and enhancement of the minority health enterprise.

It must be recognized that minority health professionals have an intimate knowledge about the large segments of the African-American and minority communities that have been abandoned to suffer high mortality rates, shortened life expectancy, debilitating poverty, disability and disillusionment, frustration and loss of hope.

Minority health care professionals are in the trenches every day diagnosing, treating, serving, and counseling underserved populations across the Nation, urban as well as rural.

Mr. Chairman and members of the subcommittee, I am sure that you would agree that having universal health insurance, in and of itself, does not guarantee the actual receipt of quality comprehensive care for all Americans.

I would like to also mention the Minority Health Improvement Act of 1993, that I will be introducing in the next few weeks. That bill is the reauthorization of my original Disadvantaged Minority

Health Improvement Act of 1990 bill, and it is designed to help address the minority health crisis.

I want to express my appreciation to Chairman Conyers who, along with Chairman Waxman, brought that bill to the floor in 1990, enacted it into law, and made it possible for that to be the law of the land today.

What is key to addressing the health care crisis is the enactment of a comprehensive health care reform bill to ensure quality, accessible, affordable, and comprehensive health care for all Americans.

What is equally crucial to alleviating the dire minority health care crisis is full participation of minorities in the health care enterprise at all levels. It is vital that we realize that health care reform is evolving against a reported backdrop of minority-owned HMO's and other health care organizations, extracting patients from African-American health care providers. As a result, minority health care providers are losing their practice at an alarming rate. This situation will only ensure the continuation of the minority health care crisis.

Mr. Chairman and members of the subcommittee, as the crisis of minority health continues, the enacted health care reform legislation must include provisions to ensure minorities have a level playing field, to strengthen Historically Black Colleges and Universities, to ensure the viability of African-American HMO's and the few remaining African-American hospitals. We are down to about 11 African-American hospitals in the entire Nation today between 1961 and 1988, some 57 closed. As Mr. Machtley mentioned, there are only seven African-American HMO's in the entire Nation.

We also need to ensure an adequate supply of minority health care professionals, not only minority primary care providers but specialists as well.

Additionally, it is absolutely paramount that the entrepreneurial opportunities of health care reform not be overlooked. They include a vast array of health careers and entrepreneurial opportunities ranging from African-American health plans and networks, to testing laboratories, to health information systems. To level the playing field in an effort to ensure that these and similar entrepreneurial opportunities become business realities for minorities, there must be built in protections for minorities on a set-aside type of basis.

Equally important as the minority health crisis remains, enacted reform legislation must not allow malpractice to be disguised as discrimination. It must include provisions to ensure minority consumers and health care providers active involvement at all levels of regional alliances, as well as the national boards, commissions and councils.

As our Nation further embarks upon health care reform, minority involvement will become even more crucial. The solutions to health care reform are complex, but they are not impossible. The challenges, it seems to me, are ours, for health care is not a right for some Americans; it is a right for all Americans.

I thank you for the privilege of testifying and would be pleased to answer any questions.

Chairman MFUME. Thank you.

Mr. Gutierrez.

STATEMENT OF HON. LUIS V. GUTIERREZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. GUTIERREZ. I come before you as the Chairman of the Congressional Hispanic Caucus and Health Judiciary Task Force Chairman to represent Congressman Serrano, the Chairman of the caucus who regretted that he cannot be here with you today.

Mr. Chairman, I appreciate the opportunity to testify on the direction of health care reform and how it must be taken to improve health care infrastructure and manpower in the Hispanic communities.

The testimony today will focus on the following Hispanic health service and needs: The need for infrastructure and manpower development in the Hispanic community and the responsiveness of the Department of Health and Human Services to the needs of Hispanics.

No single group is more negatively affected by the health care crisis than Hispanics, one out of three lacks health care coverage in this Nation. That is more than any other major group.

In 1992, Mr. Chairman, a staggering 44 percent of employed Hispanic males between the ages of 16 and 64 were uninsured, compared to 32 percent of African-Americans and 18 percent of white males.

What is more, their working poor status often makes them ineligible for public coverage through Medicaid.

Hispanic children are uninsured at twice the rate of other children. Hispanic elderly are the least likely in their age group to have health insurance coverage through Medicare.

Providing health insurance coverage may be the single most important stroke to lifting many Hispanic working families and individuals from poverty. Many preventable diseases such as diabetes, tuberculosis, AIDS, and certain cancers are major killers of Hispanics; although, early treatment could remedy the situation.

According to a 1991 article in the Journal of the American Medical Association, Hispanics have the lowest level of medical and mental health care utilization in the country.

Aside from improvements needed in financing comprehensive health services and assuring basic health care for all Americans, the vitality of community-based health care delivery systems and availability of physicians affects Hispanic access to health care.

In April, the Hispanic Caucus adopted health care reform principles. One states that a reformed health care system must improve and enhance medical teaching hospitals, solo practitioners, health maintenance organization, community health centers, and other community-based health clinics that serve Hispanics and other underserved population.

A second principle calls for greater minority access to medical education and creation of incentives to increase the number of bilingual and bicultural primary physicians and other health care providers.

The GAO, in January 1992, to give you an example, Mr. Chairman, reported in El Paso, Texas—where Hispanics represent about 75 percent of the population—only 30 of the city's 800 doctors maintained practice in the poorest parts of the city. That means

that 4 percent of the city's physicians served 32 percent of El Paso's population.

Many Hispanics and disadvantages communities currently obtain health care through a fragile network of providers. Hispanic communities are in need of linguistically and culturally appropriate services. Indeed, the lack of appropriate language services violates the civil rights of and often results in human suffering for individuals who require such services in order to access health care.

Health care reform must maintain and strengthen minority-run and -owned health care facilities as part of a viable public health network.

It is important to remember that the U.S. Department of Health and Human Services will be responsible for administering the public health component of health care reform. Existing programs and hiring practices strongly suggest that DHHS is currently not sensitive to the health needs of the Hispanic communities. Hispanic employment in the DHHS labor force is dismal, particularly at high level policy and administrative positions.

As of June 30, 1993, only 5 percent of the total 124,363 people employed at DHHS were Hispanic.

Only 2.7 percent of the management and top level policy positions were Hispanics. Those are GS and GM-14 and above or equivalents.

As of the first quarter of fiscal year 1993, only 1.6 of the Federal labor force at the National Institutes of Health were Hispanics and only four-tenths of one percent of NIH manager positions were held by Hispanics.

During the same period 2.7 percent of professional positions at Health Resources and Services Administration were held by Hispanics. It is difficult to comprehend these low staffing patterns at a time when Hispanics are a growing pattern in the United States.

Hispanics represent 1 out of every 11 persons in the United States. The Hispanic Caucus sponsored H.R. 3230, the Minority Health Opportunity Enhancement Act of 1993 and takes a thorough look at existing programs in DHHS and reviews their responsiveness to the health care needs of Hispanics. I will share a few brief findings which were deeply troubling.

Hispanics are grossly underrepresented in health care professions. However, Hispanic participation is very poor key DHHS Programs that focus on increasing the number of minority health professionals. Data indicates that, although Hispanics represent 9 percent of the U.S. population, Hispanics make up 4 percent of the U.S. physicians; and half of these physicians are foreign medical graduates.

Second, two of the criteria used in designating medically underserved areas, MUA's, exclude Hispanics. The 65 and over factor works against Hispanics, since Hispanics tend to have a large young population.

Also, although Hispanic communities experience poor health status, the emphasis on infant mortality fails to consider Hispanic health needs. Infant morbidity is more appropriate in measuring Hispanic health status. MUA designation helps in directing community health center and other resources to develop and strengthen community-based health care capacities.

The M-HOPE Act does not attempt to broadly reform the current U.S. health care system and, thus, is not intended to compete with the administration's Health Security Act or any other reform of our Nation's health care system.

Instead, by improving existing DHHS Programs, M-HOPE acts to complement health care proposals and is meant to be used as a blueprint for improving the service of Hispanics by programs at DHHS.

The Hispanic Caucus is committed to working you with, Mr. Chairman, and with this subcommittee to look for avenues to ensure that quality health care opportunities are available to all.

Thank you very much, and I ask that the complete testimony of the Chairman of the Hispanic Caucus be entered into the record.

Chairman MFUME. Without objection it is so ordered.

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

Chairman MFUME. Thank you. Extend our thanks to Mr. Serrano for making sure that that testimony is a part of formal record of our proceedings.

Mr. Stokes and Mr. Gutierrez, I know that you have a busy schedule; but I have a couple of questions. Could you share with the subcommittee what steps you think might be taken to ensure the viability of minority-owned HMO's in the overall framework of national health care reform.

Second, how you think we might be able to ensure an adequate supply of minority health care professionals well into the future.

Third, why incentives such as the one outlined in your bill that devotes specific financial assistance to individuals wishing to serve medically underserved and minority communities really becomes absolutely essential in constructing a framework for the delivery of services as we know them.

Mr. STOKES. Mr. Chairman, if I might I would like to start with the 1990 bill, the Disadvantaged Minority Health Improvement Act. The enactment of that legislation marked the realization on the part of the Congress that there is a real dearth of health professionals to attend the health care needs of rural and urban communities, particularly our large urban communities and nationwide.

The problem is exacerbated by the fact that most of the minority doctors in this country are produced by our Historically Black Colleges and Universities. In fact, over 50 percent of them are produced by colleges such as Morehouse, Howard University Medical School, and Meharry Medical School.

Even today, we are still finding that our major universities are not providing the opportunities to minority students. Therefore, in that legislation, we created what is known as Centers of Excellence to attract and recruit more minorities into the medical profession.

We also provide an opportunity for some of the loans to be waived in terms of service. This provision enable, more minority students to overcome the financial problems related to the profession.

If we are ever going to be able to attack the type of disparities that both Mr. Gutierrez and I have talked about here this morning, we certainly have to have more minority health care and health research professionals. Additionally, we have to have legislation to

make this a reality. Because, in the system that we are confronted with in this country, it is just not occurring. We need implementation through legislation like that that I sponsored in 1990, and like that which I am now preparing for reenactment in 1993.

This past September, at the Congressional Black Caucus Health Brain Trust Meetings, representatives from the six HMO's African-American HMO's, that exist in the country, testified about the precarious financial position that they operate in.

Basically, they are confined to Medicaid patients. They don't have the opportunity to exist on the same playing field as the big majority population owned HMO's. Their primary source of funding is through Medicaid, and that is a very precarious source of income for them.

We must examine that whole situation and buttress how African-American owned HMO's will continue to exist. Then, we must determine how best to expand upon them, as opposed to phasing them out of existence through the new health care legislation that is enacted. That is where we have to look. Taking their recommendations as to how we can best support and strengthen them, we can then be sure that African-American owned HMO's not only remain a part of the Nation's health care system but also a visable partner in it.

Chairman MFUME. Thank you very much, Mr. Stokes.

The Chair would recognize the Ranking Minority Member, Mr. Machtley.

Mr. MACHTLEY. Thank you very much.

Mr. Stokes, in looking at the issue of how do you keep minority physicians and health care providers in urban areas, one of the problems I think you have, as you alluded to, is that you have the large Medicaid population in these communities. So just getting health care providers into the system is only part of the problem.

Have you looked at ways of changing the Medicaid formula so that people who decide to participate in health care delivery in urban areas have the economic incentive to stay there.

In other words, you can say we will give you help to become a physician or a health care provider to get through medical school provided that you will then spend a certain number of years in an underprovided area, but once that happens and then they are free to go, obviously our system will encourage, economically, those physicians leave. I know in some of the urban areas I am familiar with, it is always a problem of getting the physicians to stay long term.

Have you looked at any ways of just changing the whole formula for reimbursement under Medicare in urban areas?

Mr. STOKES. In terms of the African-American health care providers, most of them are confined, once they graduate from medical school, to the inner city for their practice. Relatively few of them have the opportunity to practice in suburban areas. African-American health care providers are the ones who basically provide the care to the indigent and the uninsured in our inner cities, that system is just built in.

That is one of the reasons why, under any type of meaningful health care reform, African-American health care providers must be protected. They are the ones who have stayed in the inner cities

all of these years providing all of the health care. They didn't have the liberty and the luxury of being able to go out to suburban communities and enjoy the more luxurious type of practices. They are in the heart of the cities providing indigent care.

Also, one of the things that we must realize and be concerned about, when we talk about the Medicaid and Medicare systems, is that we are still talking about two tiers of care. We talk about Medicaid for the poor and Medicare for the middle class.

We must stop classifying people in categories, because they get a different type of care when we classify them as the poor, or the upper class, or the middle class. Ideally we need to merge the two, and give everybody the same type of care without distinctions whether they are poor people or middle class people.

Chairman MFUME. Mr. Hilliard.

Mr. HILLIARD. Mr. Chairman, it has occurred to me that it seems as if we are trying to Catch-22, and we don't know which one of the 2's to begin with. As I see what might be the future of health care in the future, I am very concerned about now. So it occurs to me that while we are trying to catch the fleeting star of tomorrow that we need to reassess where we are now. It occurred to me, as I heard the statistics of minority health care as it is now, and so on.

I would ask the panel to tell me what happens if the health care system is not changed in the next 2 years? What do we do in the meanwhile? That is the first question.

Then I want to go beyond that. But let me ask you that. What do we do in the next 2 years?

Mr. STOKES. The fact is that the health care system is broken. If it is not repaired, you continue to have the growing type of health care crisis that the President has referred to and almost everybody who has talked about health care in America.

There are 37 million Americans who have no health insurance, another 20 million Americans work every day but have inadequate health insurance. If you are talking about continuing that system for 2 more years, then, you add to it the type of problems that my colleague and I have talked about this morning as relates to the African-American health crisis. We have known since 1985, from the report of the Secretary's Task Force on Black and Minority Health, that there are 60,000 excess deaths per year in the Black community. That number has now gone to 75,000. These excess deaths are related to the disparity in health care in the areas of heart attack, stroke, cardiovascular disease, diabetes, suicide, and homicide, just to name a few. Therefore, if you are talking about not doing anything in the system, you are talking about the further exacerbation of that precise situation which exists today.

Mr. HILLIARD. Not so much not doing anything, but what to do?

Mr. STOKES. We must enact health care reform legislation. Now, obviously, there are about six major plans before the Congress today. However, the single-payer form is probably the best approach to it, and also we have the President's plan. The enactment of any one of those forms would certainly help bring some degree of solution and cure to the currently existing system.

Mr. HILLIARD. What about the phase-in part of the plans? If you add the phase-in period on to the 2 years, then what do we do during this period of time for the health care individuals?

Mr. STOKES. Ultimately, the Congress is going to have to, in its wisdom, make the decision whether or not to enact the law, as it should be, in its entirety, or it in phases. When I served on the Pepper Commission, we recommended that we start with just a window in certain areas. For example we considered legislation that would take care of all children and pregnant mothers. Then we considered long-term care and made recommendations for home care and institutionalized long-term care. We didn't try to do it all at once, because we felt that we just couldn't afford it.

Congress took that report and put it up on the shelf and did nothing. Now, we are confronted again with the same decision. Can we do it all at one time, or do we phase in integral parts? Of course, that is a decision that the Congress has to make.

Mr. HILLIARD. Thank you, Mr. Chairman.

Chairman MFUME. Thank you, Mr. Hilliard,.

Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Thank you, Mr. Chairman. I apologize for being late.

I simply wanted to state that this is a very important hearing because I think it is critical, as has already been stated, that minorities participate in the business opportunities that will result from health care reform.

That with health care reform, those who need specific kinds of care are able to get that care, which is not being received today because of cultural differences or even the fact that there are linguistic differences.

So very often, many of the programs that are put in place today are not reaching those that need it most. I think a perfect example is the fact that there is an extremely high incidence of AIDS among the Latino population.

One reason for that is because the information and the education that has been available in the past is not reaching that population.

It is critical that we make sure that, as we move on to health care reform, that it is done in a way that reaches all the population so that they receive the education and the proper training to make sure that the health care needs of all are dealt with.

I believe that Congressman Gutierrez has mentioned the M-HOPE bill which the Hispanic Caucus has put forward. So I will reserve my comments and questions for later.

Mr. GUTIERREZ. Just to respond quickly to many of the questions, I think that one of the most important things that we need to do, Mr. Chairman, is to look at the work that Chairman Stokes has done over the years, because a lot of what the work on the M-HOPE bill is based on is based the bill that he was able to pass in 1990 to bring it current.

If one error that we could make is not discussing among minorities here in the Congress of the United States, whether they be in the African-American, the Asian, or the Latino community and discussing and sensitizing ourselves to the differences, the unique differences amongst ourselves so that we can work together.

Or what could happen is that there will be a pool for quote, unquote, the minority community which is kept smaller instead of expanding it as each group attempts to get what they feel is needed for themselves.

So there needs to be a discussion of how you expand the resources, not simply attack the resources that we currently have and each person fighting for those limited resources. I think those discussions are ongoing.

I just thought it would not be a good idea, Mr. Chairman, for me to be here today and not clearly state that the Hispanic Caucus recognizes the work of Chairman Stokes in this area. What we need to do is continue to follow it because the Chairman has been doing this for quite a while. So it shows that you don't need health care reform in a big bill to change and ameliorate the problem.

Mr. STOKES. I want to thank Mr. Gutierrez for his comments. I am in accord with his statements with reference to the fact that, when it comes to health care disparity, African-Americans, Hispanics, and other minorities are in the same, identical boat. We need to spend our energy working together in a coalition.

I would also like to say, with Ms. Roybal-Allard here, your father and I sat next to one another on the Labor Health and Human Services and Education Subcommittee on Appropriations for about 20 years. Over that period, most of the gains made in terms of legislation enacted through that subcommittee and funds appropriated for minority programs and health education resulted from our joint efforts. He was a real champion in that regard and epitomized exactly what my colleague has talked about here today. The two of us were a real team there.

Chairman MFUME. Well, the Chair would like to again thank both of you for your time and your testimony and to remind you that we are keeping the record open for 5 legislative days if there are additional things that you would like to contribute to it.

Thank you very much for being with us.

Mr. STOKES. Thank you, Mr. Chairman.

Mr. GUTIERREZ. Thank you.

Chairman MFUME. The Chair wishes to call the second panel, the Honorable Walter Broadnax. He is Deputy Secretary, U.S. Department of Health and Human Services; Dr. Leonard Lawrence is President of the National Medical Association; Mr. George L. Fountain, Jr., vice president, District Scientific and Medical Supply Inc.; and Mr. Warren O. Cooper, president of Accu-Lab Medical Testing.

Let me again just remind all of us that the major focus of this subcommittee hearing is the larger question of whether or not health care reform is healthy for minority enterprise, whether it contributes to it.

I would call your attention back to my original remarks in which I said that I still have not seen any manifest regard for African-Americans, Asians, or Native American, primary health care physicians, or nurse practitioners, insurers, managed care organizations, generic drug makers, and distributors and others that would be involved in this massive undertaking in terms of business opportunities where the Federal Government plays such a large and critical role.

I wanted to reemphasize that and urge that you take the time that you have to speak to our larger question; the question of whether or not minority enterprise finds health care reform particularly healthy or not and what your own views are on that larger question.

Dr. Broadnax, we are happen to have you. We recognize that Secretary Shalala could not be with us because of a competing schedule. I understand that there is someone with, and if you could identify that person.

Dr. BROADNAX. Mr. Veri Zanders is here with me this morning. He is Director of our Office of Small Business Utilization.

Chairman MFUME. Dr. Broadnax, feel free to proceed.

STATEMENT OF WALTER BROADNAX, DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY VERI ZANDERS, DEPUTY DIRECTOR, OFFICE OF SMALL AND DISADVANTAGED BUSINESS UTILIZATION

Dr. BROADNAX. Thank you, Mr. Chairman and members of the subcommittee.

I am pleased to appear before you today to discuss HHS's strong commitment to the participation of small businesses and small disadvantaged businesses in the framework and mission of the Department of Health and Human Services.

HHS has an outstanding record and continually increases the number of prime and subcontract awards being made to small businesses in general and to small disadvantaged businesses in particular.

As you may already know, the fundamental mission of HHS is to protect and advance the health of the American people and to improve their quality of life. In one way or another, HHS touches the life of almost every person in the United States.

HHS oversees over 250 vital, health-related programs including AIDS research, cancer treatment, alcohol and other drug abuse prevention, immunization, Medicare, Medicaid, and Social Security; from ensuring that the medicines we take are safe to helping families, again, self-sufficiently through financial aid and job training to making sure all babies get a healthy start through good prenatal care. HHS affects nearly everyone.

In the letter of invitation, the committee requested that my statement address a number of questions with respect to HHS's small disadvantaged business programs. I welcome this opportunity to talk about HHS's small disadvantaged business program because I believe it is one of the best programs of its kind in the U.S. Government.

I will provide summary statements in response to the questions outlined in your invitation. Detailed responses are contained in my formal statement that has been provided to the committee.

The Small Business Act, as amended by Public Law 100–656, requires that the President establish annual Government-wide goals for acquisition awards to small businesses and small disadvantaged businesses. The statutory goal for small business participation and at least 20 percent of the total value of prime contract awards.

The statutorial goal for small disadvantaged business participation is at least 5 percent of the total value of prime contract awards and 5 percent of the total value of subcontract awards.

Historically, HHS has exceeded all of the statutory goals for small business participation on a consistent basis. In fiscal year 1992, HHS awarded approximately 40 percent, over $1 billion, of its total acquisition awards to small businesses. Of that amount, approximately 13 percent, which is over $328 million, was awarded to small disadvantaged businesses. We think this is particularly noteworthy.

In addition, small disadvantaged businesses received approximately 8 percent, or $18 million, of the total subcontracting dollars from prime contract it is awarded by the Department. This achievement is made probably because of institutional acceptance and support of the preference program throughout the Department. I am proud to be a part of one of the top small and small disadvantaged business programs in Government.

The Office of Small and Disadvantaged Business Utilization enjoys complete support from the Office of Secretary. This support is evidenced by the fact that the Director reports directly to the Deputy Secretary in accordance with the provisions of Public Law 100–656.

The Department's Assistant Secretary for Management and Budget provides the needed administrative and logistical support for the office. This arrangement ensures all necessary resources are available to the OSDBU.

The OSDBU establishes and maintains outreach programs to provide a flow of information about HHS small business programs to small, small disadvantaged, and women-owned businesses.

OSDBU staff provided personal counseling and marketing assistance to over 2,000 small businesses during fiscal year 1992.

OSDBU distributed over 7,000 copies of various publications designed to assist individuals and organizations in understanding the mission and programs of HHS. These publications included "Doing Business With DHHS," "HHS's Annual Report on the Small Business Programs," a "Forecast of HHS's Contracting Opportunities for Small Business," and the "Subcontracting Directory." Each publication provided information to explain current and potential contractors with continuing and available acquisition opportunities.

HHS is an active participant in most of the congressionally responsored Federal procurement conferences held each year.

Component agencies in HHS sponsor many procurement fairs to assist firms in understanding the mission and objectives of that particular agency. Hundreds of small and small disadvantaged businesses are invited to meet directly with the Agency's technical and contracting personnel. The interest in these conferences has been high, and attendance has been very good. We have utilized the Commerce Business Daily to publicize the event.

During this year's MED Week activities, OSDBU conducted a session in which several of our prime contractors participated in a forum discussion on techniques for affording SDB the maximum opportunities to be potential subcontractors.

Mr. Chairman, I would like to personally assure you that HHS places the highest priority on the full participation of small business and small disadvantaged businesses in the HHS Programs.

This concludes my opening statement. I will be pleased to respond to any questions that the committee may have for me. Thank you.

Chairman MFUME. Thank you very much.

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

Chairman MFUME. We are going to—as we afford all Agency heads and others who are Deputy Secretaries—the distinct opportunity—I don't know if it is a privilege—for you to be questioned first and separate and apart from our panel.

I would like to call your attention back to page 16 of your written statement in which you indicate that the Department has not yet at a point in finalization of the national health care reform initiative where contractual requirements can be identified.

If we recognize that—and I think we do—that significant opportunities will exist in the claims processing, auditing, accounting, medical waste disposal, medical specialize, health promotion, and marketing, and food services, can you tell the subcommittee whether or not the Department of Health and Human Services envisions any role for every minority—for minorities in the national health care reform beyond the four strict procurement categories that you have outlined in your statement for which awards have been let in the past?

Dr. BROADNAX. Mr. Chairman, I can say very directly in all honesty that in conversations that I have had directly with the Secretary in the very recent past about our opportunities to expand opportunities for minority participation in the Department, not only in terms of being able to do business with the Department through our contracting and procurement mechanisms but more broadly as well, any avenue—whether it is direct employment, whether it is serving on Departmental advisory committees—we are professionally dedicated to making sure that every opportunity can be explored and exploited. There will be no difference in regard to opportunities for minorities to do business subsequent to what we hope will be the new Health Security Act.

Chairman MFUME. So you expect opportunities beyond those four strict categories that are outlined?

Dr. BROADNAX. I guess what I am trying to say, not knowing what the final outline will look like in terms of the legislation that we are hopeful that will emerge from the Congress—that I am saying that we would look as broadly as would be required, depending on what the parameters of the particular piece of legislation was.

Chairman MFUME. Well, Doctor, I wish and hope that you would communicate back to the Secretary my desire that she would communicate to us, as soon as possible, when, in fact, she envisions a larger role for minority entrepreneurs beyond those categories in some of the other areas that I have delineated, specifically a moment ago, so that we might have some idea or at least some assurance that the Agency is sensitive, as we are, to being able to make sure that possibilities exist in the broader context of this reform package and that they are far ranging and not very narrow in their perspective.

Let me go back to your written testimony. You suggested that your office recently developed a model subcontracting back to assure consistency of information that is being submitted by prime contractor.

Could you or he take a moment to talk about this model plan and to make it available all at some date in the not too distant future to the subcommittee?

Mr. ZANDERS. Thank you. The model plan that was developed was the result of a consensus of looking at various plans at other Government agencies as well. What we did with our plan basically was to ensure consistency and even to the point of some standardizations in portions of it. Individual goals, as relating to contracts, is what the contractor would have to submit.

But what we tried to do in terms of responsibilities and some of the recordkeeping procedures that prime contractors were required to do, we tried to standardize that portion of it. Again that was just, basically, to ensure consistency and standardization.

Chairman MFUME. Are you in touch with other OSDBU's at other agencies?

Mr. ZANDERS. Yes.

Chairman MFUME. Are they looking at developing similar plans? Or are they just standing in admiration of yours.

Mr. ZANDERS. No, sir. I think that all agencies have pretty credible plans as well. This serves us as to what we were looking for from our prime contractors.

Chairman MFUME. You will make it available to the subcommittee?

Mr. ZANDERS. Yes, sir.

[The information may be found in the appendix.]

Chairman MFUME. Mr. Machtley.

Mr. MACHTLEY. I just had a quick question. On page 4, Doctor, of your testimony, you indicated that about 13 percent of the total awards was awarded to small disadvantaged businesses. We think this is particularly noteworthy.

In addition, small disadvantaged businesses receive approximately 8 percent of the total subcontracting dollars.

Do you have a goal in your Department? Is this the goal? Or do you have a goal that is higher than this?

Dr. BROADNAX. Well, what we were looking at for our guidance was, of course, the guidance that is provided statutorily in terms of 5 percent, if you look at the subcontracting goal. Of course, in terms of prime, the goal there being 20 percent. So we looked at those as benchmarks to measure ourselves against.

But again we would come back and say that, in terms of our desire, our desire is to try as much as we possibly can to maximize these opportunities and to stimulate as much growth in terms of opportunities for groups to exploit as we possibly can.

So we are certainly not satisfied, but we are proud of what we have aachieved thus far. But we would be the first to admit that there is still much more that we could do. But we use those as our benchmarks.

Mr. MACHTLEY. So you are above the 5 percent on the disadvantaged prime subcontractors but you are below the goal of 20 per-

cent that was established by statute as the amount of contracts to small disadvantaged businesses?

Dr. BROADNAX. No. I had said that the 20 percent for small business was the prime contract figure, and there we had 40 percent. So we are above the 20 percent there in the statute as well.

Mr. MACHTLEY. OK. So this 13 percent that you referred to, where does that—that is the total, 13 plus 8? Maybe I missed that 20 percent.

OK. I see where the 13 percent comes in.

Do you anticipate doing any other special marketing techniques to try and get new people, new minority groups into this——

Dr. BROADNAX. I think it is fair to say that we intend to continue to intensify our marketing efforts. We have engaged in very active marketing efforts heretofore. Some 2,000 businesses in our last budget cycle were contacted by us, and we have engaged in various fairs and all kinds of outreach activity. We think the marketing activities are paying off, and I would think that we would certainly intensify those over the next coming years and months.

Mr. MACHTLEY. Thank you very much for your time.

Chairman MFUME. Dr. Broadnax, Health and Human Services requires, as I understand it, that all companies that provide drug testing services be NIDA certified, that is National Institute of Drug Abuse. That certification creates, because of its requirement, a cost that is sometimes almost prohibitive for small and minority-owned firms.

It is $55,000 in the first year of certification, $35,000 in the second year of certification, and then $35,000 every year thereafter. It seems that the National Institutes of Drug Abuse, or whoever charges that, makes an awful lot of money. But it is a factor that can be prohibitive in terms of whether or not you are able to be certified and qualified to provide drug testing services.

Can you tell the subcommittee whether or not there are any programs, policies, or plans under way or envisioned that would assist these same firms to be able to enter this increasingly lucrative field of business?

Dr. BROADNAX. I must confess that I don't know of any program that is currently in existence to achieve this. But I would quickly say that it is something certainly worthy of review at my level. This is not something that I had focused on prior to the hearings, but I do understand the question clearly.

Chairman MFUME. It represents a hurdle, a big hurdle, particularly if you are a new or young business trying to get started.

I didn't know those costs were that high for that type of certification. But that is a lot of money just to be eligible, then, to be able to receive some considerations. I would hope that when you get a moment you would look at that; and if there are some ways that we can perhaps allow for the entry into that field to be easier for those minority businesses, it is something that this subcommittee would like to take under consideration and to be able to work with you and the Secretary on.

One other thing, Dr. Broadnax, before I go to the other persons who are here. This is a little off the subject. But you are here, and it is in the universe of things.

You know that there have been a number of reports regarding the virtual exclusion of minorities in management positions at the National Institutes of Health. It is something that concerns all of us, because it is something that suggests that there is a problem.

I have not had a chance to talk directly with the Secretary, but I would be less than honest to not say that it is something that is taking up more and more of my time.

Can you tell me if there is something that may have evolved since the recent reports that the Secretary may have undertaken to try to put an end to that very discouraging statistic?

Dr. BROADNAX. I am proud to be able to report to the Chairman and this committee that there is a whole series of actions that have been taken since the Secretary and I arrived at the Department.

As you very will know, we found a situation that was not good. We have taken hold. The Secretary personally went out and spoke to the employees at NIH, basically outlining how she was not going to tolerate discrimination in any shape or form.

I personally went out with the Assistant Secretary for Health, Dr. Lee, and the Secretary's Chief of Staff, and spent a half day with the research institute directors and the leadership of NIH talking about how we are going to turn NIH around.

At that meeting we talked about, and we have been following through on, the need to really change the culture of the National Institutes of Health. We believe that the new leadership there is committed to that.

I also oversee, for the Secretary, on a quarterly basis, a full report and update from the leadership at NIH in terms of their progress in terms of putting into place the requisite set of processes, procedures, and data reporting to keep us abreast of their progress along the line in terms of recruiting, particularly young scientists through fellowship programs, and other programs that will help them to begin to do what we call growing their own scientists and then attracting senior scientists through various routes, minorities to come into the institute.

Dr. Varmus has told me personally that he is committed to this and so is the deputy director. We will continue to monitor the situation, and we are demanding progress.

Chairman MFUME. Has the Secretary or the Agency sought to reach out to some of the existing professional organizations that may be Latino or African-American or Asian or any other minority group that has a professional organization of physicians or scientists who clearly would be not only a clearinghouse but certainly a great resource in helping you to find the people who you are looking for?

Dr. BROADNAX. We have not personally done that at the Office of the Secretary level and certainly not specifically related to this particular issue.

A lot of that outreach, though, has begun to take place at the NIH level. But, clearly, anything that we can do in that regard to help facilitate interest and attention, we certainly would be willing and want to do that. But I do know it has begun to take place at the NIH level.

Chairman MFUME. Well Doctor, thank you for allowing me to take you away from our primary focus today; but it is kind of hard to have you here and not ask that question.

Thank you also very much for your presence. If you would like to sit through the rest of the panel, you are certainly welcome to. I know that you have a lot of competing interests at the Department; but, again, we want to thank you for your presence.

The Chair would like to recognize Dr. Leonard Lawrence, president of the National Medical Association.

STATEMENT OF DR. LEONARD E. LAWRENCE, PRESIDENT, NATIONAL MEDICAL ASSOCIATION

Dr. LAWRENCE. Mr. Chairman, members of the committee, good afternoon. I am Leonard E. Lawrence, president of the National Medical Association, the oldest national African-American physicians group in the United States.

As I have listened to the introductory comments and questions of you, Mr. Chairman, and the members of your committee and Congressman Stokes and Congressman Gutierrez, I say that I am quite pleased that this process is under way.

Please allow me to share a story which captures the heart of my concern about this estimated $900 billion business of health care.

She lay on a cart in the emergency room. Her 8-year-old grandson stood beside that cart wondering when the doctors would come to see her. He had little awareness that when he had been born in that same hospital some 8 years earlier Black physicians were not allowed to come into that hospital to deliver babies, nor could he have anticipated that 22 years later he would be the chief resident in psychiatry in that same hospital system.

What struck him to the core, however, were the words he heard from a white-clad doctor: "We don't need to worry about her. She's just an old nigger." She died, in diabetic coma on that cart in that hallway.

I am the grandson mentioned in that story—a 1962 graduate of Indiana University School of Medicine and currently the Associate Dean for Student Affairs and Professor of Psychiatry Pediatrics and Family Practice at the University of Texas Health Science Center at San Antonio.

I am a child psychiatrist by training and a community advocate by choice.

Now, whether that earlier experience contributed to the career path I chose, I cannot say. Yet it is the keen recollection of that experience which motivates much of my activity and continually stimulates my resolve that no person's relative will ever again suffer such an indignity.

All of us are aware that these indignities do continue to occur and that racism is alive and well. The principles of reform presented in the President's proposed Health Care Security Act of 1993 are phenomenal perhaps; but when you factor in racism, the end result is potentially problematic.

The racial and ethnic composition of the Nation's physicians clearly does not reflect the general population and contributes to access problems for underrepresented minorities. Although earlier drafts of the President's plan mentioned the concept of affirmative

action, there are now several nondiscrimination provisions in the President's proposal based on existing law.

The National Medical Association is concerned that the proposal does not fully embrace affirmative action. African-Americans and other minorities have had experience with in the terms of "equal access" and "equal opportunity." To us that is not enough.

Therefore, the National Medical Association strongly recommends that the legislation require health plans to hire, appropriately and equitably, minority health providers as active participants within those processes.

We must address the issue of minority physicians, dentists, and other health professionals as entrepreneurs. The Washington Post recently ran an article entitled, "A Rush To 'Buy' Doctors." The article began, "Amid the uncertainty over medical reform, some companies are gobbling up what they bet will be the health care's hottest commodity in the 1990's: Doctors,".

Our NMA physician members are included in this number of physicians being gobbled up. Some of our physician members are included in the number holding out from being gobbled up, losing their patients to HMO's and subsequently losing their practices.

The National Medical Association does not want to have to appear before this committee in 1998 to testify to what is now a current fear and what may become a reality that there will only be a few major companies delivering all of the health care in the United States. But that is a possibility in this kind of monopoly arrangement where competition is the major theme; and if we do not build in some protections for minority provider networks, then we are in big trouble.

The National Medical Association, therefore, recommends establishing an African-American and other underrepresented minority business set-aside programs within regional health alliances to ensure proportional representation of providers from underserved communities.

Such a program could be implemented through provisions similar to those contained in the Defense Department contracting set aside goal.

Right now there are approximately 500 HMO's in the United States and fewer than 10 are owned or operated by African-Americans. In Detroit, there are three thriving African-American owned or operated HMO's: Comprehensive Health Services/The Wellness Plan, United American Health Services, which manages OmniCare, and LifeChoice Quality Health Plan.

The oldest of these three is Comprehensive Health Services, which reports some 100,636 members, making it the fourth largest HMO in the State of Michigan, the largest among the African-American owned and operated entities. It is still Medicaid based; but according to the Senior Vice President for Business and Fiscal Affairs, Isadore King, the key to their continued success will be vertical integration, i.e. active participation within alliances of hospitals, pharmacies, HMO's, in physician associations, et cetera.

But they need help to do it. Therefore, the NMA recommends that low-interest loans, tax and other incentives be available to strengthen the capacity of minority provider networks, most of whom function clearly in underserved areas.

A shortage of minority providers exists not only in primary care but in some specialized areas also. Among the specialty areas are general surgery, adult and child psychiatry, preventive medicine. We also need generalists with additional training in geriatrics. There must be clear acknowledgment of these training deficits with built-in incentives for training programs to correct these deficiencies.

Within the framework of the present health care system, the current physician-to-population ratio in the Nation is inadequate, and further increases in this ratio will do total enhance the health of the public or to address the Nation's problems of access to health care.

Continued increases in this ratio will, in fact, hinder efforts toward cost containment. The Health Care Security Act seems to provide for education and training of primary care physicians, and there are specific references to underrepresented minorities but no references to proportional representation.

The NMA recommends proportional representation of minorities not only in primary care training programs but also in specialty training programs. As you have heard earlier, African-American populations are dying at a rate in excess of 75,000 per year over what would ordinarily be expected. That means that we need both primary care and specialty care.

The NMA suggests the following mechanisms for recruitment: Establishing Federal grants for specialty care training, especially targeted for African-American and other underserved minorities; changing reimbursement policies for graduate medical education and focusing on those people who will provide care in the areas where the needs are greatest; strengthening the National Health Service Corps and loan repayment programs; and clearly developing competitive compensation packages for those people who will provide service in underserved areas—that is a major problem. Our physicians are there, but they are not getting paid for what they are doing compared to what their peers in the suburbs are getting—increasing research on issues related to medically underserved populations—and in this regard, the NMA clearly supports the questions of this committee about activities within the National Institutes of Health—and actively recruiting students for health careers in underserved areas. That means going into underserved areas to look for potential candidates.

Of the almost 60,000 students currently matriculating within medical schools throughout this Nation, only slightly more than 4,000 are African-American. The disparity is even more glaring concerning the other three underrepresented minority populations.

The National Medical Association supports the efforts of the Association of American Medical Colleges Project 3,000 by 2000. This project seeks to increase to the number 3,000, the number of underrepresented minority medical school students entering by the year 2000.

Theoretically, all medical schools have agreed to participate in this endeavor. While most of the discussion centers on increasing the numbers of minority applicants in the pipeline, little attention is paid to the obstacles to current admission of current candidates.

As a 21-year faculty member, I can tell you the obstacles are many; and in many respects, they are race-based. The medical college admissions test does not reflect accurately the potential of many minority students to complete a medical education. This test has been standardized on some populations. But schools have been resistant to fully embrace alternate methods of assessing a student's potential both to complete a medical curriculum and to become a competent practitioner.

Until the 1970's, most African-American physicians were educated either at Howard or Meharry. Morehouse and Drew have contributed significantly to the total number of African-American physicians in practice. But these four schools cannot do it all. They serve their students well by teaching concepts of healing in addition to concepts of securing by teaching concepts of respect for patients and how to relate to minority patients. Unfortunately, these same concepts are not taught in majority medical schools; and, unfortunately, this contributes to the lack of quality care that many underrepresented minorities that many African-American patients receive.

The NMA recommends, therefore, that specific language be included in any legislation which gives educational funding directly to historically Black colleges and universities to include consideration of active funding of an increased capacity for medical student education within these entities.

The bottom line is this: Without an adequate and continuing supply of competent, well-trained African-American physicians, a proportional number of African-American-owned and operated physician groups, and specific mandates stressing African-American inclusion, we can talk reform until we are blue in the face. Our patients and our communities will continue to suffer.

The National Medical Association promises to be persistent and precise in the advocacy of a fair and equitable health care system. I, as a representative of the National Medical Association, will be clear, direct, and, at times, passionate in my own call for equity and excellence in health care delivery because none of us wants anyone's relative to lay on a cart and be labeled an "old anything."

Thank you.

Mr. CONYERS. [presiding.] Thank you, very much. Mr. President, NMA's record is very well known to most of us working in this area. You have a very awesome chore as the current president to continue to move us forward, and you have been doing a great job. We look forward to continuing to work with you.

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

Mr. CONYERS. We are delighted to have George Fountain to bring us some abbreviated remarks considering the time constraints that we are under. All of you have prepared statements, they will be included in the record.

Mr. Fountain, we are pleased to have you here.

STATEMENT OF GEORGE L. FOUNTAIN, JR., VICE PRESIDENT, DISTRICT SCIENTIFIC AND MEDICAL SUPPLY, INC.

Mr. FOUNTAIN. Thank you, Mr. Chairman Conyers and members of the subcommittee. I am George L. Fountain, Jr., and I am the vice president of District Scientific and Medical Supply, a Black

American-owned and operated medical and laboratory supplier. I am here to provide suggestions to increase opportunities for minority medical suppliers under national health care reform.

I would like to begin by providing general background information on the industry and then discuss briefly the problems faced by Black and other minority and scientific suppliers in three areas: The ability to win private contracts, the ability to win public contracts, and the ability to obtain distribution agreements from major manufacturers.

The medical and research industries are made up of hospitals alternative care facilities, health maintenance organizations, nursing homes, teaching facilities, private physicians, and research laboratories.

The medical supply industry is primarily controlled by one large national distributor, where the research product industry is controlled by four large distributors. Distributors in these industries rely upon distribution agreements with major manufacturers; however, these major manufacturers only allow the large firms to distribute their products. This must be changed.

The smaller distributors, especially the Black and other minority distributors, must purchase products from the larger distributors at inflated prices. Our situation is made more difficult by large buying groups. These groups have hospitals and other medical providers as their members. What these groups do is consolidate the medical, scientific, and even pharmaceutical purchases of their members and bid these requirements to only large distributors and manufacturers.

These multimillion dollar contracts that result have no minority participation. This, too, needs to be changed.

The large buying groups, coupled with no requirement for hospitals and other private medical providers to use minority vendors, makes private contracting by Black and other minority medical and scientific suppliers virtually nonexistent.

Simply put, minority firms are not being given opportunities by most private medical suppliers even though most receive some type of Federal funds.

Therefore, I recommend that all medical providers that receive any type of Federal funds be required to establish specific goals to meet the socioeconomic needs of the minority suppliers within their communities. The Black and other minority suppliers must be given the equal opportunity to compete within these private facilities.

Public medical and research facilities also have invisible barriers to preclude Black and other minority medical and scientific suppliers. There is no requirement or preference given to minority suppliers under current small purchase procedures, and this is where the vast majority of medical and scientific purchases originate through small purchases.

The Federal supply schedule process is cumbersome at best and difficult at the least. As a result, there are few Black and other minority firms that hold medical or scientific Federal supply schedule contracts.

The Federal supply schedule process, Public Law 95–507 and the Walsh Healy Public Contracts Act are barriers and must become more friendly to Black and other minority firms.

I have listed a number of recommendations in my written testimony. Essentially, medical research supplies flow through a good-old-boy network in this country; and this must be changed if Black and other minority suppliers are to be given an opportunity to obtain distribution agreements with major manufacturers.

Because of this network, Black and other minority medical and scientific suppliers cannot be as competitive as this industry requires. However, if given the same opportunity to obtain distribution agreements with major manufacturers, the same opportunities to compete for private and public contracts, you will find that the minority firms can be just as competitive as other firms.

It is often easier to set up distribution agreements with foreign manufacturers than it is to establish distribution agreements with American medical and scientific manufacturers.

Therefore, I also recommend that those manufacturers who hold Federal contracts and utilize distribution networks, be required to utilize at least one Black or other minority distributor for their products.

In closing, the area of medical scientific and pharmaceutical supplies, Black and other minority firms are far behind their majority contemporaries. The free enterprise system has not worked to create a level playing field, and there is little interest in public or private industry to reverse these trends.

Therefore, it is important that these paradigms be changed and that we move toward providing equal opportunities for every Black and other minority medical scientific and pharmaceutical supplier.

It is clear that the industry is not interested in correcting the problems that exist. Therefore, legislation is desperately needed.

I thank you for this opportunity.

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

Mr. CONYERS. Thank you. I want to congratulate you because you said a lot very briefly, and it was very important testimony.

This is an area—the business side of health care delivery, especially among medium and small-sized businesses—that we are not unaware of. We are very sensitive to the issue that you brought forward. I am very, very pleased that this gets in the record right off the bat as we begin the national debate.

Mr. FOUNTAIN. Thank you, sir.

Mr. CONYERS. Is there an association of minority supply persons in the country?

Mr. FOUNTAIN. There is none that I am aware of.

Mr. CONYERS. There might be a need for one. I know that we have plenty of organizations in America, but we may want to look at that because, coming together as a group could be very, very important in helping us pinpoint this situation.

But your testimony, if there were such an association, you covered it very, very well. I commend you again.

I am pleased now to recognize Warren Cooper, who represents other parts of the supply business in health care.

We are welcomed to have your testimony at this time.

STATEMENT OF WARREN O. COOPER, PRESIDENT, ACCU-LAB MEDICAL TESTING

Mr. COOPER. Thank you, Mr. Connors and members of the subcommittee. Thank you for the opportunity to appear before you.

I am Warren Cooper. I am president of Accu-Lab Medical Testing in the inner city of Chicago, Illinois. I have been asked to talk today about some of the obstacles that my minority-owned business faces in the current health care industry.

Accu-Lab opened in the fall of 1991. We invested over $170,000 in startup cost, and we do forensic drug chemistry, hair analysis, and drug testing. To my knowledge, we are the country's first African-American owned forensic drug testing laboratory. We have certifications from the State of Illinois, the College of American Pathologists, and the Department of Health and Human Service through their CLEA Program.

We continue to be denied the opportunity to compete for public and private drug testing contracts that we are qualified to execute, solely because of our non-NIDA certification.

The best description I can give about the NIDA certification is to compare it to a modern day Hydra, which I spelled out in my written testimony.

Mr. CONYERS. Well, let's talk that out for just a minute.

Mr. COOPER. The Hydra part of it?

Hydra was a mythical creature where, if you cut off one head, it grew two others. The problem in the drug testing industry is that NIDA requires a fee of $55,000 for the first year, as the Chairman alluded to earlier. The NIDA requirement for companies to use labs that are NIDA-certified is only a smart part of the market. It is only those programs that were under an executive order, not even a vote in Congress. That is some transportation programs and some programs identified in the Government and safety and sensitive position.

But because that is standard out there now, now you have all of private industry saying, well if the Government uses NIDA, then we want to use it, too. Therefore, we are barred out of that particular aspect of health care. That is a growing business. This is a $7 billion a year industry. It continues to grow.

Mr. CONYERS. Thank you very much. The Chair is going to have to declare a very brief recess until Chairman Mfume returns because there is only a few minutes for the vote. He will likely be here within minutes.

So let's stand in recess for just a short while.

Mr. COOPER. OK. Thank you.

[Recess.]

Chairman MFUME. [presiding.] We would like to resume. I apologize for the inconvenience that the votes tend to cause.

Mr. Cooper, you were in the middle of your testimony. Please feel free to proceed.

Mr. COOPER. Currently there are no minority laboratories that are NIDA certified. They lose a share of a $7 billion industry. The NIDA fee is extremely high. Startup costs for NIDA certification is greater than $55,000 plus a yearly fee of $30,000.

This cost is prohibitive for startup or disadvantaged business such as Accu-Lab. This fee is inequitable when compared to similar

fees. For example, an average hospital of 1,000 beds in Chicago pays roughly $46,000 for a 3-year certification to perform all types of tests, from hematology to Pap smears, toxicology, and others.

The need for the NIDA certification has fostered the growth of a parasitic industry that feeds off minorities, yet bars minorities from participation. The Federal Government, by Executive Order 12564, requires that labs performing drug testing on certain Federal employees be NIDA certified. This certification requirement has created the "me too" syndrome which has public and private industry saying if NIDA is required for Government employees, then we should require it also.

Now, nearly all public and private agencies are following the Government by insisting that the lab performing their drug testing be NIDA certified, even where it is not a legal requirement.

I would like to cite quickly two examples of a long list of personal experiences that demonstrate inequity and a significant amount of dollar loss at a crucial time in my business.

The Brach Candy Company tests their employees back from a more than 6 week layoff. Their senior officers examined my lab and agreed to send their employees to my lab for testing. A week later they got the "me too" syndrome and cited my lack of NIDA certification and withdrew the business from me, causing me to lose $150,000.

There was no mandate or no law that required the lab to be NIDA certified. Simply the "me too" syndrome.

The State of Illinois Department of Alcohol and Substance Abuse, better know as DASA, awards contracts to labs to test patients in methadone rehabilitation. The value of this contract is over $200,000. Testing done on patients under doctor's care is defined as diagnostic testing. Only forensic testing is regulated by NIDA. Diagnostic testing is not. Nevertheless, DASA required all labs to be NIDA certified. Again, the "me too" syndrome prevailed causing Accu-Lab to lose substantial revenue.

The whole "me too" phenomenon does more than take business away from Accu-Lab. It creates a vicious Catch-22 situation. Here is how it works: Accu-Lab needs contracts to enable us to pay for NIDA, but we need the NIDA certification to obtain even the non-NIDA contracts. With NIDA as a condition of award, we can't compete. We can't get contracts or loans.

Joint venturing in subcontracting with the industry's leaders has been attempted but not successfully. I was told by one that, "We already have the contracts. What do we need you for?" Another said, "We give some money to the United Negro College Fund. That is the extent of our minority participation."

What fostered these attitudes is the nonenforcement of set aside programs and the inability of the past administration to monitor the efficacy of programs designed to help small and disadvantaged businesses.

One such program is the failed SBA 8a certification program in which I was denied certification. But I must say that, today I am under reconsideration.

Today I ask you to give strong consideration and make steps that would enable Accu-Lab to receive the same consideration as the

first 50 nonminority labs that applied and paid over 30 percent of NIDA certification fee, with the Government paying the balance.

I also ask this committee, as leaders of this country, to take a very active role in the enforcement of minority participation legislation and to be a watchdog over health reform ensuring that there is opportunity and equality for small businesses as full partners in health reform.

Mr. Chairman, members of the committee, thank you for the opportunity to share my experiences and concerns. I welcome any questions that you may have.

Chairman MFUME. Thank you very much, Mr. Cooper.

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

Chairman MFUME. Let me suggest that the importance of these hearings goes to the ability of this subcommittee to establish a public record of testimony that subsequently and, in the future, would undergird any legislative efforts by Members of Congress.

It gives us, if you will, what we need to proceed in many instances. It has been the absence of this public record which has been pointed to by opponents of legislation, which oftentimes we like to think of as progressive, as a rein why that legislation should not be considered.

So I want to underscore how important your testimony and the testimony of others who have preceded you is in that regard. I do have a couple of questions, and I would like to begin with Dr. Lawrence.

Doctor, HMO's servicing the Medicaid population operate under what is known as the 75/25 rule, which speaks to and sets up percentages of memberships delineated by groups.

Can you tell the subcommittee, and for the record, how you think the 75/25 rule has impacted minority-owned and operated HMO's and whether, in this larger scheme of things as we deal with health care reform, it ought to be reviewed in the light of its impact?

Dr. LAWRENCE. Mr. Chairman, I don't know the details of 75/25. But I do know that if you have 500 HMO's in the Nation and only 10 are African-American owned and operated, or less than 10, we have a major problem.

Our people cannot get financing. Our people are excluded, if you will, from major insurance companies who do provide much funding. We don't sit on the corporate boards. We are not invited to the table in that regard, not because we are not qualified, but from that perspective and the perspective of my organization because racism continues to characterize the only interaction pattern.

If you talk about who is in control economically, obviously the more you keep minority populations out, the more you keep their communities subject to the whim of a majority population. I don't mean to say that everything that is racist is based on economics, although there clearly are some people who feel that way. I don't think that minorities are being protected in their opportunity to be full participants within the economic structure of our Nation.

Yet, we are expected to participate fully in the military; we are expected to participate fully as taxpayers; we are expected to provide our bodies if we are indigent for medical students to practice upon while they are in school. I think that that kind of participation dictates that we have full and active access in all other areas

to include the structure and development and the financing and the management and operation of health maintenance organizations and regional health alliances, should they come to be.

We must be full decisionmakers and participants those processes and without legislation, without Federal legislation, we cannot be guaranteed that kind of participation.

Chairman MFUME. Well, I appreciate your earlier remarks about looking at the prospects of setting up set asides that are in line with current set asides in this instance with regard to regional alliances.

The reason I wanted to talk about the 75/25 rule is because, in that percentage of HMO's that are minority-owned and operated, that rule says that Medicaid membership cannot exceed 75 percent of the total. I didn't know whether or not the National Medical Association had some position on whether or not we ought to be reviewing that ratio and to what extent it impacts negatively on those individuals who are already minorities who are operating HMO's.

Dr. LAWRENCE. We don't have specific data in that regard but it is something that we can develop and provide to the committee. We can do that.

[The information may be found in the appendix.]

Chairman MFUME. I feel that everything that is not reformed in this bill, won't get reformed. I don't know when we will revisit this issue.

You also mentioned, Doctor, in your testimony, that a number of minority physicians were losing their patients to HMO's and then subsequently losing their practices.

Does the National Medical Association have or have you developed statistics on the number of physicians, minority physicians, that, in fact, have lost their practices over the last 5 years as a result of this outflow to HMO's?

Dr. LAWRENCE. At this point, it is anecdotal. We are attempting to develop this to be able to provide hard and specific data.

Many of the people who we are talking about don't have the resource, if you will, to constantly reach out and provide this data. They are struggling to feed their families and maintain some kind of viable income.

But, again, this is another area where we can see if we can generate some kind of hard data.

[The information may be found in the appendix.]

Chairman MFUME. Mr. Fountain, you have suggested that Public Law 95–507 and the Federal Supply Schedules and Contracts Act in other things are starting to act as barriers to preventing you from being successful at what you do.

Mr. FOUNTAIN. Yes, sir.

Chairman MFUME. I think that it is fair to say that there are a lot of people who will read this testimony whose eyebrows may have been raised to 95–507 because it was set up to ensure the kind of set aside and to assure a guarantee of participation by minority-owned firms.

So I am very interested in knowing how it is negatively impacting at least those in your field because if there are ways of correcting that, we want to be in the business of doing that.

I welcome your response to that.

Mr. FOUNTAIN. If you read 95–507 correctly, it creates a preference to small business. There is no reference to a preference for small and disadvantaged business. As a result, Federal contracting officers and purchasing agents are systematically, by passing the small disadvantaged firms and going to majority small businesses. There is no preference for them to utilize disadvantaged firms.

Chairman MFUME. I am a bit confused because I thought 95–507 was developed to ensure minority business involvement and that it was a set aside primarily within the Defense Department to begin something that would ensure and allow that. The question that has previously existed around 95–507 does not so much, with the wording of the law, but rather the definition of minority which tended to create problems.

You are suggesting that that is not the case?

Mr. FOUNTAIN. That is correct. Public Law 95–507 Chapter 3 section 221(j) establishes small purchase procedures and reserves these purchases exclusively for small business concerns. There is no mention of the utilization of Black or other minority disadvantaged firms.

Chairman MFUME. Does the language say socially or economically disadvantaged?

Mr. FOUNTAIN. No, it does not.

Chairman MFUME. I am going to get the law. This is new to me. I appreciate your calling my attention to it. Before we wrap up, we will take a look at what is exactly in the law.

I am going to go, instead, to Mr. Cooper. There was something that you said that majority-owned firms are doing testing and they have been waived from the full requirement of NIDA certification and are being allowed in paying 30 percent of that certification.

Mr. COOPER. That was the first 50 labs that made application for it. I understand that the first 8 to 10 actually received a grant from the Government to set up the mechanism and then they just declared themselves as certified. Then when they needed 50 more, they said, we will let them in at a 30 percent cost.

Chairman MFUME. When did that occur?

Mr. COOPER. 1988 and 1989. There was an article in the Washington Post 4 years ago that referenced those labs that received the grant from HHS and set up this type of mechanism.

Chairman MFUME. I am sorry that I dismissed Dr. Broadnax, because that goes to the heart of the question that, how do you facilitate entrepreneurs who are doing blood testing to come in and participate in what is an increasingly lucrative field in light of NIDA regulations.

So we have got—you are telling me we have about 100 different providers on—or 50 or more——

Mr. COOPER. We have 90 NIDA certified laboratories as of today. None of those are minority, and none of them have been.

In the past 10 years since this executive order was enacted, all the drug testing for the Federal Government and Federal mandates programs had to go to those laboratories.

But then you have got other startup companies because a company like AT&T or a drug rehab center, they don't have to use a

NIDA lab; but because that is the standard, now they are forcing a startup company from making any type of money.

There is $750 billion that is slated to go into a crime bill. That money is to be used for testing incarcerated prisoners and aftercare. If they make NIDA the standard for that in that bill, then a small company like mine won't be able to play in the NIDA field.

So you constantly have legislation being enacted that requires testing. But if they write that NIDA in there, they know that they are writing out minorities or small and disadvantaged companies at that time. The Justice Department is exempt for NIDA.

It is clearly in the Federal regulation that the Justice, the Post Office, and the military is exempt from the NIDA requirements. Yet the $11 million that is spent in Justice, someone wrote in the contract, you must use a NIDA certified lab.

The Post Office tests 150,000 people a year, and NIDA is written into that as well.

So a small company cannot get involved in this. There can't be minority participation, because no matter how much you set aside, if you write "NIDA" there, the set aside is right out the window; the guy comes back and says, we don't have any minorities who are certified so we don't have to worry about this.

Chairman MFUME. So all of the drug testing where it is required for a Federal agency to use the NIDA certification, and increasingly where it is not a requirement but it is something now that other agencies are looking at as a benchmark, is being done by 90 or so firms in the country, none of which are minority?

Mr. COOPER. That is correct, sir.

Chairman MFUME. Fifty of which had 30 percent of their entry fee waived. Is that correct.

Mr. COOPER. That is correct.

Chairman MFUME. Was the waiving done by the National Institutes of Drug Abuse?

Mr. COOPER. The waiving was done by the contractor that HHS paid to go out and look at these labs. That is called Research Triangle Institute. It is on the first page of the application which says that the first 50 labs have that waived.

Chairman MFUME. Mr. Zanders, could you come back to the panel table for a moment since you do, in some capacity, represent Dr. Broadnax and the Agency.

Would you be kind enough to share with Dr. Broadnax this portion of the testimony that he did not have an opportunity to hear, which goes back to my original question to him regarding the certification requirements.

Could you request that he submit to the committee some sort of response to the suggestions by Mr. Cooper that this waiver occurred allowing 50 firms in and that we are now in a situation where we have almost 90 firms in the country operating, working through HHS, and working with other agencies now, none of which represent any minority-owned businesses of any type.

I would appreciate it if he could communicate back to members of the full committee some type of response with respect to these new aspects of this interesting

predicament.

Mr. ZANDERS. All right. I will.

[The information may be found in the appendix.]

Chairman MFUME. Mr. Cooper, what is the prospects of Accu-Lab's longevity should you not be able to gain NIDA certification?

Mr. COOPER. My company is going to suffer. The inner-city that we serve is going to suffer. As more firms and more Governments require the NIDA certification, the less work we will have to do, unless we go and branch out into another field, which, after all, the money we have spent on the equipment that we use now, that might be a little bit frivolous.

Chairman MFUME. Mr. Fountain, on page 4 of your testimony, you say Federal contracting officers and general purchasing agents tend to routinely and consistently bypass Black and other minority medical scientific suppliers.

How do you see that taking place?

Mr. FOUNTAIN. Under small purchases, most purchasing agents are required to solicit telephone quotes from three sources of supply. In the event that there are five sources of supply and three of those sources are nonminority firms, small business firms, the purchasing agent normally will go to those three firms first.

Public Law 95–507 gives no preference for that purchasing agent to utilize the services of the minority firms whatsoever. They only have to utilize the services of small businesses.

Chairman MFUME. OK. I have received from staff Public Law 95–507, which, as you know, became law October 24 1978. I want to try, if I might, to clarify your reference earlier about it being an impediment because it doesn't set up a standard for procurement for minority-owned businesses.

What the law actually does is to break out small purchase procedures and then general purchase procedures. Small purchase procedures are considered to be those that have an anticipated value of less than $10,000 and which are subject to small purchase procedures generally and exclusively heretofore used and mentioned for small business concerns, unless the contracting officer is unable to obtain offers from two or more small business concerns.

So, I assume, then, that your remarks were set aside to reflect the law as it relates to small business purchases, those that are 10,000 or less?

Mr. FOUNTAIN. Yes, sir.

Chairman MFUME. And let me read further, to suggest that general business purchases by small business concerns owned and controlled by socially and economically disadvantaged individuals in procurement contracts of such agencies having values of $10,000 or more would, in fact, be set aside for a group of people who would then fall under this category of economically and socially disadvantaged.

I was not in the Congress at the time the law was written, but I have reviewed it many times and have seen similar laws. I think there was a deliberate effort here to set up a system that, on major purchases, based as—possibly it was on the testimony of minority entrepreneurs—that on major purchases over $10,000 that you ought to put in guarantees that there be a set aside for either to participate.

Probably what was considered small purchases, less than $10,000, were left this way for the general pool of individuals, whether you were a white-owned business, female-owned business, minority-owned business to compete from.

I wanted to clear the record on that, not to suggest that your concern is not a valid concern whether or not it creates an impediment for you; but at least, to you, then, we are talking in this instance about small business or small purchases.

Mr. FOUNTAIN. Yes, Mr. Chairman. I would just like to add that it is important to realize that the purchases for less than $10,000, it is at that level that most new firms are entering into this marketplace.

Purchases over $10,000 are very good. However, most new firms entering into the arena with purchases where purchases are very small. I think it is very important that Public Law 95–507 go one more step and give a preference to Black and other minority firms in the arena of small purchases, which right now it does not.

Chairman MFUME. The small purchases are not the purchases by the company. It is the small purchases by the Government contracting agencies. So, if an agency needs to purchase, let's say 2,000 pencils, it would fall under that category and they would try to look for the individual who, in a general sense, as a small business, not necessarily a minority, to make that purchase with.

Well it helps, certainly, to give us an idea of whether or not we ought to look, as a Congress, about modifying 95–507. Part of our overwhelming disability has been the inability to make sure that just the law itself, in terms of purchases over $10,000, was adhered to. This was an ongoing battle, one that we thought was close to playing out at the expiration of the original law. It has been continued, and it is something that has generated and taken a great deal of time by this committee and other members who are concerned about minority business development.

Mr. Zanders, you wanted to comment?

Mr. ZANDERS. Just as an add-on, there is current legislation now where the SDB set aside is coming through Congress now that I think has full support, where all agencies, Government agencies, can utilize SDB set asides, which I think would help Mr. Fountain as well. But at this point, we do not have it. But I think before the year is out or something, those SDB set asides will address the question that Mr. Fountain as.

Chairman MFUME. Do OSDBU's have, currently or implicitly, the ability to contract out these small purchases to minorities if, in fact, they realize that they are minority entrepreneurs who are outside of the agency who can provide the product or the service? Or are they limited by law here?

Mr. ZANDERS. By law in terms of we could not restrict that just to SDB's. By law we cannot do——

Chairman MFUME. I understand that. But if purchases under $10,000 are to be made to the general small business community, of which there happened to be minority business members, it doesn't count one out of the competition. It just means that the competition is broader.

But I think that what Mr. Fountain is suggesting is that there is some other layer here in which the contracting officer is perhaps deliberately overlooking minority businesses.

Whether or not that is the case, I don't know; and we won't find out in this hearing. But I wanted to know if OSDBU's or others or purchasing agents, to the best of your knowledge, look at the universe of qualified suppliers, or are the awards made in a different way through an RFP, or arbitrarily? I don't know.

Mr. ZANDERS. It is more from a universal inclusion, more so than we can set aside just for a particular group in the small purchases at this point.

Chairman MFUME. Well we will try, Mr. Fountain, to look at it as a subcommittee. I need to be honest with you, it is not a matter that has come before us before; but there are a lot of matters that don't come before us until we have a hearing.

But we certainly want to thank you and Dr. Lawrence and Mr. Cooper, for sitting with us for the morning and part of the afternoon so that we might be able to benefit from your testimony and certainly that you responded to the questions of the Chair.

As I indicated earlier, it is extremely important for us to put in place a public record and body of evidence that there are, in fact, problems that allow some justification for moving legislation, particularly in the minds of those who may be opposed to any kind of legislation,. So these hearings go a long way in achieving that.

I want to dismiss this panel and to declare this subcommittee adjourned.

Thank you very much.

[Whereupon, at 1:27 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

APPENDIX

STATEMENT OF
THE HONORABLE KWEISI MFUME
CHAIRMAN

SUBCOMMITTEE ON MINORITY ENTERPRISE, FINANCE
AND URBAN DEVELOPMENT

HEARING ON
"IS HEALTH CARE REFORM HEALTHY
FOR MINORITY ENTERPRISE?"

NOVEMBER 9, 1993

The committee will come to order. First, I would like to say good morning, and welcome, to the members of the Subcommittee, our distinguished witnesses, and ladies and gentlemen in the audience. Today, the Subcommittee will take up an issue that has been the topic of much debate and controversy since President Clinton's national address on September 22. That issue is national health care reform.

Not since the New Deal has a President proposed such a grand plan that appears to offer so much to so many. The debate over this plan however, has generated as much acclamation as it has criticism, partly because the details of the legislative proposal have not yet been released. Meanwhile, Congress has been engaged in the consideration of a broad range of proposals to control the growth in health care spending, which is at the center of the debate. Another fundamental element in this debate is the issue of how to expand health care access for an estimated 36 million uninsured Americans and a large number of underinsured, without fueling inflation in health care costs, and without imposing significant costs on the Federal or state governments. It should

be noted that the Federal government now spends about 42 cents out of every health care dollar.

All sectors of the health care industry hope to influence the shape and scope of the President's plan to address their individual concerns, and are currently staking out positions for the struggle that lies ahead. The distinct and divergent interests surrounding these debates is not surprising when one considers that the President's plan could lead to a massive redistribution of income among American workers and businesses within the estimated $800 billion health care industry.

My colleagues and I in the Congressional Black Caucus, believe the hallmark of any national health care reform package should be quality coverage for every citizen that is accessible and affordable. To paraphrase one writer, the quality of our lives is best measured by how the poor and disenfranchised among us are treated. Accordingly, we would strongly challenge any proposal that makes low- and fixed-income elderly and poor citizens choose between co-payments for health care and meals or other sustenance necessary for basic survival.

As mentioned earlier, the debates surrounding health care have focused on the need to contain medical care related costs, and how to expand health care access. When we examine the current variety of health care reform proposals, we see little evidence that

consideration is being given to the minority community beyond its health status or its role as ultimate consumer of health care services. We have not yet seen any manifest regard for Hispanic American, African-American, or Native-American primary-care physicians and nurse practitioners, insurers, managed care organizations, generic drug makers and distributors, and others involved in this massive undertaking, where the Federal government plays such a large and critical role. In addition to concerns about the potential costs imposed on minority-owned small businesses, this Subcommittee is concerned about the potential for managed competition proposals and others to limit, by exclusion, opportunities for minority providers and suppliers of health care services to participate in a meaningful fashion in the day-to-day operations of a national health care system.

While we all may question the details and implementation of a national health care system, we should recognize the courage exhibited by the President and the First Lady, to bring this issue to the forefront of political debate. Far too often, we as a nation, permit major problems to grow unrestrained while we remain paralyzed by their complexity. Since all elements of the multi-billion dollar health care industry are delicately intertwined, and require proper balance, it is imperative that we build into any comprehensive reform measure an obligatory and effective mechanism for inclusion of minorities in every facet of the effort to expand health care coverage to all citizens. That, ladies and gentlemen,

is the focus of our hearing today. Through the testimony we receive today, it is our intent to ensure that future debates on national health care reform address the entire range of economic interests of the minority community.

The Subcommittee is honored to welcome two of our distinguished colleagues who are here today to present, in outline fashion, their respective proposals for a national health care program that contemplates a broad range of health care interests of the minority community. We are also pleased to welcome the Deputy Secretary of the U.S. Department of Health and Human Services, who has been invited to share with us HHS' commitment to the participation of minority businesses in the framework of health care reform and more generally within the overall mission of the Department. Finally, we will hear from the President of the oldest national African American physicians group in the U.S., and representatives from a medical testing and a medical supply company.

Before I introduce our first two witnesses, I must advise the members and witnesses that we will proceed under the five minute rule. Accordingly, I would ask that witnesses limit their oral presentations to 5 minutes. Witnesses are further advised that your written statement shall be printed in its entirety in the official hearing record. Finally, the hearing record will be kept open for 5 legislative days to permit additional testimony from individuals not present today, and to allow Members to revise and extend their remarks. Hearing no objection, it is so ordered.

At this time, I would like to yield to the Ranking Minority Member of the Subcommittee, the Honorable Ronald K. Machtley (RI), for opening remarks.

Congressional
Hispanic Caucus
NEWS RELEASE

244 Ford Building, Washington, D.C. 20515 • (202) 226-3430

Testimony of Congressman José E. Serrano
Chairman, Congressional Hispanic Caucus

Before the House Small Business Subcommittee on
Minority Enterprise, Finance and Urban Development

Tuesday, November 9, 1993

Mr. Chairman, I come before you as Chairman of the Congressional Hispanic Caucus. I appreciate the opportunity to testify on direction health care reform must take in improving health care infrastructure and manpower in Hispanic communities. Health care reform that does not invest in our communities and empower them to develop responsive, community-based health care systems is not serious reform. A restructured health care industry must promote the development of health care providers that truly meet the needs of Hispanic and other low-income communities and must not foster a two-tier health care system.

My testimony will focus on the following:

- Hispanic health service and access needs;
- The need for infrastructure and manpower development in Hispanic communities; and
- The responsiveness of the Department of Health and Human Services (DHHS) to the health needs of Hispanics.

HISPANIC HEALTH SERVICE AND ACCESS NEEDS

No single group is more negatively affected by the health care crisis than Hispanics. Despite the fact that they work and play by the rules, one out of three Hispanics lack health insurance coverage (33%). This is more than any other major group.

Hispanic males have the highest labor force participation rate in the nation, but they tend to be employed in low-wage occupations and industries that typically do not provide health insurance benefits. In 1992, a staggering 44% of employed Hispanic males 16-64 years were uninsured, compared to 32% of African American and 18% of White males. What's more, their working-poor status often makes them ineligible for public coverage through Medicaid.

Hispanic children are uninsured at twice the rate of other children, and Hispanic elderly are the last in their age group to have health insurance coverage through Medicare.

The lack of health insurance contributes to the disadvantaged socioeconomic status of Hispanics because they must spend a larger share of their disposable income on health care. Providing health insurance coverage may be the single most important stroke to lifting many Hispanic working families and individuals from poverty.

In more human terms, lack of preventive care and early treatment mean that Hispanics are getting sick and dying unnecessarily. Many preventable diseases such as diabetes, tuberculosis, AIDS and certain cancers are major killers of Hispanics. According to a 1991 article in the Journal of the American Medical Association, Hispanics have the lowest level of medical and mental health care utilization in the country.

HISPANIC INFRASTRUCTURE DEVELOPMENT AND MANPOWER NEEDS

Aside from improvements needed in financing comprehensive health services and assuring basic health care for all Americans, the vitality of community-based health care delivery systems and the availability of physicians affect Hispanic access to health care.

In April, the Hispanic Caucus adopted health care reform principles. One principle states that a reformed health care system must improve and enhance medical teaching hospitals, solo practitioners, health maintenance organizations, community health centers, and other community-based health clinics that service Hispanic and other underserved populations. A second principle calls for greater minority access to medical education and creation of incentives to increase the number of bilingual and bicultural primary physicians and other health care providers.

For Hispanics, a simple matter such as finding a doctor or a primary care facility, something most of us take for granted, poses a huge problem. The General Accounting Office, in January of 1992, reported that in El Paso, Texas, -- where Hispanics represent about 75% of the population -- only 30 of the city's 800 physicians maintained practice in the poorest part of the city. That means that 4% of the city's physicians serve 32% of the El Paso population. In addition, there are only two federally funded health centers to serve the entire El Paso County.

In my district in the Bronx, we experience similar shortages, particularly a lack of health care providers offering primary care to Hispanics. A study by the Health Systems Agency of New York City found that the major health problems and barriers in the South Bronx included 1) adverse birth outcomes, 2) high hospital admission rates for preventable

conditions, 3) AIDS, 4) substance abuse, and 5) high proportions of non-English-speaking residents. The study noted that interventions needed to ameliorate these health risks and barriers included improved access to primary, preventive care. Yet, the few available health centers do not have the capacity to meet the demand for services by the 552,000 persons who reside in the South Bronx.

The need for improvements in the basic health care infrastructure and manpower to meet the health care demands in Hispanic communities is extensive. Many Hispanics and disadvantaged communities currently obtain health care through a fragile network of "safety-net" providers, local family practitioner, and others. Hispanic communities are in need of linguistically and culturally appropriate services. This includes interpretation and translation services for Limited-English-proficient populations. Indeed, the lack of appropriate language services violates the civil rights of, and often results in human suffering for, individuals who require such services to access health care.

Hispanic community-based and -run practices and community health centers have a proven record of meeting the needs of Hispanics. For this reason, health care reform must maintain and strengthen minority-run and -owned health care facilities as part of a viable public health network. Also, by investing in minority health care providers and community-based infrastructure, we can avoid the development of a two-tier health care system.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE TO HISPANIC HEALTH CARE NEEDS

It is important to remember that U.S. Department of Health and Human Services (DHHS) will be responsible for administering the public health component of health care reform. Existing programs and hiring practices strongly suggest that DHHS is currently not sensitive to the health needs of Hispanic communities.

Hispanic employment within the DHHS labor force is dismal, particularly at high level policy and administrative positions. As of June 30, 1993, only 5% of the total 124,376 persons employed at DHHS were Hispanics. Only 2.7% of the management and top level policy positions were Hispanic (GS/GM 14 and above and equivalents). As of the first quarter of FY93, only 1.6% of the federal labor force at the National Institutes of Health (NIH) were Hispanics, and only 0.4% of NIH manager positions were held by Hispanics. During the same period, 2.7% of the professional positions at the Health Resources and Services Administration were held by Hispanics.

It is difficult to comprehend these low staffing patterns at a time when Hispanics are a growing presence in the U.S. Hispanics represent one out of every 11 persons in the U.S.

The Hispanic Caucus-sponsored H.R. 3230, the Minority Health Opportunity Enhancement (M-HOPE) Act of 1993, takes a thorough look at existing programs within DHHS and reviews their responsiveness to the health care needs of Hispanics. I will share with you a few of the findings which were deeply troubling.

- First, Hispanics are grossly underrepresented in the health professions. Data indicate that Hispanics represent 4% of U.S. physicians, although Hispanics represent 9% of the U.S.

population. Let me clarify that many of these physicians are foreign medical graduates, whereas the U.S. medical education system seems to be graduating only half of those Hispanic physicians. However, Hispanic participation is very poor in key programs that focus on increasing the number of minority health professionals. The M-HOPE Act addresses this inequity by encouraging certain programs to more equitably allocate resources and services among groups served. It also includes an outreach and peer review process to ensure that such efforts are inclusive and target all racial and ethnic groups.

Second, two of the criteria used in designating medically underserved areas (MUAs) exclude Hispanics. The 65-and-over factor works against Hispanics since Hispanics are a young population. Also, although Hispanic communities experience poor health status, the emphasis on infant mortality fails to consider Hispanic health needs. Infant morbidity is more appropriate in measuring Hispanic health status. MUA designation helps in directing community health center and other resources to develop and strengthen community-based health care capacities. The M-HOPE Act attempts to remedy this inequity by including additional factors to the MUA index that more suitably measure health status and medical underservice, such as uninsurance and morbidity rates.

The M-HOPE Act does not attempt to broadly reform the U.S. health care system, and thus is not intended to compete with the Administration's Health Security Act or any other effort to reform our nation's health care system. Instead, by improving existing DHHS programs, the M-HOPE Act compliments health care reform proposals and is meant to be used as a blueprint for improving the service of Hispanics by DHHS programs.

I applaud the principles that underlie President Clinton's health care reform plan. These principles form the core of an effective and equitable overhaul of our nation's inefficient and often unfair health care system. Secretary Shalala has demonstrated an early interest in listening to our serious concerns on how things have been done in the past.

The Hispanic Caucus is committed to working with this subcommittee to look for avenues to ensure that quality health care opportunities are available to all. Thank you.

The Honorable Lucille Roybal-Allard
Statement

Subcommittee on Minority Enterprise, Finance and Urban Development
Opportunities for Minorities in Health Care
November 9, 1993

Mr. Chairman:

It is a pleasure to be here today.

Thank you for holding this hearing to consider the current opportunities for minorities in the health care industry, the impact of health care reform on the opportunities for minority business, and the performance of the Federal government in meeting its responsibility to develop minority health care business.

I welcome our distinguished guests. Thank you for coming. I look forward to your testimony.

The health care industry, as a whole, and the Federal government, in particular, have not done a good job in making sure that minorities have a chance to participate equally and fully in the business of health care.

Minorities are under-represented as doctors, technicians, specialists and other health care professionals. Minorities are equally under-represented as owners, managers and administrators in the non-medical business of health care.

Worse, in some ways, is the record of the Federal government. Even though the official policy is one of equal opportunity and affirmative action, the Federal government has not done a good job in recruiting, hiring, training, educating and promoting minorities in the field of health care.

As you may know, the Congressional Hispanic Caucus has introduced the Minority Health Opportunity Enhancement Act of 1993, the M-HOPE bill. This Minority-HOPE legislation is designed to correct past inequities and to ensure full and equal participation for minorities in the future.

My esteemed colleague and Chairman of the Hispanic Caucus, Representative Jose Serrano, will have more to say about the M-HOPE legislation, so I will leave that to him.

I will say, as the great debate on health care reform goes forward, it is appropriate and necessary to confront the inequities of minority opportunities in the health care industry. It is also part of our oversight responsibility to ensure that the Federal government meets its responsibility to provide opportunities for minority business and to hire and promote fairly.

Finally, it is completely appropriate for this committee to look for and to find ways to help minorities meet the challenge of health care reform.

I look forward to working with the Chairman, with members of the committee and with our special guests to make sure that opportunities exist for all in the business and in the profession of health care.

Thank you, Mr. Chairman.

Thank you Mr Chairman,

I would like to welcome our distinguished guests here today. I appreciate the time you took out of your busy schedule to appear before us today.

I am deeply concerned about the effects of health care reform on small businesses. The president's health package demonstrates how insensitivity this administration is in dealing with small businesses as it relates to health care reform.

Mandated costs and higher taxes are not the answer to our health care

dilemma. Since 2/3 of all businesses in the United States are small firms, we cannot force unreasonable costs and regulations on these jobs generators.

While these issues are being debated, there is another issue that has been overlooked and for the most part forgotten. The effects of health care reforms as it relates to the minority enterprises within the health care industry.

This is an issue that will not attract public attention but it is important none the less. This morning, our focus will be centered on the problem of minority businesses participation within the health care industry.

As an example, within the United States there are only approximately 7 minority owned HMOs and less than 3% minority physicians. In an industry that generates $800 billion, the lack of minority participation should become part of the overall health care discussions.

During my preparation for this hearing, it became clear to me that there is little information available on participation by minority owned enterprises in the health care industry.

I am concerned that, with such limited information available, these firms may go unnoticed as the health care debate on Capital Hill begins.

This hearing today will be an important step to understanding the problems and frustrations facing those minority firms already in the health care industry as well as others who wish to become part of it. Increasing the number of minority owned enterprises within the health care industry can only have benefits.

Two in particular come to mind.

1) If we take into account that most minority small businesses are located in urban areas where medicaid recipients are the highest, then the creation of more minority owned, small health care enterprises can only benefit those in need, by providing them easier access to health care providers.

2) Job creation is an another important benefit. In my home state of Rhode

Island, the health industry is the fast growing segment of our economy with most job growth occurring in this area. Any new opportunities for minority businesses in this industry can only result in even greater job growth.

If we are truly to address the issues of reform, we must understand all the players in it. An open, honest debate can only occur when all are allowed to participate. I look forward to the testimony this morning. I am here to listen and to learn.

Statement of

Walter D. Broadnax, Ph.D., Deputy Secretary

Department of Health and Human Services

Before The

Subcommittee on Minority Enterprise, Finance, and Urban Development

Committee on Small Business

United States House of Representatives

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today to discuss HHS' strong commitment to the participation of small businesses and small disadvantaged businesses in the framework and mission of the Department of Health and Human Services. HHS has an outstanding record, and continually increases the number of prime and subcontract awards being made to small businesses in general, and to small disadvantaged businesses in particular.

As you may already know, the fundamental mission of HHS is to protect and advance the health of the American people and to improve their quality of life. In one way or another, HHS touches the life of almost every person in the United States. HHS oversees over 250 vital health-related programs including *AIDS research, cancer treatment, alcohol and other drug abuse prevention, immunization, Medicare, Medicaid and Social Security*. From ensuring that the medicines we take are safe, to helping families gain self-sufficiency through financial

aid and job training, to making sure all babies get a healthy start through good prenatal care - *HHS Affects Nearly Everyone.*

We at HHS embrace the notion that the small business and the small disadvantaged business communities contribute to the economy in several critical ways: being the key generators of new jobs; applying new technologies; introducing new products; and serving new markets. This contribution is especially true of the small businesses and small disadvantaged businesses that participate in the acquisition programs at HHS. The significant contributions made by small businesses and small disadvantaged businesses, for HHS, are evidenced by the fact that there are no areas of biomedical or behavioral research in which small businesses and small disadvantaged businesses are prevented from participating. The demonstrated capabilities and competencies of small businesses and small disadvantaged businesses ensure that they are second to none in satisfying the programmatic needs of this Department. HHS remains committed to the development and expansion of acquisition opportunities which can, and will, encourage small business and small disadvantaged business participation. Small businesses and small disadvantaged businesses provide a vehicle for the transfer, dissemination, and replication of new technology that is developed in the various programmatic areas of HHS.

In order to carry out our mission responsibilities, it is the policy of HHS is to stimulate competition among potential contractors and to make awards on a basis consistent with quality, efficiency, and economy. Equally important, it is HHS' policy to ensure that

opportunities to compete for, and receive a fair share of, the Department's acquisition expenditures are provided to small businesses, small disadvantaged businesses, women-owned small businesses and labor surplus area concerns.

In the letter of invitation, the Committee requested that my statement address a number of questions with respect to HHS' small disadvantaged business programs. I welcome this opportunity to talk about HHS' small disadvantaged business program because I believe it is one of the best programs of its kind in government.

I will provide summary statements in response to the questions outlined in your invitation. Detailed responses are contained in my formal statement that has been provided to the Committee.

The Small Business Act, as amended by Public Law 100-656, requires that the President establish annual Government-wide goals for acquisition awards to small businesses and small disadvantaged businesses. The statutory goal for small business participation is at least 20 percent of the total value of prime contract awards. The statutory goal for small disadvantaged business participation is at least 5 percent of the total value of prime contract awards and 5 percent of the total value of subcontract awards. Historically, HHS has exceeded all of the statutory goals for small business participation on a consistent basis. In Fiscal Year 1992, HHS awarded approximately 40 percent

(over $1 billion), of its total acquisition awards to small businesses; and about 13 percent of total awards (over $328 million) was awarded to small disadvantaged businesses. We think this is particularly noteworthy. In addition, small disadvantaged businesses received approximately 8 percent ($18 million) of the total subcontracting dollars from prime contracts awarded by the Department. This achievement is made possible because of institutional acceptance and support of the preference programs throughout the Department. I am proud to be a part of one of the top small and small disadvantaged business programs in government.

The Office of Small and Disadvantaged Business Utilization (OBSDBU) enjoys complete support from the Office of the Secretary. This support is evidenced by the fact that the Director reports directly to the Deputy Secretary of HHS, in accordance with the provisions of Public Law 100-656. The Department's Assistant Secretary for Management and Budget provides the needed administrative and logistical support for OSDBU. This arrangement ensures all necessary resources are available to OSDBU.

The OSDBU establishes and maintains outreach programs to provide a flow of information about HHS' Small Business Programs to small, small disadvantaged, and women-owned businesses. OSDBU staff provided personal counseling and marketing assistance to over 2,000 interested small

businesses during Fiscal Year 1992.

OSDBU also developed and distributed over 7,000 copies of various publications designed to assist individuals and organizations in understanding the mission and programs of HHS. These publications included - *DOING BUSINESS WITH DHHS, HHS' ANNUAL REPORT ON THE SMALL BUSINESS PROGRAMS, a FORECAST OF HHS'CONTRACTING OPPORTUNITIES FOR SMALL BUSINESS, and the SUBCONTRACTING DIRECTORY.* Each publication provided information to acquaint current and potential contractors with continuing and available acquisition opportunities.

HHS is an active participant in most of the congressionally-sponsored Federal Procurement Conferences held each year. Component agencies within HHS sponsor mini-procurement fairs, which assist firms in understanding the mission and objectives of that particular agency. Hundreds of small and small disadvantaged businesses are invited to meet directly with the agency's technical and contracting personnel. The interest in these conferences has been high, and attendance has been very good. We have utilized the Commerce Business Daily to publicize the event. During this year's MED Week activities, OSDBU conducted a session in which several of our prime contractors participated in a forum discussion on techniques for affording SDB the maximum opportunities to be potential subcontractors.

Mr. Chairman, I would like to personally assure you that HHS places the highest priority on the full participation of small business and small disadvantaged businesses in the HHS programs. This concludes my opening statement. I would be please to respond to any questions the Committee may have.

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RESPONSES TO COMMITTEE QUESTIONS SUBMITTED IN WRITING

QUESTION: DESCRIBE YOUR AGENCY'S CERTIFICATION PROCESS OF SMALL DISADVANTAGED BUSINESSES;

Standard acquisition practices allow HHS to accept potential offerors' and bidders' good faith, self-certification representation for specific bids and/or proposals. However, challenges of, and questions concerning, a specific representation will be referred to the SBA in accordance with the Federal Acquisition Regulation 19.302.

QUESTION: DESCRIBE THE DEPARTMENTS METHODS FOR COMMUNICATING PROSPECTIVE CONTRACTING OPPORTUNITIES

HHS employs a number of methods which insure that the maximum practicable opportunity to participate in contracting opportunities is afforded to small disadvantaged businesses. Like many other federal agencies, HHS is anticipating the implementation of a government-wide Small Disadvantaged Business set-aside program.

This program will be modeled after the program now in effect at the Department of Defense, and will complement the 8(a) Program by providing additional contracting opportunities for firms, both while they are participating in the 8(a) program, and after they have graduated. However, until the actual passage of the SDB Program legislation, HHS will continue to utilize the following methods to inform small disadvantaged businesses of contracting opportunities with HHS.

- With few exceptions, HHS' acquisition officials will continue to publicize all acquisitions of $25,000 or more in the Commerce Business Daily.
- Departmental Small Business Managers will continue to routinely include the names of small disadvantaged businesses on the solicitation mailing lists.
- In certain acquisition areas that support research and development programs, Sources Sought Synopsis notices will continue to be published in the Commerce Business Daily. These notices specifically request only small businesses to respond in order to assist in the final determination to set-aside an acquisition when there are questions concerning the availability of small business with the prerequisite capability. The notices provide potential sources with information concerning an upcoming acquisition and give the potential sources an opportunity to submit information which demonstrates their capabilities. This process essentially serves as a "market survey" of potential sources.
- The Office of Small and Disadvantaged Business Utilization (OSDBU) will continue to develop and disseminate the Department's annual **Forecast of HHS' Contracting Opportunities for Small Business**. This publication is published pursuant to Public Law 100-656. The Forecast is a marketing tool to assist small businesses and small disadvantaged

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businesses in determining where to market their products and services for potential contracting opportunities. The Forecast specifically indicates the acquisition opportunities for small business and 8(a) firms.

- OSDBU will continue to conduct bi-monthly "Marketing and Counselling Sessions," which provide information on how to do business with HHS. These sessions offer; 1) a comprehensive overview of the component agencies under HHS; 2) Marketing techniques for potential contractors on how to make their capabilities and services known; 3) a point of contact for acquisition assistance within a particular component, and 4) the dissemination of technical assistance publications, which include How To Do Business With HHS, Subcontracting Directory, and Location Directory of Small Purchase Bulletin Boards.

- OSDBU participates in numerous small business conferences throughout the fiscal year. These conferences included state and local government sponsored fairs, congressionally sponsored procurement conferences, and the SBA/MBDA MED Week activities. In addition, OSDBU facilitated HHS' participation in several national events hosted by the National Business League, the National Contract Management Association, the National Association of Black Procurement Professionals, the National Association of Professional Asian American Women, and the Latin American Management Association.
- OSDBU is participating in an effort with National Institute of Standards and Technology to meet the electronic small business notice requirements under the President's memorandum for streamlining procurement through electronic commerce.

QUESTION: WHAT ARE THE HISTORICAL (FY' 1990, 1991 AND 1992) AND CURRENT TARGET PERCENTAGES FOR CONTRACTS AWARDED TO SDBs. (THIS DATA SHOULD BE PROVIDED SEPARATELY FOR PRIME CONTRACTORS AND SUBCONTRACTORS AND SHOULD ALSO BE SEGREGATED BY ETHNICITY* AND GENDER)

(*) HHS does not maintain contract award information that reflect ethnicity.

See Attachment #1

QUESTION: DESCRIBE THE PROCUREMENT CATEGORIES FOR WHICH THE AWARDS HAVE BEEN LET

Attachment #2 depicts how HHS spends contract dollars for various commodities. For purposes of simplicity, the commodity categories have been divided into four (4) groups:

1. **Management Consulting services** - includes such areas as studies, conferences, training, technical assistance, surveys, program evaluations, logistical-management and research support, and biomedical research requirements.

2. **ADP Services** - includes database development and management, data entry services, hardware and software maintenance, computer systems analysis, computer repairs, information retrieval services, and computer programming requirements.

3. **Products** - Includes the purchase of equipment, office and, business supplies, textile goods, office furniture, paper products, laboratory equipment, and chemicals.

4. **Construction Services** - includes activities such as architectural and engineering services, construction of dwellings and office buildings, general contractors and special trade contractors, renovation and alterations, and excavation and demolition work.

QUESTION: PROVIDE AN EXPLANATION OF WHY THE ACTUAL AWARD PERCENTAGE TO SDBs ACHIEVED DEVIATES FROM THAT WHICH HAS BEEN MANDATED.

HHS has exceeded all of the statutory minimums for the past several years. In Fiscal Year 1992, of the total value of prime contracts awarded, HHS awarded 40 percent to small businesses, and over 13 percent to small disadvantaged businesses. Over 50 percent of the total value of subcontracting awards went to small businesses.

The Small Business Act, as amended by Public Law 100-656, requires that the President establish annual Government-wide goals for acquisition awards to small businesses and small disadvantaged businesses. The statutory goal for small business participation is at least 20 percent of the total value of prime contract awards. The statutory goal for small disadvantaged business participation is at least 5 percent of the total value of prime contract awards and 5 percent of the total value of subcontract awards.

This impressive record of achievement can be directly attributed to the Department-wide support of the spirit and intent of the small business program and to the capability and competence of the small businesses and small disadvantaged businesses participating in the acquisition process at HHS.

QUESTION: PROVIDE AN OVERVIEW OF ANY PROGRAMS OR INITIATIVES DEDICATED TO MINORITY ENTERPRISE DEVELOPMENT.

HHS' Office of Small and Disadvantaged Business Utilization conducts one of the most extensive outreach efforts in all of Government to identify potential small disadvantaged business contractors who can participate in HHS' programs.

The Small Business Act, as amended by Public Law 95-507, established the Office of Small and Disadvantaged Business Utilization (OSDBU) in each federal agency. The primary responsibility of the OSDBU is to foster the use of small and small disadvantaged businesses as federal contractors. Within HHS, this task is effectively carried out by our OSDBU. OSDBU develops and implements appropriate outreach programs aimed at heightening the awareness of the small disadvantaged business community to the contracting opportunities available with HHS. These outreach efforts include activities such as sponsoring and participating in small business fairs, procurement conferences, trade group seminars, and other forums which promote the utilization of small and disadvantaged businesses as potential contractors. The OSDBU also conducts bimonthly counseling sessions for anyone interested in knowing about how to do business with HHS.

The OSDBU, after consultation with the Small Business Administration, establishes and monitors HHS' acquisition goals to ensure that the maximum practicable participation of small disadvantaged businesses in all Departmental acquisition processes is carried out. In order to assist the Department in achieving the established acquisition goals for the procurement preference programs, the OSDBU provides technical advice and assistance to Departmental acquisition officials as needed.

Additionally, the Office of Small and Disadvantaged Business Utilization enjoys complete support from the Office of the Secretary. This support is evidenced by the fact that the Director, OSDBU reports directly to the Deputy Secretary of HHS, in accordance with the provisions of Public Law 100-656. The Department's Assistant Secretary for Management

and Budget assists in this effort by providing the needed administrative and logistical support for OSDBU. This collaboration insures all necessary resources are available to OSDBU.

QUESTION: WHAT IS THE ROLE OF SMALL AND DISADVANTAGED BUSINESS ENTERPRISE UNDER THE PROPOSED NATIONAL HEALTH CARE REFORM

The stated acquisition policy of HHS is to stimulate competition among potential contractors and to make awards on a basis consistent with quality, efficiency, and economy. It is also HHS' stated policy to ensure that opportunities to compete for, and receive a fair share of, the Department's acquisition expenditures are provided to small businesses, small disadvantaged businesses, women-owned small businesses and labor surplus areas.

At this particular time, finalization of the National Health Care Reform initiative is not to the point that we can accurately identify any type of resulting contractual requirements. However, the acquisition review process employed by HHS requires first consideration be given to the 8(a) Program for possible award, then to small business set-aside consideration and finally to open or unrestricted competition. This review process is applicable to ALL potential acquisitions prior to being released to the general public. All acquisitions must have approval of from the Contracting Officer, the Small Business Specialist, and the SBA Procurement Center Representative. These three individuals must concur with the method of procurement for the acquisition prior to being issued.

With the existing exemplary record of small disadvantaged businesses' participation in all facets of acquisition within HHS, we are confident that there will be ample opportunities available when the National Health Care Reform program is established.

QUESTION: IS THE AGENCY IN COMPLIANCE WITH SECTIONS 211 AND 221 OF P.L. LAW 95-507 RELATING TO CONTRACT OPPORTUNITIES AND SUBCONTRACTING PLAN REQUIREMENTS FOR INCLUSION OF SMALL BUSINESS CONCERNS OWNED AND CONTROLLED BY SOCIALLY AND ECONOMICALLY DISADVANTAGED INDIVIDUALS;

I am pleased to report that HHS is in full compliance with Public Law P.L. 95-507, Sections 211 and 221, relating to increasing contract opportunities for small business concerns through the placement of subcontracting plans in contracts, and the establishment of goals for small business participation. For the past several years, HHS has met or exceeded its subcontracting goals for small disadvantaged businesses.

Our OSDBU recently developed a "Model Subcontracting Plan" which is included in solicitations issued by our acquisition offices. This "Model Subcontracting Plan" was developed to ensure the consistency of information being submitted by prime contractors. We at HHS are especially proud that the "Model Subcontracting Plan," developed by HHS' OSDBU, has been incorporated as a guidance tool in SBA's Standard Operating Procedures for the Subcontracting Assistance Program.

QUESTION: PROVIDE AN ORGANIZATIONAL CHART ILLUSTRATING REPORTING LINES BOTH ADMINISTRATIVELY AND ORGANIZATIONALLY AND THE NAME OF THE APPOINTED DIRECTOR OF THE OFFICE OF SMALL AND DISADVANTAGED BUSINESS UTILIZATION.

Mr. Verl Zanders is the Acting Director for the Office of Small and Disadvantaged Business Utilization for HHS. Mr. Zanders has been serving in this capacity since February 1993. Mr. Zanders develops and implements policies and procedures that are designed to foster the awareness of the small and minority business community to the contracting opportunities available through HHS.

Prior to this appointment, Mr. Zanders had been the Deputy Director of the Office since 1989. He was responsible for the day-to-day operation of the office as it related to policy and management of the small business program. Mr. Zanders has the distinction of serving as the SBA Procurement Center Representative for HHS for over 9 years. During his tenure as the SBA Representative, he was directly responsible for assisting HHS in increasing small disadvantaged businesses participation in previously untapped areas of procurement. Mr. Zanders was honored by HHS, while he worked for SBA, for his contribution to the SDB programs for HHS. Additionally, Mr. Zanders was honored by the SBA with the *1992 Federal Advocate Award*.

Mr. Zanders is a participating member of the HHS' Executive Commitee for Acquisition, which allows for the exchange of information concerning departmental acquisition policies as well as issues pertaining to the socio-economic programs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

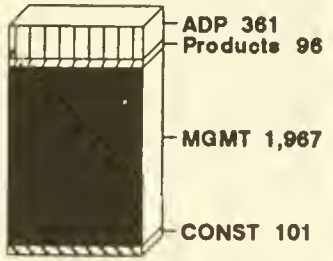
CATEGORY		FY 90	FY 91	FY 92
		(Dollars In Millions)		
TOTAL ACQUISITION		$2,188.0	$2,677.0	$2,571.0
TOTAL MINORITY BUSINESS AWARDS		$270.0	$285.0	$328.0
(Includes 8(a))	Percent	12.3	10.6	12.8
GOALS – 8(a)		$129.0	$154.0	$190.0
	Percent	5.9	5.8	7.4
ACHIEVED – 8(a)		$189.0	$222.0	$238.0
	Percent	8.6	8.3	9.3
GOALS – MINORITY BUSINESS		$39.0	$46.0	$86.0
(Non 8(a))	Percent	1.8	1.7	3.3
ACHIEVED – MINORITY BUSINESS		$31.0	$63.0	$91.0
(Non 8(a))	Percent	1.4	2.4	3.5
GOALS – WOMEN–OWNED BUSINESS		$65.0	$78.0	$98.0
	Percent	3.4	3.7	4.5
ACHIEVED – WOMEN–OWNED BUSINESS		$89.0	$116.0	$104.0
	Percent	4.1	4.3	4.1
TOTAL SUBCONTRACTING DOLLARS		$252.0	$271.0	$227.0
GOALS – SMALL DISADVANTAGED BUSINESS		$12.0	$12.0	$21.0
	Percent	4.8	4.4	9.3
ACHIEVED – SMALL DISADVANTAGED BUSINESS		$19.0	$24.0	$18.0
	Percent	7.5	8.9	7.9

NATIONAL INSTITUTES OF HEALTH

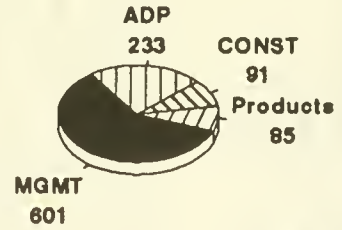
CATEGORY		FY 90	FY 91	FY 92
		(Dollars In Millions)		
TOTAL ACQUISITION		**$937.3**	**$960.3**	**$1,007.3**
TOTAL MINORITY BUSINESS AWARDS		**$67.3**	**$90.5**	**$80.3**
(Includes 8(a))	**Percent**	**7.2**	**9.4**	**8.0**
GOALS – 8(a)		$23.0	$46.0	$52.0
	Percent	2.5	4.8	5.2
ACHIEVED – 8(a)		$50.0	$72.5	$62.0
	Percent	5.3	7.5	6.2
GOALS – MINORITY BUSINESS		$39.0	$46.0	$65.0
(Non 8(a))	Percent	4.2	4.8	6.5
ACHIEVED – MINORITY BUSINESS		$14.0	$15.0	$16.0
(Non 8(a))	Percent	1.5	1.6	1.6
GOALS – WOMEN–OWNED BUSINESS		$18.0	$24.0	$27.0
	Percent	1.9	2.5	2.7
ACHIEVED – WOMEN–OWNED BUSINESS		$18.0	$27.0	$25.0
	Percent	1.9	2.8	2.5
TOTAL SUBCONTRACTING DOLLARS		**$26.0**	**$28.0**	**$41.0**
GOALS – SMALL DISADVANTAGED BUSINESS		$8.0	$9.0	$15.0
	Percent	30.8	32.1	36.6
ACHIEVED – SMALL DISADVANTAGED BUSINESS		$1.0	$1.0	$3.0
	Percent	3.8	3.6	7.3

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION				
CATEGORY		FY 90	FY 91	FY 92
		(Dollars In Millions)		
TOTAL ACQUISITION		$163.0	$161.0	$176.0
TOTAL MINORITY BUSINESS AWARDS		$44.0	$53.0	$46.0
(Includes 8(a))	Percent	27.0	32.9	26.1
GOALS – 8(a)		$18.0	$31.0	$35.0
	Percent	11.0	19.3	19.9
ACHIEVED – 8(a)		$51.0	$41.0	$41.0
	Percent	31.3	25.5	23.3
GOALS – MINORITY BUSINESS		$1.0	$2.0	$4.0
(Non 8(a))	Percent	0.6	1.2	2.3
ACHIEVED – MINORITY BUSINESS		$3.0	$3.0	$7.0
(Non 8(a))	Percent	1.8	1.9	4.0
GOALS – WOMEN–OWNED BUSINESS		$11.0	$17.0	$22.0
	Percent	6.7	10.6	12.5
ACHIEVED – WOMEN–OWNED BUSINESS		$25.0	$24.0	$22.0
	Percent	15.3	14.9	12.5
TOTAL SUBCONTRACTING DOLLARS		N/A	$1.100	$0.250
GOALS – SMALL DISADVANTAGED BUSINESS		N/A	$0.750	$0.025
	Percent		68.2	10.0
ACHIEVED – SMALL DISADVANTAGED BUSINESS		N/A	0.153	0.430
	Percent		13.9	172.0

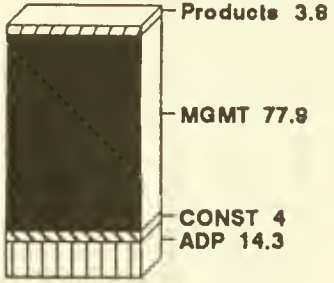
DHHS' Total Awards by Commodities



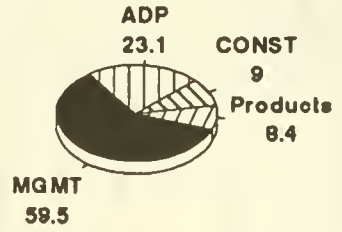
Total Acquisition Dollars
(Dollars in Millions)



Total Small Business Dollars
(Dollars in Millions)



Percentage of Total Acquisition



Percentage Awarded to
Small Businesses

Testimony of
Leonard E. Lawrence, M.D.
President, National Medical Association
before the
House Small Business Subcommittee on Minority Enterprise,
Finance and Urban Development

Tuesday, November 9, 1993

Mr. Chairman, Members of the Committee, Good Morning. I am Leonard E. Lawrence, President f the National Medical Association, the oldest national African American physicians group in the United States. Please allow me to share a story which captures the heart of my chief concern about this business of health care.

She lay on a cart in the emergency room. Her eight year old grandson stood beside that cart wondering when the doctors would come to see her. He had little awareness that when he had been born in that same hospital some eight years earlier, Black physicians were not allowed to come into that hospital to deliver babies. Nor could he have anticipated that twenty-two years later, he would be the chief resident in psychiatry in that same hospital system. However, what struck him to the core were the words he heard from a White-clad doctor, "We don't need to worry about her. She's just an old Nigger." She died, in diabetic coma on that cart in that hallway.

I am the grandson mentioned in that story -- a 1962 graduate of Indiana University School of Medicine and the Associate Dean for Student Affairs and Professor of Psychiatry, Pediatrics and Family Practice at the University of Texas Health Science Center in San Antonio. I am a child psychiatrist by training and a community advocate by choice. Now, whether that experience contributed to the career path I chose, I cannot say. Yet it is the keen recollection of that experience that motivates much of my activity and continually stimulates my resolve that no person's relative will ever again suffer such an indignity.

All of us are aware that these indignities continue to occur and that racism is alive and well. The principles of reform presented in the President's proposed Health Security Act of 1993 are phenomenal, but when you factor in racism, then the end result is potentially problematic.

Point #1

The racial and ethnic composition of the nation's physicians does not reflect the general population and contributes to access problems for underrepresented minorities. Although earlier drafts of the President's plan mentioned the concept of affirmative action, there are now several non-discrimination provisions in the President's proposal based on existing law. The National Medical Association is concerned that the proposal does not fully embrace affirmative action. African Americans and other minorities have had experience with the terms "equal access" and "equal opportunity". That is not enough.

♦ Therefore, the NMA strongly recommends that the legislation require health plans to hire, appropriately and equitably, minority health providers as employees.

We also must address the issue of minority physicians, dentists and other health professionals as entrepreneurs. The Washington Post recently ran an article entitled *A Rush to 'Buy' Doctors*. The article began, "Amid the uncertainty over medical reform, some companies are gobbling up what they bet will be health care's hottest commodity in the 1990s: doctors." Our NMA physician members are included in this number of physicians being "gobbled" up and our physician members are included in a number holding out, losing their patients to HMOs and subsequently losing their practices. The National Medical Association does not want to appear before this Committee in 1998 to testify to what is now a current fear and what may become a reality that there will be only a few major companies delivering all of the health care in the United States. But that is a possibility in this kind of monopoly arrangement where competition is the major theme and if we do not build in some protections for minority provider networks, **now**.

♦ The National Medical Association recommends establishing an African American and other underrepresented minority business "set-aside" program within Regional Health Alliances to ensure proportional representation of providers from underserved communities. Such a program could be implemented through provisions similar to those contained in Public Law 99-661, Section 1207 (The Department of Defense Contracting Goal).

There are approximately five hundred (500) HMOs in the United States, less than 10 are owned or operated by African Americans. In Detroit, there are three thriving African American owned or operated HMOs --Comprehensive Health Services/The Wellness Plan, United American Health Services which manages OmniCare, and LifeChoice Quality Health Plan. The oldest of these three is Comprehensive Health Services/The Wellness Plan which reports some 100,636 members. This report makes it the fourth largest HMO in the state and the largest among the three African American owned and operated HMOs. It is still Medicaid based but according to the Senior Vice President for Business and Fiscal Affairs, Isadore King, the key to their continued success will be vertical integration -- the alliance of hospitals, pharmacies, HMOs, independent physician associations, etc.

- The NMA also recommends that low-interest loans, tax and other incentives are available to strengthen the capacity of provider networks in underserved areas.

Point #2

Shortages of minority providers exist not only in primary care but some specialized areas. Among the specialty areas are general surgery, adult and child psychiatry and preventive medicine, and generalists with additional geriatrics training. There must be clear acknowledgement of these training deficits with built in incentives for training programs to correct these deficiencies.

Point #3

Within the framework of the present health care system, the current physician–to–population ratio in the nation is inadequate. Further increases in this ratio will do little to enhance the health of the public or to address the nation's problems of access to health care. Continued increases in this ratio will, in fact, hinder efforts to contain costs. The Health Security Act provides for education and training of primary care physicians (who will get fifty–five percent of the training slots). There are specific references to underrepresented minorities but no references to proportional representation.

> ♦ The NMA recommends proportional representation of minorities not only in primary care (generalists) but specialty training programs. The NMA suggests the following mechanisms for recruitment: (1) establishing federal grants for specialty care training, especially targeted for African American and other underserved minorities; (2) changing reimbursement policies for graduate medical education; (3) strengthening National Health Service Corps and loan repayment programs; (4) developing competitive compensation packages; (5) increasing research on issues related to medically underserved populations; (6) and actively recruiting students for health careers in underserved areas.

Of the almost 60,000 students currently matriculating within medical schools throughout this nation, only slightly more than 4000 are African American. The disparity is even more glaring concerning the other three underrepresented minority populations (Mexican Americans, Mainland Puerto Ricans, and Native Americans). The National Medical Association supports the efforts of the Association for American Medical Colleges' (AAMC) Project 3000 by 2000. This project seeks to increase the

number of underrepresented minority medical school applicants to 3000 by the year 2000. Theoretically, all medical schools have agreed to participate in this endeavor. While most of the discussion centers on increasing the numbers of minority applicants in the pipeline, little attention is paid to the obstacles to the admission of current candidates. The Medical College Admission Test (MCAT) does not reflect accurately the potential of many students to complete a medical education. The test has been standardized on some populations but schools have been resistant to fully embrace alternate methods of assessing a student's potential both to complete a medical curriculum and to become a competent practitioner.

Until the 1970s, most African American physicians were educated at either Howard University College of Medicine or Meharry Medical College. Morehouse and Charles R. Drew have contributed significantly to the total number of African American physicians in practice. These four schools served their students well by not only teaching the concepts of healing but respect for patients and how to relate to those patients. Today the majority of African American students are being educated in majority institutions. The number of African American physicians needed in this health care crisis is too great for our four African American medical institutions to address. Unfortunately, however, the acceptance of African American students within the majority educational environment is sometimes filled with prejudice, insensitivity, and racism, as oppose to education, nurture, and support.

♦ The NMA recommends that specific language is included which gives educational funding directly to Historically Black Colleges and Universities (HBCUs) to include consideration of funding and increased capacity for medical student education.

The bottom line is this -- without an adequate and continuing supply of competent, well-trained African American physicians, a proportional number of African American owned and operated physician groups, and specific mandates stressing African American inclusion, we can talk "reform" until we are blue in the face. Our patients and our communities will continue to suffer. The National Medical Association promises to be persistent and precise in the advocacy of a fair and equitable health care system. I, as a representative of the National Medical Association, will be clear, direct and at times passionate in my call for equitable and excellent health care delivery system -- because none of us want anyone's relative to again lay on a cart and be labeled an "Old Anything." Thank you.

Testimony of

George L. Fountain Jr.
Vice President
District Scientific and Medical Supply, Inc.
a Black owned and operated distributor of medical and laboratory supplies
Gaithersburg, MD

Submitted to:

The U.S. House of Representatives
Committee on Small Business
Subcommittee on Minority Enterprise, Finance,
and Urban Development
Representative Kweisi Mfume, Chairman

November 9, 1993

Testimony of George L. Fountain Jr.
Vice President
District Scientific and Medical Supply, Inc.
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Submitted to the U.S. House of Representatives
Committee on Small Business Representative Kweisi Mfume, Chairman
November 9, 1993

Thank you for the opportunity to provide information, as it pertains to being a Black-American medical and scientific supply company. I am submitting this testimony to provide suggestions on the utilization of minority medical suppliers under National Health Care Reform.

I would like to begin by providing general background information on the industry, and then discuss the problems faced by Black and other minority medical and scientific suppliers in three areas: 1. The ability to win public contracts; 2. The ability to win private contracts and 3. The ability to obtain distribution agreements from manufacturers.

General Background:

The medical and research industry is made up of hospitals (public and private), alternate care medical facilities, health maintenance organizations, private physicians, nursing homes, teaching facilities, and laboratories. The medical supply industry is primarily controlled by one large national distributor (Baxter Healthcare); numerous regional distributors; and many small local distributors. The scientific industry is controlled by four large distributors (Fisher Scientific; Baxter Scientific; VWR Scientific and Curtain Matheson Scientific). These large distributors often own some manufacturing companies; however; most distributors in both industries rely upon distribution agreements from key manufacturers. The major manufacturers within these industries (i.e. Johnson & Johnson; 3M; Becton Dickenson, Corning Glass, Nalge just to name a few) only allow the large firms to distribute their products. The smaller distributors, especially the Black and other minority distributors, must purchase these products

from the large distributors at inflated prices. The major manufacturers have no interest or requirement to set up distribution through small, or Black or other minority suppliers.

In the medical industry the situation is further complicated for Black and other minority suppliers, by large buying groups. The Volunteer Hospital Association; Sun Health; The University Buying Group; The Daughters of Charity; and The National Area Shared Services are some of these buying groups. These groups have hospitals and other medical facilities as their members. What these groups do is consolidate the medical purchases for all of their members and send these purchase requirements to only large distributors and/or manufacturers for bidding. However, this bidding process is not open to small, Black or other minority suppliers. In fact, there is only one buying group that I am aware of that has any small, Black or other minority contract holders - The National Capital Area Shared Services.

The bids, and ultimately the contracts, issued by these buying groups are so large that they are usually awarded to manufacturers or large distributors only. When the manufacturers are awarded contracts, they usually designate a distributor to perform the contract. This distributor is often given a rebate by the manufacturer for the special pricing that is offered. However; the distributors designated by these manufacturers are not Black or other minority businesses.

Problems to winning public contracts

Black and other minority medical and scientific suppliers face numerous challenges in competing for public contracts. It is important to note that a large percentage of the items procured within this industry are through small purchases, less than $25,000. The following are the major problems that I have encountered in seeking public contracts for medical and scientific supplies as a Black American business person:

Problem # 1:

Public Law 95-507 Chapter 3 Sec. 221(j) establishes small purchase procedures, and reserves these purchases exclusively for small business concerns. However; there is no mention of the utilization of Black or other minority, disadvantaged business concerns. As a result, Federal contracting officers and general purchasing agents are consistently bypassing Black and other minority medical and scientific suppliers, which limits their opportunity to provide market pricing for small purchases. I can only imagine that this is also occurring within other small purchases as well.

The area of small purchases is well suited for Black and other minority firms to compete. It is also at this level that you will find most new businesses enter the public contracts market. These types of procurement opportunities are well suited for Blacks because the purchases are easily financed through either vendor trade credit, or short term private financing. Small purchases are labor intensive, and require extensive sales marketing and follow-up on the part of the supplier. In other words, small purchases is hard work, and Black and other minority businesses are accustom to hard work. However; it is imperative that legislation be provided to assist these firms in receiving more small purchase opportunities..

Recommendation to correct problem # 1:

Public Law 95-507, **must** include a statement that gives Black and other minority businesses a preference over non-minority small business firms. I also recommend that purchases from 0 to $5000 be completely set aside for Black and other minority businesses when such firms are available, and that small purchases be included in 8(a) set aside contracts. Such a set aside would dramatically expand opportunities for Black and other minority firms, in all industries. This set aside would not only help to create short term jobs, but would increase employment for the segment of our population that needs help - Blacks.

In addition, this recommended change would cause large manufacturers to seek out Black and other minority businesses to distribute the manufacturers' products. There are only a few Black or other minority medical and scientific suppliers nationwide, and those that survive in this industry often find themselves competing against their supplier - large distributors and manufacturers. As a result, the Black and other minority firms prices will be higher, and we find ourselves being ridiculed by customers for not being price competitive. If given the same opportunity of dealing directly with the manufacturer, Black and other minority distributors can be extremely competitive with the large distributors. Our general overhead is much lower, therefore, our profit margins can be lower and these savings can be passed on to the ultimate consumer. However; as a Black or minority medical or scientific supplier, you only get one chance to be competitive in this industry. If you are labeled as being non competitive, in public or private industry, your business will have a difficult time in receiving any additional opportunities.

Problem # 2:

The Federal Supply Schedule system is a major problem for Black and other minority medical and scientific suppliers. The Schedule contract often will take precedent over small purchase procedures, as outlined in PL 95-507. Moreover; you will find very few Black or other minority medical and scientific suppliers that hold Federal Supply Schedules. As a result, the large businesses that are on the Federal Supply Schedule are getting around PL 95-507 by receiving small purchase orders for the items they have on the schedule. Thus further eroding the opportunities for small, Black and other minority firms, to participate in small purchase orders.

The process in obtaining a Federal Supply Schedule is difficult and seems impossible for many small businesses, especially Black businesses. Therefore few even try. The forms that are

required are cumbersome, and difficult to understand, and the information requested, often has no bearing on the applicants ability to perform. There are just too many obstacles that prevent Black and other minority firms from being awarded Federal Supply Schedules, i.e. the test for commerciality, and the Buy American Act.

Under the Federal Supply Multiple Award Schedule program, there can be hundreds of supply schedule contracts for the same basic item. There is no requirement that a Black or other minority schedule holder be used over any other firm. As a result, for those minority firms that do receive Federal Supply Schedule Multiple Award contracts, marketing these contracts to the thousands of Federal agencies is expensive. In my experience the overall sales that we have generated through these multiple award schedules do not pay the cost for our being involved in this program.

Recommendation to correct problem # 2:

1. The opportunities for Black and other minority businesses to obtain Federal Supply Schedule Contracts and Schedules must be increased. There must be greater emphasis placed on the using activities to utilize the Federal Supply Schedules of Black and other minority firms with a priority. Multiple award schedules should be eliminated all together. The amount of time spent by the user searching all the Multiple award schedules is greater than locating the same item on the open market at a lesser price.

2. The General Services Administration along with the Department of Veterans Affairs which administer Federal Supply Schedule Contracts for medical, scientific and chemical supplies, must seek to establish a set aside for Black or other minority suppliers. Furthermore; these agencies must assist the Black or minority contractor in marketing and identifying specific opportunities to increase the value of the contract held. The office of Small and Disadvantaged Business Utilization (SADBU) within these two agencies must be empowered to do more to help

the businesses they supposedly represent.

3. I further recommend that a match maker program be established to pair Black and other minority businesses with specific Federal facilities to utilize the products that they provide. I would also recommend that the SADBU Specialist (SADBUS) conduct regular meetings with minority vendors from all industries to access the programs offered and continue to make improvement upon these programs.

4. Federal agencies must be required to utilize the Federal Supply Schedules of Black or other minorities. The SADBUS in all agencies should constantly be striving to identify and increase the percentage of business done with Black Federal Supply Schedule contractors. Black and other minority Federal Supply Schedule contractors should receive a reasonable percentage of procurements from Federal agencies. I recommend that incentives be established in each agency, that will help Federal agencies locate Black and other minority Federal Supply Schedule contractors, and utilize their services.

Problem # 3:

The Walsh Healy Public Contracts Act (WHPCA), which defines a regular dealer as "a person (or concern) who owns, operates, or maintains a store, warehouse, or other establishment in which the materials, supplies, article, or equipment of the general character listed are bought, kept in stock, and sold to the public in the usual course of business". This definition can create a hardship for Black medical and scientific suppliers. Contracting officers often will take a strict interpretation of the Walsh Healy Act when evaluating Black and other minority firms for contracts. For instance a medical item such as "Catheters" has over two hundred variations, most distributors can not afford to maintain stock of each item. Most firms will monitor the demand for the entire product line and begin to stock as the demand requires. However; WHPCA does

not take this basic business principal into consideration when evaluating a firm as a "regular dealer".

My firm was recently denied an opportunity at the National Institutes of Health (NIH) because we did not inventory **enough** of a certain commodity to be classified as a regular dealer for that commodity. The term "enough" is a subjective call by the contracting officer, as there are no specific guidelines as to what constitutes enough inventory in the WHPCA. We had sales for the commodity in question, we simply had not reached sufficient demand within our accounting period to justify stocking these items. The NIH contracting officer took a strict interpretation of the WHPCA, and did not take into consideration that our business, like so many others, has to have sufficient demand for a product before that item can be stocked. The WHPCA does not take into consideration economic order points, product demand, or <u>just in time</u> inventory systems.

The only recourse a business has to appeal an adverse ruling by a contracting officer as to the regular dealer status is to appeal to the Small Business Administration or to the Department of Labor. Both appeals processes are costly in the terms of the revenue lost, and the time consumed during the appeal process; therefore, it usually is not pursued.

<u>Recommendations to correct problem # 3:</u>

The WHPCA needs to be updated so that a firms ability to perform on public contracts, as a regular dealer, is not based solely on how much or how little inventory they have on hand. The fact that a firm has performed adequately in the past should be the only gauge for future performance. It seems that the true intent of the WHPCA is to ensure performance by public contract holders. Today's "regular dealer" has access to the inventory of it's major suppliers through electronic data interchange, fax capabilities, next day delivery services, and other

methods of rapid performance. The WHPCA originally written in 1929 could not possibly have foreseen the changes in technology that so greatly affects it's definition of a "regular dealer". Nor could the WHPCA have taken into consideration the needs of Black and other minority businesses when it was written.

1. Therefore, I am recommending that the WHPCA be amended to redefine a "regular dealer" as a firm that can show consistent ability to perform on public contracts, and meet the required delivery schedules. The stocking levels should be at the discretion of the supplier and their own internal requirements and capabilities.

Problem # 4:

The newest and most detrimental program to affect Black medical suppliers is the Defense Logistics Agencies "Prime Vendor Program". The Defense Personnel Support Center (DPSC), Directorate of Medical Materiel is selecting **regional** prime vendors for brand name specific medical supplies covering two product classes pharmaceuticals and medical/surgical. The medical/surgical items must be disposable, consumable items. Many of these items were previously purchased under small purchase procedures, and in several cases from small and often minority firms. As a part of the Prime Vendor Program, DPSC establishes Distribution and Pricing Agreements (DAPA's) with pharmaceutical and medical/surgical product suppliers. Under a DAPA, the agreement holder consents to allow the Prime Vendor (usually a large business distributor) to distribute its products to participating hospitals and agrees that the prime vendor will be charged no more than the prices set forth in the agreement.

The problems with the Prime Vendor program, as it pertains to Black and other medical and scientific suppliers, are numerous. The prime vendor program takes preference over the traditional purchasing avenues utilized by Black and other minority suppliers, i.e., small purchases, and 8(a) set asides. The Prime Vendor Program also has a preference over Federal

Supply Schedule contracts. The Prime Vendor contract that was awarded for the Washington D.C. area is valued at $100 million dollars over a five year period. The contractor is a large business distributor that has agreed to subcontract 25% to minority firms. I have spoken with the Prime Vendor, and they have clearly stated that they will utilize minority delivery services, janitorial services, secretarial services and lastly, other minority medical suppliers. The Prime Vendor went on to state," That in order to be utilized, a minority medical suppliers must have: (1.) A DAPA (2.) An order from a hospital for the exact items that company has on DAPA (3.) Substantial inventory levels and (4.) Provide immediate delivery."

The procedures in obtaining a DAPA are cumbersome and are not friendly to Black and other minority medical and scientific suppliers. In fact, there is no requirement that if a Black medical supplier were to be awarded a DAPA, that the Federal hospital will purchase that specific brand. As a result, it is not a good business decision for any company large or small to stock merchandise under these parameters. In essence, the Prime Vendor program has taken responsibility to use Black and other minority firms away from the Federal activity. The DPSC now expects the Prime Vendors to meet socioeconomic requirements, even though these firms have had very poor track records in meeting these goals in the past. The Prime Vendor program not only closes the door of opportunity for many Black and other minority medical and scientific suppliers, it also prevents new firms from entering this vast marketplace.

Recommendations to correct problem # 4:

1. The area to be serviced by the Prime Vendor should be much more narrow in scope, to cover one or two medical facilities per contract, not regional. The result would be a much higher probability that a Black or other minority medical supplier could compete and win a Prime Vendor contract. This contract could then be used as a stepping stone for larger Prime Vendor opportunities. Furthermore; at least one facility within any given region could be totally

set aside for participation by Black and other local minority suppliers only. This will greatly help to develop the minority businesses located within the communities of these Federal facilities, instead of placing more Federal dollars with large national distributors that usually have few ties to the immediate local community, or Black and other minority medical and scientific suppliers.

2. The DAPA program should require the medical and pharmaceutical manufacturers who sell their products to the Federal Government, to have some Black and other minority sources of distribution. This will force these firms to seek out minority business involvement and open a door of opportunity that has otherwise been closed.

3. The DPSC, along with the SBA must work together to decrease the barriers that have been established that prevent Black and other minorities from being awarded Prime Vendor contracts, and DAPA's. For example, the numerous complicated forms, representations and certifications that are required should be reduced or eliminated. The DAPA agreement, as it stands, is still no guarantee of sales for any DAPA holder. Therefore, they should be awarded with the least amount of restrictions.

4. Prime Vendor contracts awarded to large businesses, should not over ride small purchase procedures. The Prime Vendor program must not take away the few opportunities Black and other minority firms have had at these Federal facilities and give them to a large business. This program should not have a preference over 8(a) set asides or Federal Supply Schedule contracts.

5. If the Prime Vendor is required to use Black and other minority firms, they must be consistent with the scope of the contract award. For instance, if the contract is for medical supplies, and the Prime Vendor has stated a 25% minority business participation, this

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participation must be 25% of the medical purchases from minority firms. Unrelated non-medical services, i.e., secretarial, janitorial, should not be included towards this percentage.

6. The Federal facilities that use the Prime Vendor program, should not be expected to meet their obligations to Black and other minority medical suppliers, solely through the subcontracts of the Prime Vendor. These Federal facilities must still be held accountable in other programs for the dollars spent in the area of medical and scientific supplies with Black and other minority suppliers. Under the current Prime Vendor program, I know of no such accountability that is required. These facilities must be made aware of the DAPA's that are held by Black and other minority medical and scientific suppliers, and every effort must be made by the Small Disadvantaged Utilization Specialist at these facilities to ensure that these DAPA's are utilized to the maximum extent possible. This can be done by coordinating meeting with suppliers and department end users, trade shows, or even set asides of specific commodities. If this program is to work for Black and other minority medical and scientific suppliers the Federal facilities that use the Prime Vendor must be required to utilize Black and other minority DAPA holders.

Problems with private industry:

The number one problem encountered by Black medical suppliers in dealing with private medical facilities (hospitals, health maintenance organizations, and alternate site facilities) is the lack of opportunity. Black medical suppliers are not afforded the equal opportunity to compete for contracts with most private hospitals, health maintenance organizations (HMO) or private physicians. These facilities are not required to utilize Black medical suppliers, and most do not. Even though, these facilities receive Federal funding of some type, few have minority outreach programs that really work to attract Black or other medical and scientific suppliers. I have had personal experience with Johns Hopkins Hospital, George Washington University Hospital, and GHA (a Washington DC based HMO) just to name a few facilities. These facilities have no

interest or requirement to increase opportunities for Black medical and scientific suppliers. They receive hundreds of millions of Federal dollars, they serve large Black populations, yet their combined purchases from Black or other minority medical or scientific suppliers would not exceed 1% of annual medical supply purchases. Even though there are numerous Black and other minority medical and scientific supply firms that are available.

HMO's, alternate care medical centers, religious affiliated hospitals, and private physicians are the least interested in dealing with Black and other minority suppliers. Even though, these facilities claim to be cost conscious, they actually do very little comparative shopping, and comparisons of alternate brands. Making a sales call onto one of these facilities, as a Black business person, is one of the most unproductive activities that one can do. In this arena the "good old boy network" is alive and well.

Recommendation:

1. I would strongly recommend that under Healthcare Reform, any medical facility that receives Federal funds of any type be required to follow the guidelines of Public Law 95-507. In addition; Public Law 95-507 must be enhanced to clearly state that Black and other minority businesses be given a preference for small purchases Without this preference Black firms will not receive any opportunities from a large majority of medical providers. Even though many medical providers are small businesses themselves, this should not preclude them from seeking Black and other minority firms from which to do business.

If the Black or other minority firm is given the opportunity to bid, they are bid against the large distributor. In some instances we are even bid against the manufacturer, thus making it virtually impossible to be competitive.

2. Private medical facilities must be required to set specific goals for participation by Black and other medical and scientific suppliers. The Federal agency that issues funds to these facilities, must monitor their progress on a regular basis. Corrective action must be taken by those facilities that ignore socioeconomic programs.

3. Hospitals, medical centers, medical teaching facilities and even private doctors that receive Federal funds must be required to establish minority outreach programs. These programs should concentrate on locating and utilizing Black and other minority suppliers within their local community. In some cases a mentor-protégé program may have to be implemented to enhance opportunities for Black and other minority medical and scientific suppliers.

4. In order for Black and minority medical suppliers to effectively compete for private contracts, these facilities must provide Black suppliers a preference in procurement opportunities. For example, a particular product line can be bid to small businesses, and another product line to Black businesses. A percentage preference on all purchases less than $5000 can be given when small or Black firms are involved in the purchase process at these facilities.

5. The major hospitals have a tremendous amount of influence with the manufacturers and the large buying groups that provide them with supplies and services. I recommend the hospitals use their influence to insist that their major manufacturers and buying groups provide products through Black and other minority medical and scientific suppliers. It is just as simple as the hospital telling it's primary manufacturers that they desire to purchase their products through a Black or other minority supplier. This will open the door of opportunity for a Black or other minority supplier. This approach is very effective as it ensures that the facility will continue to enjoy favorable pricing levels set by the manufacturer. Moreover, it allows the Black or other minority medical or scientific supplier to add a major product line that can be marketed to similar facilities.

6. Last, but surely not least it is imperative that Black and other minority medical and scientific suppliers be paid for the goods and services rendered in a timely manner. Even the most competitive business with all the right product lines, can not survive without adequate cash flow. If fast payment discounts are offered, they should be taken by private institutions. Taking these discounts not only saves these facilities money, it helps reduce the need for a Black or other minority firm to seek outside financing.

Problems in obtaining distribution agreements:

1. The major medical, scientific and pharmaceutical manufacturers have long established distribution networks. These networks do not include Black or other minority medical or scientific suppliers. In fact, when applying for a dealership with a major medical, pharmaceutical or scientific manufacturer, the standard response for a Black or other minority distributor is "There is adequate coverage within your area, please apply again later." This is the response that my firm has received from major manufacturers. In several instances, we even held

Federal contracts to provide their products and we were still denied distributorships. As a result, we were forced to purchase the products from large distributors at inflated prices, thus limiting our profit margins and our ability to remain in business.

2. Black and other minority medical and scientific suppliers will not be able to grow to the maximum extent possible under a free enterprise system, without being able to obtain distribution agreements with major manufacturers. In essence our businesses are being held in economic slavery by the major manufacturers in the country. In fact, it is easier to establish distribution agreements with foreign manufacturers as a minority business than it is to obtain distribution agreements from major American manufacturers.

Recommendation:

Most major medical, scientific, and pharmaceutical manufacturers hold some type of Federal contract. It is imperative that manufactures begin to provide information on the number of Black and other minority distributors that are authorized to carry their products. The contracting officer, the SADBUS, and the SBA should work together to help manufacturers locate Black and other minority firms for distribution opportunities. Whenever possible, manufacturers should be required to provide at least one Black or other minority distributor on all Federal contracts that utilize a distribution network.

Closing:

In closing I feel it is important to restate that the Black and other minority businesses are employing a large percentage of minority workers in this country. Therefore, it is critical to our nation's development that we do all we can to assist businesses that create jobs for this segment of our population.

In the area of providing medical, scientific and pharmaceutical supplies, Black and other minority firms are far behind their contemporaries. The free enterprise system has not worked to create a level playing field for all participants, and there is little emphasis in public, or private industry to reverse these trends. Therefore; it is so important that, as we move towards Healthcare reform, and providing Healthcare to every American, that we also move towards providing opportunities for every Black and other minority medical, pharmaceutical and scientific supplier. In doing so, we must never forget those that helped to build this great country. Those that lost their lives on slave ships, or those that lost their dignity building the railroads, just to name a few. Furthermore; let us not lose sight of those Black medical and scientific entrepreneurs of today that are working to shape the future. It is imperative that laws be enacted that will continue to see that the future growth of Black and minority businesses are enhanced within the land of the free and home of the brave.

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Written Testimony

For the U.S. House of Representatives
Committee on Small Business
Sub-Committee on Minority Enterprise, Finance, and Urban Development
November 9, 1993

From Warren O. Cooper
President
ACCU-Lab Medical Testing Inc.
Chicago, IL

November 3, 1993

The Hon. Kweisi Mfume
Chairman
Sub-Committee on Minority Enterprise, Finance, and Urban Development
United States House of Representatives
Room 568-A
Ford House Office Building
Washington, DC 200515

Dear Chairman Mfume:

Please find enclosed 50 copies of the testimony I have been asked to provide the Sub-Committee on Minority Enterprise, Finance, and Urban Development on November 9, 1993.

Thank you for the opportunity to testify about this important matter. I look forward to meeting you and the other members of the Sub-Committee next week.

Sincerely,

Warren O. Cooper
President

WOC/cvjc

Enclosures

II. Introductory Statement

Mr. Chairman, members of the Sub-Committee, guests. My name is Warren Cooper. I am president of Accu-Lab Medical Testing Inc. in Chicago, IL. Thank you for the invitation to share with you today my experiences as principal of a minority-owned drug testing lab. I commend you for being the first to take a comprehensive look at the serious issues within the drug testing industry. And I applaud your commitment to ensuring that minority-owned firms participate as full partners in healthcare reform.

Background

I graduated from Arizona State University with a B.S. degree in Business; I spent in year in business school before returning to Chicago. In 1974 I joined the Cook County Sheriff's Department -- two years later I was shot on duty. The wound left me paralyzed on my left side, unable to move my left arm. It was then that I decided to go to law school. While a student at St. Louis University, 17,000 air traffic controllers were fired, opening up a new career field to me. I needed money because funds for grad school had been cut; I took the test, scored 97 out of 100, and began work as an Air Traffic Controller assigned to Midway Airport.

As an Air Traffic Controller I broke new ground. I helped negotiate the drug testing implementation in the Federal Aviation Administration (FAA) between the union and then-FAA Administrator Elizabeth Dole. I developed and implemented a curriculum for the City Colleges of Chicago to enhance employment opportunities for minorities in the FAA. The program resulted in 15 minorities being employed by the FAA. I later became the first African-American certified Air Traffic Control Specialist assigned to Chicago O'Hare International Airport.

Methadone clinics in the heart of Chicago offered me seats on their boards. And it was then that I realized there was a serious lack of information in my community. That's when I decided to

become one of the teachers my community desperately needed, one of those "I'll tell you" people. That's how I came to open Accu-Lab in 1991.

We do forensic drug chemistry, hair analysis and drug testing. And to my knowledge, we are the only African-American-owned drug testing lab in the country. Our competition consists of drug testing labs such Roche Bio Med and Smith-Kline-Beecham, Met-Path, National Laboratory Services and Med-Tox. My clients run the gamut from individuals seeking a second opinion on test results to private companies such as Marshall Fields, Arrow Lumber and Handy Andy stores.

Unlike our competitors, Accu-Lab Medical Testing is located in the city proper, minutes from the central business district and less than three miles north of the nation's largest concentration of public housing complexes. It is imperative, we believe, to be visible in our community. To be a role model that lives and works in, and hires from the community.

You have invited me here to provide testimony in a number of areas that affect my ability to compete in an adolescent industry -- drug testing. Specifically my testimony covers the following:

a. Arrogance of existing players in industry
b. NIDA experience
c. Ability to win public/private contracts
d. 8a certification
e. Suggestions for rectifying the situation

II. A Closed Industry

The United States government, through Executive Order 12564 and subsequent legislation enabling creation of National Institute on Drug Abuse (NIDA) lab certification standards, has created an industry that is monolithic in reach, parasitic in growth and arrogant in attitude.

This industry, drug testing, is populated by names familiar to those involved in the debate over healthcare -- Roche, Smith-Kline and others who have prospered and made their fortunes on a segment of society either plagued by drug abuse, or seeking to protect itself from the effects of drug use. It is a $7 billion industry so removed from new competition that major players can say with impunity things like "we have the contracts, what do we need you for?" and "I give to the United Negro College Fund -- that's the extent of my minority participation." Ladies and gentleman of this committee, meet Hydra.

You may recall from Greek mythology that Hydra was a many-headed monster that grew two heads to replace each one that was cut off. Hercules finally killed Hydra by cauterizing each neck as a head was cut off. What we have here today, in the NIDA certification standard, is the modern-day equivalent of Hydra.

First parallel

Hydra had many heads; NIDA certification erects multifaceted obstacles for minority-owned labs. Its high cost -- $55,000 the first year, $30,000 annual renewal fee -- effectively bars new entrants into the drug testing industry. NIDA creates its own catch-22 for new labs: we need NIDA certification to get clients, but we need clients to pay for NIDA. When contracts require NIDA as a condition of award, we can't compete. And we can't get credit. Again, that catch-22. Without clients that represent sufficient accounts receivables -- or huge collateral -- banks won't make you a loan.

Healthcare reform promises to expand the scope of drug testing in our society. Heightened emphasis on education and rehabilitation means a likely increase in funds for diagnostic drug testing. A shift from interdiction toward rehab and aftercare represents a major opportunity for labs such as mine to succeed in the marketplace.

But if current trends continue, healthcare reform will become another of Hydra's heads. As more agencies identify the need for diagnostic drug testing, they will want assurances that the labs doing the testing are "qualified". They will look to NIDA as the arbiter of a lab's qualifications and the lock-out will continue unabated. This can occur in spite of the legislative intent which focuses on forensic testing which can be replicated for a court of law, and not diagnostic, defined as those tests ordered for persons under a doctor's care. Let me cite an example of how this can and is happening.

The State of Illinois' Department of Alcohol and Substance Abuse (DASA) awards drug testing contracts to labs to test patients in methadone rehabilitation. Diagnostic testing. The value of this contract exceeds $200,000. Although there are no provisions in the NIDA certification standards that address diagnostic testing, DASA requires all labs that test methadone clients to be NIDA-certified. As a result, my lab was locked out of that contract.

Second parallel

Cut off one of Hydra's heads and it grows two new ones to replace it. The same can be said for NIDA-certification: it sprouts in areas exempted by the legislation, creating a "me-too" syndrome among local, state, county and government agencies that contract for drug testing. Executive Order 12564 covered all agencies of the Executive Branch; exempted from the Order (and the scientific and technical guidelines for drug testing programs the Secretary of Health and Human Services was authorized to promulgate) were the United States Military, the United

Postal Service and "employing units in the Judicial and Legislative Branches." In short, these agencies are exempt from NIDA-certification requirements, yet they use it as a benchmark of qualification. What we are experiencing now is quasi-governmental bodies such as the Chicago Park District jumping on the NIDA bandwagon.

In that instance, the Chicago Park District conducted employee drug testing in-house by non-technical personnel. A change in policy prompted the agency to stop in-house testing and seek a lab for this purpose. I won the contract and went to bed one Thursday evening with the contract a done deal By 3 p.m the next day, it was yanked. Why? Because a Park District employee complained that Accu-Lab was not NIDA-certified.

Time and again we have watched private agencies use NIDA certification to prevent minorities from getting drug testing contracts. A vice president and the medical director of Brach's Candy, a major employer on Chicago's west side, decided it made good business sense to expand their use of minority businesses and agreed to award Accu-Lab the contract to test their Chicago workforce. Yet they were overruled by Brach's legal department. Again, the issue was our lack of NIDA certification. Now that company is spending in excess of $100,000 for drug testing with a lab in Wisconsin.

What's disturbing about these and other examples I could cite is how this "me-too" syndrome affects inner city communities. This isn't just about Accu-Lab being locked out of the drug testing industry -- it's about starving inner city communities of desperately-needed role models, of fostering an environment where no minority-owned lab will prosper, or be in a position to give back to the community. A corollary issue is that the labs getting the business are located in the suburbs. They aren't hiring community residents, doing outreach in inner city schools, or providing pro bono services to organizations that need the service but can't afford it. We are.

Since we opened our doors in 1991, Accu-Lab has provided pro bono services to several community-based organizations. One such group, the Ada S. McKinley Community Services Foster Care, requires natural parents to be tested for drugs as a condition for reuniting their families. This testing had been provided Ada McKinley by community-based organizations, but was suspended due to federal funding cuts. We provide free drug testing to families that cannot afford the service and, in the process, help reunite families separated by drug abuse.

Another program, Families with a Future, works with pregnant women who are drug abusers. Participants who wish to mentor others in the program must be screened for drug use. Again, we provide this service at no charge. This is another community program that cannot survive without getting some type of drug testing. And nobody's giving it out free. I don't see any programs in America that are reaching into the community as we are and it's necessary.

Another of the multifaceted barriers NIDA certification standards erects is in the area of governmental set-aside programs. As it stands, agencies required by federal law to set-aside a percentage of contracts for minority business enterprises are off the hook when it comes to NIDA. All one need do is write NIDA certification into the specs for forensic or diagnostic testing, and set-aside becomes a moot issue. If the specs require NIDA certification, it makes no difference how much is set-aside. If there are no NIDA-certified minority labs, how can that be done? You have frustrated the set-aside intentions by simply writing in NIDA. Regardless of whether it's required or not, you've frustrated it.

Also frustrated by this requirement are any attempts at joint-venturing with larger labs. I have tried repeatedly to joint-venture and sub-contract with the two leaders in the drug testing industry. The first problem: I needed NIDA certification to do any portion of the work. But the second, and more insidious, was the attitude of these firms. Roche Bio Med told me, "we already have the contracts? What do we need you for?" Smith-Kline-Beecham told me, "We

give some money to the Untied Negro College Fund. That's the extent of our minority participation." Whether intentional or by default, the high price of NIDA certification fosters such arrogance because it's common knowledge there is no enforcement of set-asides and that emerging labs such as mine will be hard-pressed to generate enough business to pay the fees.

8a certification process

Muddying the waters is the Small Business Administration's (SBA) 8a certification program. To qualify for set-asides mandated by federal law, I need to be certified as a minority-owned business. Fine. But in testimony before a hearing of the Commerce, Consumer and Monetary Affairs Sub-Committee of the Committee on Government Operations, SBA Administrator Jane Palsgrove-Butler said approximately 475 firms were 8a certified in 1992. These firms represented from all 50 states and included the District of Columbia and Puerto Rico. This means approximately 9.13 business in each state were certified 8a in a 12-month period.

Accu-Lab began the 8a process in May, 1992, yet we still are not certified. At the time, I was still employed as an Air Traffic Control Specialist. I flew to Washington, met with an administrator for the program and was assured my application package was in order. One catch: I had to quit my federal job. I complied, quit a job that paid nearly $90,000 in salary and bonuses, and still I am not certified. Now I'm wondering: "What do I do next?"

Were it not for the fact that most federal agencies will require this certification to do business with them, I'd scrap 8a certification. The process is laborious and confusing, the questions onerous and sometimes without merit. What is the relationship to my being a minority business enterprise of W-2s for the spouses of all members of your board of directors?

A request for Access

Executive Order 12564 covered forensic drug testing of Executive Branch employees and called for certification of labs conducting urine drug testing. Public Law 100-71 required the Secretary of DHHS to publish standards for laboratory certification. Early players in this process were the National Institute on Drug Abuse, which was comprised largely of technical specialists and scientists who ultimately left to form their own drug testing labs. Another key early player was the Research Triangle Institute (RTI), which was contracted by NIDA to implement a program for certifying labs.

To my understanding, the first 10 labs were NIDA-certified at no cost to the owner. Under the contract, 50 more labs applied for NIDA certification. NIDA paid 70% of their certification expenses. Subsequent labs are certified at their own expense; these fees which total $55,000, must be paid in advance and are non-refundable.

The present structure of NIDA certification perpetuates exclusion of minority-owned labs and presents an effective barrier to all but the most deep-pocketed of new entrants. I converted all my assets to cash to finance Accu-Lab's start-up. It's almost unconscionable to ask a start-up business to invest that kind of money with no guarantee of business. Because, you realize, NIDA certification does not guarantee me one specimen. It simply says I qualify to do any and all specimens. Trying to generate the $55,000 fee in advance for NIDA certification gets me right back to the catch-22 I described earlier: I need NIDA certification to get clients and I need clients to pay for NIDA certification. It's time, I believe, to level the playing field.

This administration didn't create this problem -- they have a rare opportunity to rectify the problem. An opportunity to extend President Clinton's promise of fairness and equality of opportunity for all Americans to this industry. An opportunity, quite simply, to right a wrong. This administration was elected on a plank, on a promise of fairness and equality for all

Americans. Mr. Clinton was elected by young people, people who want to do something with their lives, because they believed in his promise of fairness and opportunity. This Committee realizes that small business has a vital place in America. And the results of what this Committee is doing is partly why I'm here testifying today.

III. Strategies for Slaying Hydra

First of all, I don't think that you take away NIDA certification. Accu-Lab fully recognizes and understands the goals of NIDA. We think it brings stability, standardization and uniformity to this type of testing. Even though it seems to frustrate me to no end, I still think that you need uniformity in drug testing, you need to have guidelines, you need to have accountability. Therefore, the key is to make NIDA-certification accessible to minority labs. And there are several ways to do it.

We believe the first 10 labs got NIDA certification free -- they didn't pay a thing. The next 50 labs paid 30%, the government absorbed 70% of the cost. We ask the Committee to consider the following:

1. Certify the first 10 minority labs free, as was done for first 10 NIDA-certified labs.
2. Defer fees for the first 10 minority labs over a three-year period. Waive the fees until that firm shows some income, not a profit, but an income of $150,000. Then they would be able to set-aside payment to be able to sustain the NIDA certification. Then protect them against annual fee increases with a grandfather clause. Give them a year with the NIDA certificate, a chance to go back to those same people who said you've got to have NIDA; if those contracts begin to flow into that lab, then they'll have income to be able to pay the NIDA fees. And I would say no more than three years. If a business can't sustain itself to pay that type of fee in three years, it's not going to happen.

3. The other part of it is to review, monitor and if necessary, revise government procurement practices among those agencies exempt from NIDA. Allow them to set-aside part of those drug testing contracts to enable non-NIDA labs to compete in area of diagnostic testing. If they're exempt, then why are they making NIDA certification a requirement?

These three actions alone would end the near monopoly deep-pocketed labs have on this industry.

IV. Closing

This hearing is a symbol of hope at Accu-Lab that this administration, the leadership of this committee, will be able to look seriously at these problems and find some solutions. That's our quality of life. We all have our own private lives and our families to raise. However, we all have a commitment to the inner city and we all have a commitment to what we do. What we're seeking are solutions, support, and your help as we try to make American history and become first African-American NIDA-certified in the country, and that beacon of hope for our community.

Moreover, this hearing offers the hope that finally, we will have the opportunity to compete. Now I can't sit here and say if you stamp NIDA on my forehead today and I walked into Ryerson Steel, I would have a contract. I still have to be competitive. I still have to be able to deal with my major competitors who are profiting, **profiting** a million plus a year. The only thing that NIDA does is it just makes me eligible. I still have to sell myself, have to sell my services, I have to sell my abilities. What I don't have to sell anymore is my qualifications to do this because now the government has said I'm qualified.

It may help me enter the government maze of doing drug testing, and it will take further support from this committee to do that. I may have to call on The Chairman, I may have to call on the Hon. Cleo Fields or the Hon. John Conyers. I may have to do a lot of things. But now I'm qualified and that's the difference. That's all NIDA does -- it qualifies me.

Finally, though, what we're talking about is people's lives, their welfare, whether they're going to go forward or back up. It's cheaper for me to do a test for them, to try and get them back with their family, to try and keep them off drugs than it is for them to go out, commit a crime and now we have to pay $75 a day to incarcerate them and we still have to dry them out. The more I can do for the community, the better the community becomes. The more I get business, either private or public, the more I can do for the community. The goal is to have a balance of both. Thank you.

REMARKS OF

THE HONORABLE LOUIS STOKES
(D-OH)

BEFORE THE

HOUSE SUBCOMMITTEE ON MINORITY ENTERPRISE, FINANCE AND URBAN DEVELOPMENT

MINORITY PARTICIPATION IN THE HEALTH CARE ENTERPRISE

NOVEMBER 9, 1993

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to appear before you to discuss a very pressing national issue, "health care reform," and more specifically, minority participation in the resulting "health care industry enterprise." As the Chairman of the Congressional Black Caucus Health Braintrust, and as a member of the Appropriations Subcommittee on Labor, Health and Human Services, and Education, I would also like to take this opportunity to thank you for the cooperation and assistance you have afforded my advocacy to help bring health care to the forefront, and to help ensure minorities' fullest participation in the nation's health enterprise at all levels.

Mr. Chairman, the reform of our nation's health care system affects each and every one of us -- individually, collectively, personally and professionally. As our nation stands poised to affect major changes in the health care delivery system -- whether the legislation which gets enacted mirrors single payer or managed competition, or is some mixture thereof -- to be effective in addressing the health care needs of African Americans, it is vital that the legislation provide for the expansion, strengthening, and enhancement of the minority health enterprise.

Also crucial to the reform debate is recognition of the fact that minority health professionals have an intimate knowledge about the large segments of the African American and minority communities that have been abandoned to suffer high mortality rates; shortened life expectancy; debilitating poverty, disability and disillusionment; frustration and loss of hope. Minority health care professionals are in the trenches everyday, diagnosing, treating, serving, and counselling underserved populations across-the-country, urban as well as rural.

Mr. Chairman and members of the Subcommittee, I am sure that you would agree that having universal health insurance -- in and of itself -- does not guarantee the actual receipt of quality, comprehensive care for all Americans. As such, health care reform is a matter that Americans in general, and minorities in particular cannot afford to passively await. The cost is just too great. For the African American community, that excess cost has already translated into far too many startling statistics. Let me take a moment to share just a few of them with you.

- The infant mortality rate for African Americans is more than twice the rate for whites.

- Both cancer incidence and mortality rates are higher for African Americans than for whites.

- In 1990, the life expectancy for white males was 8.2 years longer than for African American males.

- African American children continue to be at greatest risk for vaccine-preventable infectious diseases.

- African American elderly suffer a greater prevalence of chronic conditions.

- AIDS, HIV infection, is now the 6th leading cause of death for African Americans while it is the 10th for whites.

- African Americans are two times more likely to die from a stroke than whites.

- Homicide is the number one cause of death for African American males and females ages 15 to 24.

As this data reveals, minority health is in a crisis.

Mr. Chairman, I would like to mention that the Minority Health Improvement Act of 1993 that I will introduce this week, which is the reauthorization of my original Disadvantaged Minority Health Improvement Act of 1990 bill, is designed to help address the crisis. This bill compliments health care reform.

However, what is key to addressing the health care crisis is the enactment of a comprehensive health care reform bill to ensure quality, accessible, affordable, and comprehensive health care for all Americans. What is equally crucial to alleviating the dire minority health care crisis is full participation of minorities in the health care enterprise at all levels. In fact, for African Americans and other disadvantaged minorities, health care reform is truly a matter of life and death.

It is vital that we realize that health care reform is evolving against a reported backdrop of majority population owned -- HMOs and other large health care organizations -- extracting patients from African American health care providers. This adverse situation is coupled with reportings that these HMOs and other large health care providers are refusing to accept African American physicians, dentists, and other health professionals as members of their organizations. As a result, not only are minority health care providers losing their practice at an alarmingly escalating rate, minorities' jobs in general are at stake. This situation will only ensure the continuation of the minority health care crisis.

Mr. Chairman and members of the Subcommittee, as the crisis in minority health continues, the enacted health care reform legislation must include provisions to ensure minorities a level playing field. The enacted reform legislation must include provisions to strengthen Historically Black Colleges and Universities, institutions that have graduated the majority of the nation's minority health care providers; and to ensure the viability of African American HMOs and the few remaining African American hospitals. Mr. Chairman, these are badly needed health care delivery organizations, and their very survival is threatened as the minority health care crisis continues.

With regard to health care manpower, the enacted reform legislation must include provisions to ensure an adequate supply of minority health care professionals. This includes not only minority primary care providers but specialists as well. For minorities, an emphasis on primary care alone will only exacerbate the already dire minority health care crisis.

As the minority health care crisis continues, the enacted reform legislation must include provisions that require health plans to hire minority health care providers and administrators as well.

The entrepreneurial opportunities of health care reform must not be overlooked. They include a vast array of health careers and entrepreneurial opportunities ranging from African American health plans and networks, pharmacies, testing laboratories, health information systems, medical supplies and equipment services, elderly care facilities, health promotion and marketing services, and education outreach services. These are just a cross section of the many other health related career opportunities.

To level the playing field in an effort to ensure that these and similar entrepreneurial opportunities become business realities for minorities, there must be built-in protections for minorities on a "set aside " basis.

Equally important, as the minority health crisis remains, the enacted reform legislation must not allow malpractice to be disguised as discrimination. Additionally, the enacted legislation must include provisions to ensure minority consumers and health care providers -- active involvement at all levels of regional alliances as well as the national boards, commissions, and councils.

So, Mr. Chairman and members of the Subcommittee, as our nation further embarks upon health care reform, minority

involvement will become ever more crucial. The solutions to health care reform are complex, but they are not impossible. The challenge is ours, for health care is not a right for some Americans, it is a right for all Americans.

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Testimony for the Record:

Mr. Pernell J. Williams, President
District Healthcare and Janitorial Supply, Inc.
3152 Bladensburg Road, N.E.
Washington, D.C.

November 9, 1993
Impact of Health Care Reform on Minority Businesses

Committee on Small Business
Subcommittee on Minority Enterprise,
Finance and Urban Development
United States House of Representatives

Mr. Chairman and Members of the Subcommittee

I am Pernell J. Williams, founder and President of District Healthcare and Janitorial Supply, Inc. (DHC) of Washington, D.C. I am pleased to have this opportunity to present testimony with respect to the impact of health care reform on minority businesses relative to current and future business opportunities with the Department of Health and Human Services (HHS). I wish to thank Representative Mfume and his staff for allowing my testimony to be submitted to the record.

District Healthcare and Janitorial Supply, Inc. is a 8(a) certified African-American small business in the medical supply distribution industry. Since 1985, we have serviced local government hospitals in the metropolitan area.

I have discussed with Mr. Verl Zanders, of HHS, on numerous occasions improprieties on procurement procedures at the National Institute of Health (N.I.H.) for small purchases under $10,000 without any remedial action on the following:

1. Continuous awards to certain medical suppliers for repeat procurement without rotation for those particular supplies being routinely purchased.

2. Minority small business given no preference as "historically disadvantaged status" when N.I.H. continues to award bids up to $10,000 to majority small businesses that have up to 500 employees and are "self certified being a small business" utilizing "good ole boy networks".

3. Percentage given of 13% minority business utilization are questionable considering only a handful of selected "self certified minority firms" get majority of business shown in this report to inflate and mislead exactly how many different minorities contribute to this 13% data.

4. No documentation on 8(a) medical supplier contracts utilizing small and minority small manufacturers are available. **Not one single 8(a) medical supply contract** awarded in the past 5 years without any projected forecast for future 8(a) medical supplier contracts.

Recommendations:

1. Once a small business or minority small business is repeatedly awarded a particular contracts, mandatory rotation of that business after three (3) awards to provide competitive mix.

2. Establish set-aside preference to small minority businesses and integrate as part of contracting officer and agency's performance review to utilize **local certified** minority small businesses.

3. Utilize local certification from local and federal government agencies (i.e. MD, DC, VA certifications along with 8(a) certified firms) to deter false "self certifications" of small businesses and minority business status. Document number of firms that constitute the 13% to clarify using only a few "self certified" firms having a overwhelming majority of the minority small business pie.

4. Project real dollars to be spent with 8(a) firms in the medical supply distribution industry. Make awards with preference to local 8(a) certified medical suppliers. Provided documentation on 8(a) contracts awarded (if any). We know how to do business with HHS through contacts - now we need contracts.

5. Promote local certified small and minority small business in the medical supply industry to stimulate the local economy within each agency in partnership with the local minority trade small business associations.

In summary, statistics show small businesses are dominant in creating new jobs. It is necessary that small business is not hurt while implementing new procurement policies as well as looking at and changing old procurement policies. As a local minority small business, we employ minorities who would otherwise not have jobs, provide scholarships to minority youth to encourage not discourage productivity.

Small and minority businesses and particularly African-American small businesses are vital to reducing local unemployment and crime, while stimulating economic growth that not only will benefit Washington, D.C. but the entire nation. At this point, I believe Congress is the only hope for minority small business to generate fairness, trust and confidence throughout all agencies within the federal procurement system.

THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON D C 20201

DEC 7 1993

The Honorable Kweisi Mfume
Chairman
Subcommittee on Minority Enterprise,
Finance and Urban Development
568-A Ford House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

First and foremost, please accept my apologies for the delay in responding back to the Committee with the requested information that resulted from HHS' recent testimony before the Committee.

Under Enclosure #1, copies of the "Model Subcontracting Plan" and Enclosure #2, the optional subcontracting plan Review Form are provided for your information. The "Model Subcontracting Plan" has been designed to be consistent with the Federal Acquisition Regulations (FAR), however, other formats of a subcontracting plan may also be accepted. All of the essential information necessary to meet the criteria of the FAR have been incorporated. The optional subcontracting plan Review Form incorporates a check-off format for the review of the elements in order to determine an acceptable subcontracting plan. Additionally, this Review Form reflects a single record of the review recommendations/comments of the Contracting Officer, the Small Business Specialist, and the SBA Procurement Center Representative.

There were several questions raised during the testimony of Mr. Warren O. Cooper, President, ACCU-Lab Medical Testing, before the Committee referencing ability of a small and/or minority-owned business to enter into the drug testing arena and to become and remain certified as an approved testing laboratory. These issues and related discussion are as follows:

ISSUE: In order to be a viable competitor in the drug testing industry, ACCU-Lab is required to meet National Institute on Drug Abuse (NIDA) (currently the Substance Abuse and Mental Health Services Administration (SAMHSA) certification standards.

RESPONSE:

The National Laboratory Certification Program (NLCP) was developed to implement "The Mandatory Guidelines For Federal Workplace Drug Testing Programs," adopted in April 1988. The NLCP which established the scientific and technical guidelines

for Federal drug-testing programs. These guidelines detail comprehensive standards for laboratory procedures, specify drugs for which Federal employees can be tested, and establish appropriate standards and procedures for periodic review of laboratories, and the criteria for certification and revocation of certification of laboratories engaged in urine drug testing for Federal agencies. Under the NLCP, SAMHSA has a contract with Research Triangle Institute (RTI) to certify laboratories for Federal drug testing.

In addition, the requirement for certification under the NLCP has been adopted by the U.S. Department of Transportation and the Nuclear Regulatory Commission for the federally regulated industries of transportation and nuclear power. Various levels of government and other non-Federal organizations have also accepted the NIDA/SAMHSA certification standards for use in their own programs. Therefore, what began as a Federal standard for testing of Federal employees has been expanded by practice--not by Federal practice--to performing drug testing for other organizations.

ISSUE: During the initial phase of the Federal drug testing program, the Federal Government subsidized part of the costs of obtaining certification. Today, the costs of obtaining and maintaining certification effectively preclude entry into the market by new companies, particularly small disadvantaged businesses.

RESPONSE:

At the time of the initiation of the NLCP, an insufficient number of laboratories were available to perform the necessary drug testing in accordance with Federal standards within the time required to implement the Executive Order. In an effort to stimulate interest by testing laboratories, NIDA waived 70 percent of the fees associated with initial performance testing (PT) and on-site inspections requirements for the first 50 laboratories to request certification. The availability of the NIDA waiver was advertised in the Commerce Business Daily in 1988, and in scientific journals, newswire services, and through direct mail. There was an overwhelming response to these announcements, and a total of 94 applications were returned to RTI. These applications were subsequently reviewed by RTI, and the application, and other fees, for the first 50 laboratories were waived. After completing the various testing cycles and on-site inspections, 37 of the first 50 laboratories were awarded certification. Even these laboratories, however, have had to pay all costs associated with maintaining their certification annually.

Since that initial effort at certification, the NIDA program has been continued with subsequent testing contracts awarded to RTI. There are now approximately 92 laboratories certified under this program, with a number of other laboratories in the process of obtaining certification. Currently, laboratories are evaluated based on their technical competence alone; the only prerequisite to application and consideration of certification is the payment of the necessary fees. Once certified, laboratories are inspected on a periodic basis to ensure continued adherence by the standards. The cost of these inspections is borne solely by the laboratories. Because there is currently an adequate number of certified laboratories capable of meeting testing requirements for Federal employees, SAMHSA is not actively soliciting new testing facilities. Laboratories do continue to apply for certification by NIDA because the NLCP standards have become the accepted standard for forensic drug testing.

The costs associated with applying for, achieving, and maintaining certification have increased only slightly since the program's inception. The increases are due mainly to increased travel costs, inspection fees, and certain other administrative costs. However, for a firm trying to enter the industry a significant cash outlay is required in the first year including an initial application fee of $750, an initial certification fee of $16,010 and annual certification fees totaling $27,750.

ISSUE: There is no requirement in the NIDA/SAMHSA certification program to set-aside a portion of the contracting/subcontracting opportunities for participation by minority business enterprises. Further, Federal agencies/activities specifically exempted from coverage by the Executive order, but which have otherwise adopted the NIDA/SAMHSA standard, are bypassing the set-aside requirements.

RESPONSE:

As indicated, the NLCP has been primarily concerned with the technical qualifications of the laboratories and has not sought to influence the representation of small and small disadvantaged businesses in the pool of certified laboratories. Currently, SAMHSA has no reliable statistics regarding the size or business status of the laboratories receiving certification.

HHS will work with the Public Health Service to develop a comprehensive methodology to determine the constraints--including financial--which may contribute to the lack of participation by small and small disadvantaged businesses. If this effort proves that small and small disadvantaged businesses are

underrepresented as a result of impediments created by the NLCP, HHS will consider ways to modify the certification process to insure increased participation by such organizations. Additionally, if the proposed effort identifies the primary impediment to be financial, HHS will work collaboratively with NLCP and other federal agencies such as the Small Business Administration, to identify possible remedies such as subsidies or exemption from the fees.

We will also work with the exempted agencies and programs to evaluate the appropriateness of their using minority-owned laboratories.

We will advise your office of the results of our efforts. If you have additional questions or comments, or require additional information, please feel free to contact me or Verl Zanders, Director, Office of Small and Disadvantaged Business Utilization, on (202) 690-7300.

Sincerely,

Walter D. Broadnax

Enclosures

Enclosure 1

1

SMALL BUSINESS AND SMALL DISADVANTAGED BUSINESS

MODEL SUBCONTRACTING PLAN OUTLINE *

Identification Data

Contractor: _____

Address: _____

_____

Solicitation or Contract Number: _____

Item/Service: _____

Total Amount of Contract (Including Options) $_____

Period of Contract Performance (DAY, MO. & YR.) _____

* *Federal Acquisition Regulation (FAR), paragraph 19.708(b) prescribes the use of the clause at FAR 52.219-9 entitled "Small Business and Small Disadvantaged Business Subcontracting Plan." The following is a suggested model for use when formulating such subcontracting plan. While this model plan has been designed to be consistent with FAR 52.219-9, other formats of a subcontracting plan may be acceptable. However, failure to include the essential information as exemplified in this model may be cause for either a delay in acceptance or the rejection of a bid or offer where the clause is applicable. Further, the use of this model is not intended to waive other requirements that may be applicable under FAR 52.219-9.*

1. Type of Plan (Check One)

_____ Individual plan (All elements developed specifically for this contract and applicable for the full term of this contract).

_____ Master plan (Goals developed for this contract; all other elements standard; must be renewed annually).

_____ Commercial products plan (Contractor sells large quantities of off-the-shelf commodities to many Government agencies. Plans/goals negotiated by a lead agency on a company-wide basis rather than for individual contracts. Plan effective only during year approved. Contractor must provide copy of lead agency approval).

2. Goals

State separate dollar and percentage goals for small business concerns and small disadvantaged business concerns as subcontractors, for the basic and each option year, as specified in FAR 19.704.

A. Total estimated dollar value of all planned subcontracting, i.e., with all types of concerns under this contract, is $_____.

B. Total estimated dollar value and percent of planned subcontracting with small businesses (includes small disadvantaged businesses): **(% of "A")**

$_____ and _____ %

C. Total estimated dollar value and percent of planned subcontracting with small disadvantaged businesses: **(% of "A")**

$_____ and _____%.

D. Total estimated dollar value and percent of planned subcontracting with **OTHER THAN SMALL BUSINESSES: (% of "A")**

$_____and_____%.

E. Provide a description of all the products and/or services to be subcontracted under this contract, and indicate the types of businesses supplying them: (i.e., OTHER THAN SMALL BUSINESSES (OTHER), SMALL BUSINESS (SB), SMALL DISADVANTAGED BUSINESS (SDB))

Subcontracted Product/Service	(check all that apply) OTHER	SB	SDB

(Attach additional sheets if necessary.)

F. A description of the method used to develop the subcontracting goals for small and small disadvantaged business concerns (i.e., explain the method and state the quantitative basis (in dollars) used to establish the percentage goals, in addition, how the areas to be subcontracted to small and small disadvantaged business concerns were determined, and how the capabilities of small and small disadvantaged businesses were determined --include any source lists used in the determination process).

_____

_____

_____

_____

_____

G. Indirect costs have been _____have not been ___included in the dollar and percentage subcontracting goals stated above. (check one)

H. If indirect costs have been included, explain the method used to determine the proportionate share of such costs to be allocated as subcontracts to small business and small disadvantaged business concerns.

_____

_____

_____

_____

_____

_____

_____

3. Program Administrator

Name, title, position within the corporate structure, and duties and responsibilities of the employee who will administer the contractor's subcontracting program.

Name: _____

Title: _____

Address: _____

_____

Telephone: _____

Duties: Has general overall responsibility for the contractor's subcontracting program, i.e., developing, preparing, and executing individual subcontracting plans and monitoring performance relative to the requirements of this particular plan. These duties include, but are not limited to, the following activities:

A. Developing and promoting company-wide policy initiatives that demonstrate the company's support for awarding contracts and subcontracts to small and small disadvantaged business concerns; and assure that small and small disadvantaged businesses are included on the

source lists for solicitations for products and service they are capable of providing;

B. Developing and maintaining bidder's lists of small and small disadvantaged business concerns from all possible sources;

C. Ensuring periodic rotation of potential subcontractors on bidder's lists;

D. Ensuring that procurement "packages" are designed to permit the maximum possible participation of small and small disadvantaged businesses;

E. Make arrangements for the utilization of various sources for the identification of small and small disadvantaged businesses such as the SBA's Procurement Automated Source System (PASS), the National Minority Purchasing Council Vendor Information Service, the Office of Minority Business Data Center in the Department of Commerce, and the facilities of local small business and minority associations, and contact with Federal agency's Small and Disadvantaged Business Utilization Specialist (SADBUS).

F. Overseeing the establishment and maintenance of contract and subcontract award records;

G. Attending or arranging for the attendance of company counselors at Business Opportunity Workshops, Minority Business Enterprise Seminars, Trade Fairs, Procurement Conferences, etc;

H. Ensure small and small disadvantaged business concerns are made aware of subcontracting opportunities and how to prepare responsive bids to the company;

I. Conducting or arranging for the conduct of training for purchasing personnel regarding the intent and impact of Public Law 95-507 on purchasing

J. Monitoring the company's performance and making any adjustments necessary to achieve the subcontract plan goals;

K. Preparing, and submitting timely, required subcontract reports;

L. Coordinating the company's activities during the conduct of compliance reviews by Federal agencies; and,

M. Other duties _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Equitable Opportunity

Describe efforts the offeror will make to ensure that small and small disadvantaged business concerns will have an equitable opportunity to compete for subcontracts. These efforts include, but are not limited to, the following activities:

A. Outreach efforts to obtain sources:

1. Contacting minority and small business trade associations;

2. Contacting business development organizations;

3. Attending small and minority business procurement conferences and trade fairs; and

4. Requesting sources from the Small Business Administration's Procurement Automated Source System (PASS).

5. Newspaper, magazine ads which encourage new sources

B. Internal efforts to guide and encourage purchasing personnel:

1. Presenting workshops, seminars, and training programs;

2. Establishing, maintaining, and using small and small disadvantaged business source lists, guides, and other data for soliciting subcontracts; and

3. Monitoring activities to evaluate compliance with the subcontracting plan.

C. Additional efforts:_____

_____

_____

_____

_____

_____

_____

5. Flow-Down Clause

The contractor agrees to include the provisions under FAR 52.219-8, "Utilization of Small Business Concerns and Small Disadvantaged Business Concerns", in all subcontracts that offer further subcontracting opportunities. All subcontractors, except small business concerns, that receive subcontracts in excess of $500,000 ($1,000,000 for construction) must adopt and comply with a plan similar to the plan required by FAR 52.219-9, "Small Business and Small Disadvantaged Business Subcontracting Plan." (FAR 19.704 (a)(4)).

6. Reporting and Cooperation

The contractor gives assurance of (1) cooperation in any studies or surveys that may be required; (2) submission of periodic reports which show compliance with the subcontracting plan; (3) submission of Standard Form (SF) 294, "Subcontracting Report for Individual Contracts, "and SF-295, "Summary Subcontract Report," in accordance with the instructions on the forms; and (4) ensuring that subcontractors agree to submit Standard Forms 294 and 295.

Reporting Period	Report Due	Due Date
Oct 1 - Mar 30	SF-294	04/30
Apr 1 - Sep 30	SF-294	10/30
Oct 1 - Sep 30	SF-295	10/30

ADDRESSES

(a) SF-294 to be submitted to cognizant Contracting Officer

(b) SF-295 to be submitted to:

Office of Small and Disadvantaged Business Utilization
Department of Health and Human Services
200 Independence Avenue, SW
Humphrey Building, Room 517-D
Washington, D.C. 20201

7. Recordkeeping

The following is a recitation of the types of records the contractor will maintain to demonstrate the procedures adopted to comply with the requirements and goals in the subcontracting plan. These records will include, but not be limited to, the following:

A. Small and small disadvantaged business concerns source lists, guides, and other data identifying such vendors;

B. Organizations contacted in an attempt to locate small and small disadvantaged business sources;

C. On a contract-by-contract basis, records on all subcontract solicitations over $100,000 which indicate for each solicitation (1) whether small business concerns were solicited, and if not, why

not; (2) whether small disadvantaged business concerns were solicited, and if not, why not; and (3) reason for the failure of solicited small or small disadvantaged business concerns to receive the subcontract award;

D. Records to support other outreach efforts, e.g., contacts with minority and small business trade associations, attendance at small and minority business procurement conferences and trade fairs;

E. Records to support internal guidance and encouragement provided to buyers through (1) workshops, seminars, training programs, incentive awards; and (2) monitoring of activities to evaluate compliance; and

F. On a contract-by-contract basis, records to support subcontract award data including the name, address and business size of each subcontractor. (This item is not required for company or division-wide commercial products plans.)

G. Additional records:_____

_____

_____

_____

_____

This subcontracting plan was submitted by:

Signature:_____

Typed Name:_____

Title:_____

Date Prepared:_____

Phone No.: _____

Enclosure 2

SUBCONTRACTING PLAN REVIEW

ORIGINAL SUBMISSION [ ] DATE: _____
REVISED SUBMISSION # [ ] DATE: _____

Part A – General Information:

1. RFP or Contract Number	2. Title of Requirement		
4. Contractor's Name	5. Contractor's Address	6. Period of Performance (Base & Options)	
7. Contract $ Amount (Base)	Option #1	Option #2	Option #3
8. Contracting Officer		9. Date Received by SADBUS for Review	

Part B – Plan Requirements:

	CO		SADBUS		SBA/PCR	
	A	U	A	U	A	U
1. Subcontracting Goal Data: a. Total Subcontracting Dollars and Percentages						
b. Total Subcontracting with Small Business and Percentages – Percent of 1a.						
c. Total Subcontracting with Small Disadvantaged Business and Percentages – Percent of 1a.						
d. Total Subcontracting with Other than Small Business and Percentages – Percent of 1a.						
2. a. Subcontracting Opportunities (Description of a list of all principal products/services to be subcontracted to all types of concerns) COMMENTS:						
b. Methodolgy used to Develop Goals (e.g., historical trends, information on technical and competitive bidding, formula for calculating the goals, etc.) COMMENTS:						
3. Subcontracting Plan Administrator's Name and Duties COMMENTS:						
4. Description of Efforts to Ensure Small Business and Small Disadvantaged Business Equitable Opportunity to Compete for Subcontracts COMMENTS:						

SUBCONTRACTING PLAN REVIEW

Part B – Plan Requirements – Continued

	CO		SADBUS		SBA/PCR	
	A	U	A	U	A	U
5. Required Flow–Down Clause to be Included in Prime Contractor's Subcontracts COMMENTS:						
6. Reports and Records: a. Agreement to submit required reports COMMENTS:						
b. Agreement to cooperate in studies, surveys, etc., conducted by the ACO, PCO, SBA and others COMMENTS:						

Part C – CO Determination -- SADBUS and SBA Recommendations:

	CO		SADBUS		SBA/PCR	
	YES	NO	YES	NO	YES	NO
1. The Proposed Plan meets the requirements of FAR 19.708(b)						
2. The Proposed Plan requires an additional pre–award review						

ADDITIONAL COMMENTS:

CO _____ Date _____ SADBUS _____ Date _____ SBA/PCR _____ Date _____

*NOTE: A = Acceptable U = Unacceptable

REMINDER: Final subcontracting plans should be distributed in accordance with FAR 19.705–6 and other supplemental agency regulations/directives; i.e., DHHS OSDBU, Agency SADBUS and SBA/PCR

"IS HEALTH CARE REFORM HEALTHY FOR MINORITY ENTERPRISES"

COMMENTS BY:

Rudolph A. Coleman
President and CEO

In spite of numerous public policies of remediation, the asymmetrical patterns which characterize minority groups in American society continue to prevail. Indeed, the data are so familiar that its citation constitutes the repetitive. Minority groups are disproportionately represented amongst the unemployed, the impoverished, and the socially disadvantaged. And, given the intimate linkages between the socio-economic and the etiological, it is not surprising that morbidity and mortality rates are also higher for minority populations.

Accordingly, the minority community necessarily applauds any effort to reduce health costs and simultaneously enhance accessibility to health care for minority as well as majority Americans. However, the outcomes associated with various policies often embody unanticipated outcomes and unintended effects. Thus, it becomes important to assess the impact of the proposed health reform upon minority populations.

Such a discussion is, however, implicitly bifurcated. On the one hand, one must assess how the various proposals will affect minority populations' demand for health care. However, an equally important but less overt consideration is the potential impact of health reform upon minority enterprises in general, and African American enterprises in particular. The comments herein address the latter, rather that the former, issue. It is important to disaggregate the potential impact and examine African American businesses because African Americans businesses are losing ground amongst minority businesses[1]. From 1982 to 1987, for example, African American businesses dropped from 40% to 35% of all minority businesses. Similarly, African American businesses receipts dropped from 27% to 25% of all minority receipts[2].

When African Americans firms are separately profiled, it becomes clear that less than 3% of all firms or 424,165 firms, are African American. Approximately 47% of these firms gross $5,000 or less in sales receipts, 80% earn $25,000 or less, and a mere 1/2 of 1% gross $1 million or more[3]. Nearly, half of all African American firms are in services (209,547) and 30,026 or 14.3% are in health services[4]. It is this segment of minority firms which are the subject of this discussion. These health firms are distributed across a number of SIC codes[5].

The health care industry has a number of important characteristics. First entry and exit is somewhat restricted. Educational requirements, legal rules and regulations, licensure requirements, and in some cases, the costs associated with medical technology, as well as other factors comprise significant barriers to entry. Second, because health care is a service, the quality of its delivery cannot be objectively appraised. Accordingly, health care providers, health managers, etc. from African American business enterprises are more likely to be subject to bias and subjectivity in the appraisal of performance because of their historicity. Third, the administrative and organizational apparatus for entry into the market includes significant gatekeepers with the power to skew the decision-making process away from African American and other minorities. Fourth, because African Americans health care firms are small, their costs may be higher because they are below the minimum efficient size. Thus, the higher cost structure may lead to lower survival rates. Taken together then, African American health firms exist within a market structure which

represents a constant challenge to their survival. Will the proposed health reform package exacerbate these already threatening conditions and/or create new opportunities?

Health Management Resources, Inc. (HMR) feels that there are a number of elements in the proposed health reform package which may, without additional safeguards, have adverse consequences for African American firms. These areas can be briefly summarized.

First, HMR applauds the fact that the Health Security Act does fund an annual Health Profession Workforce Account. In particular, this program includes a special provision to extend training to minorities and disadvantaged persons in the areas of medicine, osteopathy, dentistry, nursing, public health etc. It also includes special programs to retrain some categories of workers through the Department of Labor. However, the statues do not include measures to ensure that minority business enterprises are included in the solicitation and selection process for firms to deliver such services.

Second, the health reform proposals are platformed upon a managed care model of service delivery. Simultaneously, it includes special provisions for training health care professionals and administrators in managed care. However, the managed care model has developed in isolation from most minority firms and minority health care professionals. Thus, measures are needed to promote the acceptance of managed care amongst African American health service enterprises and to train then to integrate themselves into this model.

Third, and of, perhaps, the greatest concern to HMR, the Health Security Act introduces a complex administrative mechanism for the execution of its mandates. The regional Alliances, the National Health Board, etc., all constitute new gatekeepers in the criteria. The administrators may be able to screen out African American enterprises from procurement activities. As currently written, the Act provides no new guidelines for the affirmative inclusion of minority firms.

Fourth, while there are approximately nine African American managed care organizations, more African American managed care firms are needed to ensure equity in the new health care climate. However, the $500,000 minimum capital requirement may comprise a barrier to entry. Additionally, if such firms service high risk patients, even the subsidy for special populations and patients/mix based capitation rates may not offset the risks implicit to their unique clientele. Thus, African American managed care organizations may encounter special problems in formation and continuation. Again the current law does not include sufficient safeguards in this regard.

Concluding Remarks

Health Management Resources, Inc., fully recognizes and supports the President's bold and pioneer efforts. The comments herein are designed to ensure that the expected outcomes are equitable as well as efficient.

[1]U.S. Department of Commerce, survey of Minority Owned Business Enterprises: Series MB87-4 Summary: 1987, pg. 6.

[2]ibid, pg. 6

[3]ibid, pg. 17

[4]ibid, pg. 2

[5]ibid,

MSA

Medical Service Agency, Inc.

• MAILING ADDRESS
20 ERFORD ROAD
LEMOYNE, PA 17043

• (717) 761-5266
Fax (717) 761-6213

WRITTEN TESTIMONY

of

Dr. David L. Dalton
President and CEO
MEDNET[SM]
a minority owned prescription drug benefit provider and administrator
Lemoyne, Pennsylvania

Submitted to the U.S. House of Representatives Committee on Small Business
Sub-Committee on Minority Enterprise, Finance, and Urban Development
Representative Kweisi Mfume, Chairman

Submitted November 18, 1993

Mr. Chairman, I am submitting this written testimony for the record to address the problems MEDNET has encountered as a minority owned and operated prescription drug benefit provider.

I would like to begin with the background of the company. Since its inception in 1987, MEDNET[SM] has earned national recognition as a prescription drug benefit provider and administrator specializing in formulary development, flexible plan design with aggressive cost containment features and state-of-the-art, on-line claims processing and adjudication. The fundamental strength of the MEDNET program is the active involvement of all elements of the pharmacy community, including academic and clinical pharmacists, over 45,000 independent and chain retail pharmacies, mail-order options, and drug manufacturers. This

combined effort results in aggressive management programs. We also provide a Consumer Prescription Drug Card Program for individuals who have no prescription coverage or whose drugs are covered under the major medical portion of their health insurance. MEDNET is managed and directed by individuals with over 80 years of pharmacy experience and solid financial credentials.

In your letter, you encouraged us to provide our views on the problems hindering minority owned business from winning public and private contracts as well as suggestions as to how minority businesses can be given fair and equitable treatment under the proposed health care reform. Our views on problems hindering minority owned businesses include:

- Decline of African-American participation in the health care and pharmaceutical industries;
- Compliance with Public Law 95-507;
- No standard set-aside program across all Federal agencies;
- Lack of minority participation in developing Affirmative Action programs;
- Artificial barriers within procurement practices;
- Sole-source or Prime Vendor program is exclusionary to minority vendors.

Let me now amplify these various views. First, as you may know, less than 1% of all health care providers are African-American. African physicians and dentists have been forced to care for the very ill, indigent population with access to minimum resources. There are no African-American pharmaceutical companies. Only one African-American pharmacy

administrator that is continually fighting for equal access. African-American hospitals have declined to only six (6) and there are seven (7) African-American HMOs in the nation.

These statistics documented by others continue to verify that African-American participation in the health care system is effectively non-existent. Therefore, it is clear that a level playing field must be created to permit development, training and bidding opportunities to occur.

With regard to compliance of Public Law 95-507 and other federal laws governing access for small, socio-economically disadvantaged businesses in the competitive subcontracting bidding process, I recommend enforcement with serious penalties through a central compliance monitoring system reporting to a minority oversight administrater possibly within the Equal Opportunity Commission staff. An example of inconsistency among federal laws is clear in the following scenario: the federal law governing the Federal Employees Health Benefits (FEHB) Program exempts contracts with health benefits carriers from the competitive bidding requirements applicable to other government contracts.

As to the problem of set-aside programs, it is my view African-American and other minority providers need additional equal access which would mirror Public Law 99-661, the Department of Defense Contracting Goal. Public Law 95-507 should be amended to specifically legislate the utilization of African-American or other minority disadvantaged businesses into government contracts.

Next in the area of Affirmative Action, MEDNET agrees with the National Medical Association's recommendation that health care reform legislation requires health plans to hire and contract appropriately and equitably, minority health provider. A study by the National Minority Health Association found no African-American corporate officers in majority controlled managed care entities.

A major problem for African-American business is the "artificial" barriers found within the procurement system such as the perpetuation of the "good old boys" network and sole-source provider vendor programs. A solution to this problem could be to strengthen the role of the Office of Small and Disadvantaged Business Utilization (OSDBU) by providing responsibility for establishing procurement programs to ensure and increase minority participation. Enhance the OSDBU's role of recruiting minority owned businesses for maximizing sub-contracting opportunities.

Last, but not least, is the Prime Vendor and Sole Source providers programs within various federal agencies eliminates participation of African-American and other minority suppliers including small purchases under $25,000.00. Not only does this close the door of opportunity, it prevents new firms from being considered as prospective prime contractors. This happens because prime vendor programs have released the obligation to use minority owned businesses from federal agencies. Most put the responsibility to meet the socio-economic requirements of Public Law 95-507 on the contractor.

As this related to health care reform and its Regional Health Care Alliances, there must be adequate provisions for minority providers to compete at all levels of the Alliance.

In conclusion, I want to thank the Committee for allowing MEDNET to respond to your request to focus on minority enterprise participation in the health care industry. We stand ready to continue to work with the Committee to support ways to ensure minority participation in the delivery of health care services.

STATEMENT OF BRUCE RAFFEL
VICE PRESIDENT
RAFFEL HEALTHCARE GROUP, INC.
BALTIMORE, MARYLAND
BEFORE THE SMALL BUSINESS COMMITTEE
SUBCOMMITTEE ON MINORITY BUSINESS OPPORTUNITY
U.S. HOUSE OF REPRESENTATIVES
NOVEMBER 9, 1993

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting our company to testify before the Subcommittee on the important issue of health care reform, and in particular the impact it may have on minority owned businesses. President Clinton has proposed comprehensive legislation which attempts to take on the dual problems of our health care system, the lack of access of too many to health care and the steadily increasing costs to individuals and employers of providing access to that system.

In 1975 my mother founded our firm, which today ranks as the third largest woman-owned firm in the Baltimore Metropolitan area, as well as the seventh largest minority categorized firm, according to the State data. Our business is the operation of nursing homes. We now own and operate three nursing homes, two in the City of Baltimore and one in Baltimore County, caring for almost 600 patients and employing approximately 525 staff members. We are proud of the quality service we offer. Our company was the first and still one of the few long term care facilities in Maryland to accept HIV positive patients. We serve a diverse population group, with patients from the inner city as well as the suburbs and more rural areas. We naturally have an interest in reforms which will further access of individuals to long term care.

But perhaps even more important to us is the immediate impact this series of reforms will have on our own employees and the way we operate our business. Almost since the founding of our company we have offered comprehensive and affordable health care access to our employees. Over the years we have continued to refine our health care program, as the interest of our employees evolved and as our costs changed. Within the past decade we have utilized nearly every form of health coverage, from traditional indemnity insurance to PPO's and HMO's. We presently self fund our plan, offering our employees fully paid individual coverage for a generous benefit package. Family and dependent coverage is also available with an employee contribution.

As we have read about the Clinton proposal, we have a very real concern that the structure of the program will not permit us to continue this effective and flexible coverage which we are able to provide our employees. This is because we would have to join a regional health alliance in order to purchase coverage from a third party. We would not be able to retain our present coverage because our firm is not large enough to opt out of the plan by meeting the threshold test of 5,000 employees, which the President proposes for obviously big business. We are confident that our benefits package already

meets and exceeds any governmentally mandated standard. Our package offers the same coverage from a starting level position to the President of the company. We can afford such benefits because we can manage our own plan effectively. Being tossed into the health alliances disturbs us because it will remove any opportunity for the employer to manage and fine tune the benefits his employees want.

Let me provide an example. Our employees are typically women, mostly nurses and nurses assistants. Family planning is a concern for many employees. Under previous insurance plans, the insurance carrier or HMO usually provided coverage only for a specific method of birth control, prescription drugs. When we changed to a self funded plan, whose coverage details we were able to design, we responded to the interest of several employees by ensuring that Norplant and other non-medication options were available to our employees and their families. This decision was not driven by cost or regulation, but simply by our interest in being responsive to our employees, and actually caring about their health needs.

When we changed from purchase of coverage to a self funded plan, our costs immediately were reduced by more than 20 percent. This reduction in costs was primarily attributable to cutting out layers of bureaucracy and middlemen, and dealing directly with our employees and their health care providers. We are now offering our employees annual flu shots for half of our costs of acquiring the vaccine. We offer as part of our coverage HIV screening; insurance experts tell us this benefit is not typically

available. In fact, our coverage is more comprehensive now than it was under older plans, even though our costs are less. One major reason is that we stress preventative health care. Our plan is regulated through ERISA, and we carry stop loss coverage to financially protect the plan in the case of very large claims.

But the important point is not simply that the employer has been able to save money with self funded plans, but that we have been able to take those savings and use them for additional employee health benefits which we could not previously afford. We have established a stop smoking program, and a comprehensive employee assistance program for alcohol or substance abuse issues. This is very unusual for a small company.

In summary, we stopped dealing with large insurance companies and HMO's, because their bureaucracy was inflexible, their coverage was not comprehensive and their costs were high. Our self funded plan has allowed us to expand coverage and control our costs.

One argument that we know has been made against our type of system is that it would allow companies with "healthy" employees to go off on their own, leaving the alliance plans to receive only the higher medical risk consumers. This makes no sense to us. Our own company has an employee profile that many insurance brokers have advised us is "high risk," urban and female in health care professions. With our large workforce we have the usual variety of health problems, from minor to catastrophic and long term. But we are offering our employees and their families very comprehensive

coverage at a cost affordable to our company, precisely because we have gone around these insurance experts and their bureaucracies. If some system of "risk adjustment" were imposed on plans which are not part of the central health alliances, it would probably benefit us, given the population we cover under our self funded plan.

OPPORTUNITIES FOR MINORITY BUSINESS

The key to our success is our ability to provide quality and cost effective service to our patients, with a motivated workforce. Long term care is a labor intensive business. Hiring, training and retaining quality employees is an essential part of our efforts. Providing those employees with comprehensive and generous benefits is a constant goal. In this we are no different than most businesses, including most minority businesses. This is why we are gravely concerned about the proposals for exclusive health alliances, which most employers would have to join. Forcing such action will eliminate the ability of the employer to structure and manage health care costs. We do not need a large state-run health alliance bureaucracy taking over for the large insurance companies. Because of our positive experience with self funding, we have learned that our employees are most satisfied with their health care coverage when it is most directly under their control. Our own self funded plan allows that employee input. Eliminating that possibility in the name of health reform would be a step backward for our employees and their families.

We can better achieve the objectives set forth by the President -- including choice, universal coverage and portability -- through reforms in the marketplace, not elimination of the marketplace.

We ask the members of this Subcommittee, as well as other members of Congress to support voluntary Health Alliances, keeping the option of employers to self-insure.

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